DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1525

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00023

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245269**

2.STATE VENDOR OR MEDICAID NO.
(L2) **686240300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **1115 4TH AVENUE NORTH**
(L5) **SAUK RAPIDS, MN** (L6) **56379**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **162** (L18)

13.Total Certified Beds **162** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	162			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Judy Loecken, Unit Supervisor 01/06/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/06/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 6, 2022

CMS Certification Number (CCN): 245269

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 20, 2021 the above facility is certified for:

162 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 162 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 6, 2022

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: CCN: 245269
Cycle Start Date: November 4, 2021

Dear Administrator:

On December 21, 2021, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On December 28, 2021 the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 20, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 22, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 22, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 22, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 20, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1525

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(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **1115 4TH AVENUE NORTH**
(L5) **SAUK RAPIDS, MN** (L6) **56379**

4. TYPE OF ACTION: **2** (L8)

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3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/04/2021** (L34)

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2 AOA 3 Other

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	162			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord HFE - NE II 12/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/31/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 22, 2021

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: CCN: 245269
Cycle Start Date: November 4, 2021

Dear Administrator:

On November 4, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 22, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 22, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 22, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 22, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Shepherd Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 22, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 4, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine

that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	**1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/01/21-11/04/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health (MDH). The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/01/21-11/04/21, a standard recertification survey was conducted at your facility by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health (MDH). A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5269083C (MN75877) however NO deficiencies were cited. The following complaints were found to be UNSUBSTANTIATED: H5269082C (MN76555) however related deficiencies were cited at F641. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/01/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		12/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse, and neglect were reported to the State Agency (SA) for 1 of 2 (R85) residents allegations were reviewed. Findings include: R85's annual Minimum Data Set (MDS) dated 7/16/21, indicated R85's diagnoses included cerebrovascular accident (CVA) with right sided weakness, heart failure, diabetes mellitus, and vascular dementia. R85's annual MDS dated 7/16/21, indicated R85 had a severe cognitive impairment. R85 needed extensive assistance of two with activities of daily living (ADL's) and had no behaviors. A facility incident form dated 10/27/21, at 3:50 p.m. indicated R85 had a fall from a full body mechanical lift while two staff were transferring R85 from bed to the wheelchair. R85 was lowered to the floor and staff proceeded to notify nursing. The incident form stated R85 was lying on his back with his head laying on the left leg of the full body mechanical lift. R85's left leg was straight upward with his foot still in the full body mechanical lift. R85 had a good range of motion (ROM) on the left side, and right side with the stoke damage was at baseline. There was a small scrape on back of left hand and a small bump on the back of R85's head. R85 was assisted into the wheelchair when the assessment was completed with the full body mechanical lift. There were no ill effects that	F 609	The facility does have a process in place to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not involve serious bodily injury to the facility administrator and to other required officials in accordance with State law. Regarding resident 85. The facility recognizes the resident did have a witnessed fall from a mechanical lift and the facility does recognize the staff failed to fully follow the facilities policy. Staff did, however, follow all manufacturer's recommendations for operation of the lift. All previous falls/incidents of resident 85 will be reviewed to ensure that no other falls should have been reported to the state agencies. Regarding all other residents in the facility, the facility Abuse Prevention Plan has been reviewed and no areas of revision were found to be required. Nursing staff will be re-trained regarding their responsibility to the regulation with enhanced focus on the definition of neglect and reporting to the appropriate agencies. To assure the deficient practice has not affected any other residents residing in the facility an audit of incidents not filed	

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	245269	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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F 609	Continued From page 3 occured to R85. During an interview on 11/4/21, at 10:25 a.m. the assistant director of nursing (ADON) stated she was called immediately after the incident occurred with R85. ADON went to R85's room and assessed R85 and started the investigation process for the incident. The ADON stated R85 did not sustain a significant injury or harm, the care plan was followed and thought we did not need to report to the SA. The ADON stated the two employees did not follow the facility procedure for the full body mechanical lift. The ADON stated it could be neglect from the staff. The facility Lift Orientation on Hire dated 2/24/21, indicated there were two lift types used at the facility a sling lift (for residents that cannot bear weight) and standing lift (residents who can bear weight but do not have enough strength to do on their own). How to use the sling lift directed staff to: 4. Attach all four hooks to the harness. 5. Recheck all four hoops a second time before lifting a resident. Each staff member checks the other staff member's hoops once a slight tension is on the sling. 6. One staff member watches, guides the resident to ensure everything is attached correctly and that legs, arms are not going to be bumped at that the resident will sit properly in a chair or lie properly in the bed. 7. The other staff member operates the lift with a smooth motion and uses good body mechanics to move the lift. The facility policy Abuse Prevention Plan, dated 3/19, indicated maltreatment was defined as verbal, sexual, physical, and mental abuse;	F 609	with the state agency for the last 6 months will be complete to determine if those should have been reported to the state agency. To assure continued compliance the facility QA team/designee will conduct routine audits of accidents in the facility daily for one week, weekly for two weeks, monthly for two months and periodically after that to assure ongoing compliance. To assure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings. Completion date of compliance December 15, 2021.	

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F 609	Continued From page 4 corporal punishment; neglect; involuntary seclusions, financial exploitation, and misappropriation of property. Abuse Prevention Plan revealed all alleged incidents of maltreatment are reported to the appropriate agencies immediately as required and all necessary corrective actions, depending on the results of the investigation, are taken. "Immediately" means as soon as possible.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one resident (Resident (R) 9) out of 27 sampled residents had an accurate Minimum Data Set (MDS) assessment. Findings include: The "Resident Assessment Instrument (RAI) Manual," dated 10/01/19, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment ..." Review of the undated "Admission Record" in the electronic medical record (EMR) under	F 641	The facility does have processes in place to ensure that MDS assessments are done accurately to reflect the resident's status. Regarding resident 9, the facility recognizes there was an error in coding on the MDS dated 8/3/2021. The facility notes the assessment was completed and documented correctly indicating the resident "requires verbal cues and encouragement at meals." The MDS was mistakenly coded incorrectly. An attestation to correct the miscoded MDS has been completed to correct the inaccurate MDS. An audit will be completed for this resident on MDSs completed looking back to admission to assure accuracy and if any inaccuracies are noted, an attestation of those MDSs will also be completed to reflect an accurate picture of the resident's status.	12/15/21

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F 641	Continued From page 5 the "Profile" tab, revealed R9 was admitted to the facility 06/27/19 with diagnoses that included unspecified dementia without behavioral disturbances and weakness. Review of the quarterly "MDS" with an Assessment Reference Date (ARD) of 08/03/21, located in the EMR under the "MDS" tab, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated the resident was severely cognitively impaired. The assessment indicated R9 required supervision and one staff member to physically assist to eat. An observation was conducted on 11/01/21 at 1:06 PM, R9 picked up a regular spoon and fed himself. There was no staff member sitting next to the resident during this observation. The observation ended on 11/01/21 at 1:38 PM. During an interview on 11/02/21 at 1:19 PM, Registered Nurse (RN) 3, reported she was one of the facility staff members who completed MDS assessments. She stated when a resident required supervision and physical assist, typically a staff member sat next to the resident to provide cueing, load the eating utensil with food, and feed the resident during mealtime. RN3 stated R9 was coded incorrectly on the quarterly MDS. RN3 stated R9 required supervision during mealtime and set up of his meal tray only. RN3 confirmed the resident was able to feed himself during the look back period of the quarterly MDS. During an interview on 11/04/21 at 10:15 AM, the Director of Nursing (DON) stated it was her expectation that the assessments be performed in the manner as required by the RAI manual.	F 641	Regarding all other residents in the facility, it is noted the facility does not have a specific policy related to MDS coding. The practice of the facility is to complete the assessment and MDS process as indicated in the RAI manual. Those who complete MDSs will be re-educated to their responsibility to the regulation and to double check their work to assure accuracy. The facility does also comply with MDH Case Mix review audits. To assure the deficient practice has not affected any other residents residing in the facility an audit of all completed MDSs will be conducted back one month with comparison of the MDS to the completed assessment documented in the residents' medical record during the look back period of the MDS. To assure continued compliance the facility QA team/designee will conduct routine audits of completed MDSs in the facility; with comparison of the MDS to the completed assessment documented in the residents' medical record during the look back period of the MDS, daily for one week, weekly for two weeks, monthly for two months and periodically after that to assure ongoing compliance. To assure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings. Completion date of compliance December 15, 2021.	

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure empty and full oxygen tanks were stored separately on 1 of 6 (Silver Bay household) units to prevent nursing staff from grabbing an incorrect oxygen tank during an emergency to prevent any accidents/hazards to the residents. Findings include: During an observation of the Silver Bay household oxygen storage room, on 11/02/21 at 3:11 PM with registered nurse (RN)-3, there were multiple empty and full standard-sized oxygen tanks on one side of the room. There was a large, hand-written sign posted on the wall above the tanks which stated, "* Empty Tanks * Full Tanks." RN3 counted the empty tanks and stated there were 36 empty oxygen tanks and 23 full oxygen tanks. The tanks were co-mingled, there was no segregation between the empty and full tanks. During an interview on 11/02/21 at 3:24 PM, the Assistant Director of Nursing (ADON) stated she never knew that empty and full oxygen tanks were not to be stored together. The ADON was asked for policies on accident hazards and	F 689	The facility does have processes in place to ensure the resident environment remains as free of accidents and hazards as possible. The facility recognizes there were full and empty portable oxygen tanks co-mingled in the oxygen storage room and that there was not separation between the two types of tanks. The oxygen supply room will be re-organized to provide separation of full and empty tanks. There will continue to be signage to direct staff and vendors where respective tanks should be placed for storage and to easily find needed oxygen in an emergency. An oxygen storage policy will be composed, and all appropriate staff will be re-educated to their responsibility to the regulation. To assure continued compliance the facility QA team/designee will conduct routine audits of the oxygen storage room daily for one week, weekly for two weeks, monthly for two months and periodically after that to assure ongoing compliance. To assure ongoing compliance, results from these audits will be reviewed at the	12/15/21

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F 689	Continued From page 7 oxygen tank storage. During an interview on 11/02/21 at 3:34 PM, the Maintenance Director stated his expectations were for staff to keep the empty and full tanks separated. The Maintenance Director stated signs were posted above the stored tanks in the oxygen storage room, which indicated a side for empty oxygen tanks and a side for full oxygen tanks. The Maintenance Director stated he rarely entered the oxygen storage room. The Maintenance Director was asked for a policy on oxygen storage. During an interview on 11/02/21 at 4:03 PM, RN3 stated there were no policies on oxygen storage. During an interview on 11/04/21 at 8:47 AM, the Maintenance Director stated the empty and full oxygen tanks needed to be stored separately so nursing staff were able to clearly identify the full tanks from the empty ones in case there was an emergency of a resident needing oxygen quickly. During an interview on 11/04/21 at 10:14 AM, the Director of Nursing (DON) stated empty oxygen tanks should not be co-mingled with full oxygen tanks to ensure nursing staff were grabbing a full tank during an emergency with a resident.	F 689	facility Quality Assurance meetings. Completion date of compliance December 15, 2021.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		12/6/21

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F 880	Continued From page 8	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 9 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection prevention measures were maintained related to indwelling urinary catheter use for one (Resident (R) 5) of three reviewed for catheter use. Findings include: Review of R5's undated "Admission Record," located in the Electronic Medical Record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on 09/04/09 and readmitted on 08/05/19 with diagnoses including but not limited to, neuromuscular dysfunction of the bladder (inability of the bladder to empty properly) and quadriplegia related to cerebral palsy.	F 880	The facility does establish and maintain, and infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Regarding resident 5, the facility recognizes the urinary catheter bag was found to be laying on the floor and not in the basin that was in the room for the catheter to be placed in. Resident 5's catheter bag was placed into the supplied basin when staff became aware that it was not in the appropriate place. In addition starting on 12/3/2021 a cloth dignity bag has been attached to resident 5's bed for the catheter bag to be placed	

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F 880	Continued From page 10 During an observation on 11/01/21 at 1:30 PM, R5 was in bed in her room with an indwelling catheter lying directly on the floor. During an observation on 11/01/21 at 2:50 PM, R5 was in bed in her room with an indwelling catheter lying directly on the floor. During an observation on 11/02/21 at 1:30 PM, R5 was in bed in her room with an indwelling catheter lying directly on the floor. During an interview on 11/03/21 at 12:50 PM, Certified Nursing Assistant (CNA) 1 stated the catheter bag should be placed in the wash basin and should not be lying on the floor. During an interview on 11/03/21 at 12:55 PM with Licensed Practical Nurse (LPN) 1 stated for infection control purposes, the catheter bag should not be touching the floor and should always be placed in a wash basin. During an interview on 11/04/21 at 10:30 AM, the Assistant Director of Nursing (ADON) and Infection Preventionist (IP) stated the expectation was for staff to place the catheter bag in a clean wash basin and not placed directly on the floor. According to the facility's policy provided titled, "Urinary Collection Bag Care Procedure," revised February 2019, " ...when attaching a bedside bag hang the bag on the bed frame and place in protective cover, place inside a basin ..."	F 880	in to better ensure compliance and reduce risk of catheter bag being left/ falling out onto the floor. Regarding all other residents who may be affected by this deficient practice an audit was conducted on 11/24/2021 and found zero catheter bags directly on the floor. In addition, a root cause analysis will be completed with the QAPI committee including the infection preventionist and governing oversite to identify problems that created the deficient practice and interventions that will prevent recurrence of the practice. All applicable policies will be reviewed and revised as necessary, and all applicable staff will be re-educated on their responsibility to the regulation with enhanced education on Urinary catheter bag management infection control practices. To assure continued compliance the facility QA team/designee will conduct competencies of applicable staff and conduct routine audits of location of urinary catheter bags daily on each shift for one week, weekly for two weeks, monthly for two months and periodically after that to assure ongoing compliance. Audits will continue until 100% compliance is met. To assure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings. Completion date of compliance December 6, 2021.	

Electronically delivered
November 22, 2021

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

Re: State Nursing Home Licensing Orders
Event ID: 152511

Dear Administrator:

The above facility was surveyed on November 1, 2021 through November 4, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2021**

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GOOD SHEPHERD LUTHERAN HOME	**1115 4TH AVENUE NORTH** **SAUK RAPIDS, MN 56379**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the NFPA 101 (2012 edition), Life Safety Code, Chapter 19 Existing Health Care, and the NFPA 99 (2012 edition), Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/01/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	**1115 4TH AVENUE NORTH** **SAUK RAPIDS, MN 56379**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as one building: Good Shepherd Home is a 2-story building with a partial basement. The building was constructed at 6 different times: The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1969, an addition was added to the east that was determined to be of Type II (111) construction. In 1980, an addition was	K 000		

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K 000	Continued From page 2 added to the northwest that was determined to be Type V (111). In 1997, an addition was added to the west that was determined to be of Type V (111) construction. In 2002, an addition was added to the Main Dining Room that was determined to be of Type V (111) construction. In 2010 a two story addition was added that was determined to be of Type II (111) construction located on the southwest corner of the facility. In 2010 a two story addition was added that was determined to be of Type II (111) construction located on the northeast corner of the facility. In 2010 a one story addition was added that was determined to be of Type V (111) construction located north of the chapel. The building is fully sprinkler protected and the facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 162 beds and had a census of 117 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		12/15/21

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K 345	Continued From page 3 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm system per NFPA 101 "Life Safety Code" 2012 edition, section 9.6.1.3, and NFPA 72 "National Fire Alarm and Signaling Code" 2010 edition, sections 14.4.5.1, 14.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/02/2021, at 9:40 AM, it was revealed during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor that at the time of the inspection, the facility had completed the annual fire alarm system testing; but upon further review of the annual fire alarm testing documentation, it was found that the inspection report did not contain a detailed list of all the fire alarm devices that had been tested, type of testing conducted, or the results of the testing completed on each individual device. It was also noted in the comment section of the fire alarm testing documentation by the testing agent who wrote "test stored in panel log," but the information was not accessible or printed out at the time of the survey. 2. On 11/02/2021, at 9:40 AM, it was revealed during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor that the facility could	K 345	A detailed listing of fire alarm initiating devices will be noted within the contractor's annual report including: device type, test type and test result of each device. 2. As part of the preventative maintenance software program, a semi-annual inspection of all initiating devices will be conducted by the maintenance department. Findings will be reported to the the VP of EVS and the Maintenance Supervisor. Inspections will be completed by December 17, 2021.3. The VP of EVS will verify the discrepancy related to the amount of heat detectors noted in the 2020 and 2021 fire alarm report by December 17, 2021.After completion of the yearly inspection by the contractor, the VP of EVS or the Maintenance Supervisor will verify the the annual report. Compliance will be monitored by the VP of EVS and the Safety Committee. 4. The two heat detectors within the elevator shaft will be tested by December 17, 2021. After completion of the yearly inspection by the contractor, the VP of EVS or the Maintenance Supervisor will review the annual report and correct deficiencies within two weeks. Compliance will be monitored by the VP of EVS and the Safety Committee.	

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K 345	Continued From page 4 not provide any current documentation verifying that the semiannual visual inspection has been completed on all initiating devices. 3. On 11/02/2021, at 9:40 AM, it was revealed during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor, that the heat detector device quantities differed between the 2020 fire alarm inspection documentation and the 2021 fire alarm testing documentation. The total number of heat detectors annotated on the 2020 fire alarm testing documentation was 38 and the number of heat detectors annotated on the 2021 fire alarm testing documentation was 37. The facility could not provide any documentation or explanation for the device count discrepancy. 4. On 11/02/2021, at 9:40 AM, it was revealed during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor, that in both the 2020 and 2021 fire alarm annual test documentation that 2 heat detectors had not been tested or inspected. It was noted in the comment section of the 2021 annual fire alarm that "2 heats missed in the elevator shaft," and there was no mention to the same effect within the comment sections of the 2020 annual fire alarm testing documentation. The documentation shows that these two heat detector devices have surpassed the maximum of 18 months between testing events. An interview with the Maintenance Supervisor verified these findings at the time of discovery.	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		12/17/21

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K 353	Continued From page 5 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not maintained per NFPA 101 (2012 edition), The Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/02/2021, at 11:23 AM, it was revealed that there is a corroded fire sprinkler head located in the wall outside of the dietary manager's office and that there are four corroded fire sprinkler	K 353	Inspection of individual sprinkler heads will be conducted by the Maintenance Department on an annual basis. Findings of the inspection will be submitted to The VP of EVS and the Maintenance Supervisor.Compliance will be monitored by the VP of EVS and the Safety Committee. By December 17, 2021, all sprinkler heads will be inspected and the 5 corroded sprinkler heads found during the inspection will be replaced.	

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K 353	Continued From page 6 heads in the dining room area that is located next to the dietary manager's office. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/02/2021, at 10:04 AM., it was revealed during the review of all available fire drill documentation and interview with the Maintenance Supervisor, that the facility failed to conduct a day shift fire drill for the fourth quarter	K 712	The VP of EVS will develop a fire drill plan assuring that fire drills are conducted once per quarter per shift at varying times and not within 1/2 hour of shift change.Drills will be scheduled through the preventative maintenance software program. A work order to complete the drill will be automatically generated per given time line. Compliance will be monitored by the VP of EVS, Frank Carter and the Safety Committee. The fire drill plan will be completed by December 1, 2021.	12/15/21

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K 712	Continued From page 7 within the last 12 months. An interview with the Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 712		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the annual electrical outlet testing and maintenance per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4. This deficient	K 914	Testing of electrical outlets within patient bed locations willbe conducted annually and scheduled through thepreventative maintenance program.The VP of EVS and Maintenance Supervisor are responsible	12/17/21

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K 914	Continued From page 8 finding could have an isolated impact on the residents within the facility. Findings include: On 11/02/2021, at 10:10 AM, during the review of all available electrical outlet maintenance and testing documentation and an interview with the Maintenance Supervisor, it was revealed that the facility had failed to conduct an annual electrical outlet inspection of all electrical outlets located within the patient/resident sleeping locations. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 914	for assigning the work order to staff and assuring that outlets are tested within the require time-line.Compliance will be monitored/reviewed by the SafetyCommittee. Testing of the outlets will be completed by December 17, 2021.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		12/15/21

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K 923	Continued From page 9 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5.2 and 11.6.2.3. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 11/02/2021 at 12:15 PM, it was revealed that in the oxygen storage room located in the Silver Bay unit had both full and empty oxygen cylinders were being stored in the same location. It was further revealed that the empty cylinder was not being segregated from the full cylinders at the time of the survey. 2. On 11/02/2021 at 12:15 PM, it was revealed that in the oxygen storage room located in the	K 923	Oxygen containers located within storage rooms will have signs identifying placement of "Full and Empty" containers. Nursing staff isresponsible for placing containers in their proper location and assuring containersare kept in the provided storagerack or carriage. Compliance will be monitored by maintenance staff during daily rounds and deficiencies reported to the VP of EVS and the Maintenance Supervisor. Findings will be reported at the monthly Safety Committee. Monitoring will begin November 29, 2021.	

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K 923	Continued From page 10 Silver Bay unit there were four oxygen cylinders that were not properly secured in a tip resistant manner. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 923		