



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 9, 2026

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

RE: CCN: 245269
Cycle Start Date: September 8, 2026

Dear Administrator:

On September 8, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Correction of the Life Safety Code deficiency cited under K921 - Electrical Equipment Testing and Maintenance at the time of the July 9, 2026, abbreviated standard extended survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of August 11, 2026, has been approved or forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency / these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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September 9, 2026

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

Re: Reinspection Results
Event ID: 235D1F-H2

Dear Administrator:

On September 8, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 9, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

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July 24, 2026

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

RE: CCN :245269

Cycle Start Date: July 9, 2026

Dear Administrator:

On July 9, 2026, a survey was completed at your facility by the Minnesota Departments 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor

St. Cloud B District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 426-0175

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **October 9, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **January 9, 2027** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens

State Fire Safety Supervisor

Health Care & Correctional Facilities

MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145

St. Paul, MN 55101

Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler".

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us



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July 24, 2026

Administrator

GOOD SHEPHERD LUTHERAN HOME

1115 4TH AVENUE NORTH

SAUK RAPIDS, MN 56379

Re: State Nursing Home Licensing Orders

Event ID: 235D1F-H1

Dear Administrator:

The above facility survey was completed on July 9, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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.

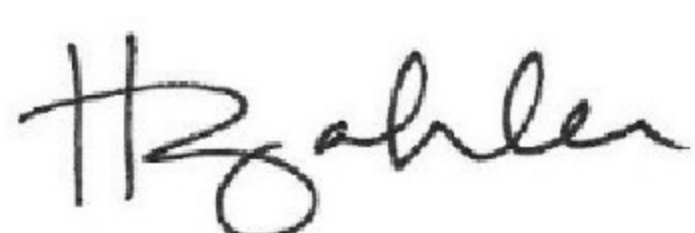
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH , SAUK RAPIDS, Minnesota, 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
E0000	Initial Comments On 7/6/26 through 7/9/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. 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.			E0000			07/30/2026
F0000	INITIAL COMMENTS On 7-6-6 through 7-9-26, a standard recertification survey (S5269041) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H (iQIES #). NO deficiencies were cited. H52693146C/2984280 H52693148C/2633020 H52693147C/2574238 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 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.			F0000			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
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F0572 SS = F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was displayed for residents, visitors, and staff to review. This had the potential to affect all residents currently residing in the facility, as well as all staff and visitors. Findings include: On 7/8/26 at 8:47 a.m., it was observed that RBOR poster was displayed in a locked glass case in a small common area near the entrance and was dated 1/16. On 7/8/26 at 12:02 p.m., director of Social Services confirmed the poster was outdated and a new one needed to be ordered. A facility policy was requested but none provided.			F0572	The facility does provide a notice of rights and services to the residents upon admission and during the resident's stay in the facility both orally and in writing in a language that the resident understands. The facility does also provide the resident with the State-developed notice of Medicaid rights and obligations. The facility recognizes that on 7/8/26 the RBOR poster located near the entrance was dated 1/16. The facility has received updated posters with the most current information as of 7/20/26. Updated posters will be hung in replacement of outdated posters. Staff who are responsible for maintaining this posting have been re-educated to their responsibility to this regulation with enhanced focus on assuring the poster remains up to date with the most current information. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits of the poster being up to date weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications			F0554	The facility does allow for residents to self-administer medications if the IDT and provider have determined that the practice is clinically appropriate.		08/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
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F0554 SS = D	Continued from page 2 if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 2 of 2 residents (R2, R69) reviewed for medication administration. Findings include: R69's comprehensive MDS assessment dated 4/15/26 indicated R69 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and renal insufficiency. R69's self-administration of medication inquiry form signed by R69 on 4/15/26 indicated R69 did not want to self-administer medications either independently or after set-up by facility staff. During observation and interview on 7/6/26 at 11:04 a.m., a bottle of Nystatin powder with a pharmacy label containing R69's name was observed on the dresser. R69's orders reviewed on 7/8/26 lacked an order for self-administration of medication. R2's quarterly minimum data set (MDS) assessment dated 6/1/26, indicated R2 was cognitively intact and had the following diagnoses: heart failure, high blood pressure, end stage renal disease (ESRD) and diabetes. R2's self-administration of medication inquiry form signed by R2 on 8/28/25 indicated R2 did not want to self-administer medications either independently or after set-up by facility staff. During observation and interview on 7/6/26 at 3:32 p.m., a bottle of antifungal powder with a pharmacy label containing R2's name was observed on the bedside table in R2's room. R2's orders reviewed 7/8/26 lacked an order for self-administration of medication. During interview on 07/09/2026 at 7:28 a.m., licensed practical nurse (LPN-A) stated medications could be left at the bedside only if they have the doctors order to leave them and they have been			F0554	Continued from page 2 The facility recognizes that during an observation on 7/6/26, R69 and R2 had access to topical medication in their room and lacked an assessment and physician's order for self-administration. Regarding residents 69 and 2; both residents have been asked if they wish to self-administer medications. A self-administration assessment will be completed, a physician order will be obtained, and their care plan will be revised. Regarding all other residents who may be affected, a room audit will be completed to ensure no other medications are unsecured in a resident's room who does not have an order for self- administration. In addition, all residents who do self-administer medications will be audited to ensure an assessment has been completed, and they have a provider order for self-administration of medications. Staff who are responsible for administering medications will be re-educated to their responsibility to this regulation with enhanced focus on assuring medications are not left out in residents' rooms if there is not a provider order to do so as well as an assessment for self-administration has been completed. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring no medications are left out in a resident room and any new individuals wishing to self- administer medications will have an assessment completed and a provider order obtained daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. The facility does not have a formal policy related to self-administration of medication, however, does have process that includes an assessment form to be completed by the RN case manager and reviewed by the interdisciplinary team prior to the beginning of self- administration which is reviewed by the primary provider to determine if it is clinically appropriate. Date of completion for this correction is Aug 24, 2026		08/24/2026

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F0554 SS = D	Continued from page 3 assessed as safe to self-administer. During interview on 7/9/26 at 4:51 p.m., Director of Nursing (DON) confirmed R69 and R2 did not have a SAM assessment and stated her expectation for SAM was residents were assessed and had a physician's order before a SAM was put in place or medications be left at bedside. DON went on to state it was important for residents to be assessed to ensure the 5 rights of medication administration were being followed, important for staff to know what medications the resident is taking and to prevent another resident gaining access to medications. A policy for self-administration of medications was requested but not provided.			F0554			08/24/2026
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by:			F0561	The facility does promote and facilitate resident self-determination through support of resident choices. The facility does recognize that on 7/7/26, R 72 did not have clear access to the contents of the refrigerator due to the safety mats being placed in front of the refrigerator door. Regarding R72, staff have re-educated R72, if there is a need that they are not able to independently complete, they are encouraged to utilize their call light to receive staff assistance to complete that need. Facility staff primarily caring for R72 have been educated to assure safety mats are not placed in a way that impairs R72s ability to access personal belongings especially the contents of the in-room refrigerator. This information will also be included in R72 plan of care. Regarding all residents who may be affected by this practice, a room audit will be completed facility wide to ensure there are no pieces of equipment interfering with residents' access to their personal belongings. All residents are encouraged to use their call light if they need staff assistance obtaining something they would like to have. Staff who are responsible for condition of resident rooms will be re-educated to their responsibility to this regulation with enhanced focus on checking before leaving room that equipment is not interfering with access to personal belongings. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring no equipment is interfering with		08/24/2026

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F0561 SS = D	Continued from page 4 Based on observation and interview, the facility failed to promote independence for 1 of 1 resident (R 72) reviewed for self determination. Findings include: R72's face sheet printed 7/9/26, indicated admission date of 4/10/25, and had diagnoses of Cerebral Infarction affecting left side, type 2 Diabetes, and difficulty in walking. R72's care plan printed 7/9/26, indicated at risk for falls, resident needs a safe environment with even floors free from clutter, when in bed place blue mats on each side of the bed.During observation and interview on 7/7/26 at 5:02 p.m. R72 was sitting in wheelchair with a blue mattress on the floor opposite side of the bed and blocking access to the refrigerator. R72 stated he was not able to access his pop or yogurt that was in the refrigerator. During observation on 7/8/26 at 4:48 p.m. R72 was sitting in his wheelchair. There were 2 blue mats on the floor opposite side of bed and blocking access to the refrigerator. on 7/9/26 at 8:09 a.m. nursing assistant (NA)-A stated resident needed assistance with activities of daily living (ADLs) and keeping his room picked up and organized. NA-A stated R72 required mats when in bed and staff were expected to move them when he was out of bed. NA-A stated R72 would not be able to safely access the refrigerator when the mats were left on the floor. The mats should be placed out of the way. On 7/9/26 at 8:15 a.m. LPN-C stated R72 was able to self-propel himself enough to retrieve items from the refrigerator. The mats should not be left on the floor when R72 was out of bed. On 7/9/26 at 8:41 a.m. ADON stated she expected mats to be removed from the floor and placed out of way when residents were not in their beds. It was an issue if a resident was not able to access their refrigerator when capable of doing so. Policy was requested but none provided.			F0561	Continued from page 4 resident access to personal items in room daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification.			F0641	The facility does coordinate each assessment with the appropriate participation of health professionals, and the assessment does accurately reflect the resident's status. The facility does recognize that R55 and R16 had an error in the coding of their MDS due to a missing assessment for bed rail use. Both residents had bed rails in place which were not accounted for on their MDS. Regarding R55 and R16, a bedrail assessment will be completed to determine if bedrails are appropriate to be used. If not, the bed rails will be removed, and care plans will be updated accordingly. R55 and R16 will have their most recent MDS corrected through an attestation to ensure they accurately reflect the		08/24/2026

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F0641 SS = D	Continued from page 5 §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 2 of 6 resident reviewed for bedrails. Findings include: R55's comprehensive minimum data set (MDS) dated 6/1/26 indicated R55 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and arthritis. Section P of the MDS which covers restraints and alarms indicated R55 did not use bedrails. During observation and interview on 7/6/26 at 10:24 a.m., R55's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R55 stated they had been there since her admission. R55's medical record was reviewed and did not indicate the use of bedrails. R16's quarterly MDS assessment dated 6/1/26 indicated R16 was cognitively intact and had the following diagnoses: coronary artery disease, heart failure, and high blood pressure. Section P of the MDS which covers restraints and alarms indicated R16 did not use bedrails.			F0641	Continued from page 5 status of the residents during the assessment period. Regarding all other residents who may be affected by the deficient practice, an audit of all residents who have bedrails in place will be completed to ensure there is an assessment completed. In addition, an audit of their MDSs will also be completed to ensure they are accurate. The facility does not have a policy specific to MDS coding; however, the facility follows the guidelines as per the RAI manual for MDS coding. Staff who are responsible for coding bedrail use on the MDS/completing the assessment will be re-educated to their responsibility to this regulation with enhanced focus on the importance of the completion and accuracy of bedrail use assessments and MDS coding. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring accuracy of assessments and MDS daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026

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F0641 SS = D	Continued from page 6 During observation and interview on 7/6/26 at 2:13 p.m., R16's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R15 stated he did not use them for positioning. R16's medical record was reviewed and did not indicate the use of bedrails. During interview on 7/9/26 at 4:51 p.m., director of nursing (DON) stated she expected the MDS assessment to be accurately completed and to include all necessary information pertaining to the resident's current health conditions. DON stated it was important to have the assessments be accurate as it drives the resident plan of care and ensures the resident received appropriate care. DON went on to state the MDS assessments also drive reimbursement and if incorrect the facility would not receive proper reimbursement. A policy was requested but not provided.			F0641			08/24/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interview, the facility failed to update the provider of a weight change per physician order for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8's annual Minimum Data Set (MDS) dated 5-13-26, indicated R8 was mildly cognitively impaired, was admitted on 11-3-25, and had the following diagnoses: coronary artery disease, heart failure (HF) (hearts failure to pump blood efficiently and can cause weight fluctuation), hypertension (HTN) (high blood pressure), and dementia.			F0684	The facility does ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choice. The facility does recognize that on 5/30/26 and 6/4/26 R8 had a weight change that was not reported to the provider as per provider order. Regarding R8 the provider was notified of the dates and weight changes that were not reported timely. No new orders were given at that time. Medication errors will be completed for the staff who did not follow the MD order with re-education on the facility expectations of following provider orders and notifications to providers. Regarding all other residents who may be affected by the deficient practice, an audit for all residents who have an order for notifications related to weight changes will be completed looking back 30 days to ensure provider orders were followed related to notifications of weight changes. The facility does not have a policy specific to weight change notifications. The practice of the facility is to comply with provider orders related to individual resident needs. Staff who are responsible for monitoring weight changes and completing provider notifications will		08/24/2026

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F0684 SS = D	Continued from page 7 R8's clinical physician orders dated 7-9-26, indicated the following order: daily weight- every day shift (REPORT CHANGE OF 3LBS OVERNIGHT). Start date 4-9-26 R8's weights and vitals dated 7-9-26, indicated the following weight fluctuations: On 5-29-26 weight-153.5lbs On 5-30-26 weight-149.5lbs, which showed a change of 4lbs. On 6-3-26 weight-148.5lbs On 6-4-26 weight-153.5, which showed a change of 5lbs. R8's medical record lacked any evidence that the provider was ever updated per the provider order. On 7-9-26 at 12:08p.m. via email, the director of nursing confirmed the provider was never updated of the weight changes. On 7-9-26 at 4:51p.m., the director of nursing stated their expectation was the provider should have been updated on these weight changes per the physician order and stated the importance of preventing decline in regards to the residents HF, and in order start treatment as soon as possible if ordered by the provider. A policy for provider notification was requested and none was provided.			F0684	Continued from page 7 be re-educated to their responsibility to this regulation with enhanced focus on the importance of timely provider notifications and following orders as they are given by providers. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring weight monitoring is completed, and changes are reported timely as per provider orders daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026
F0689 SS = D	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 observation, interview and document			F0689	The facility does provide a resident environment that remains as free of accidents/ hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The facility recognizes that during an observation on 7/6/26 R5 was transferred with a mechanical standing lift and did not come to a full stand. The transfer was completed without accident or injury to the resident. Regarding R5; when facility staff were notified of the observation, RN-A immediately reassessed the transfer needs of R5. The care plan was revised as applicable. Due to R5's medical condition and goals of care, further transfer assessment by skilled therapist is not clinically appropriate. Regarding all other residents who may be affected;		08/24/2026

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F0689 SS = D	Continued from page 8 review, the facility failed to ensure resident receive adequate supervision and assistance for 1 of 1 resident (R5) when transferred with and EZ stand lift. Findings include: R5's admission Minimum Data Set (MDS) dated 5/11/26, indicated cognitive deficit and dependent for toileting, Diagnoses included: Alzheimer's disease, dementia, fracture, and repeated falls. R5's care plan printed 7/8/26, indicated moderate risk for falls related to weakness. Toileting: EZ stand w/2A [with 2 assist]. Does not ambulate at this time. During observation on 7/6/26 at 1:49 p.m., nursing assistant (NA)-D entered R5's room with EZ stand. NA-D placed harness, safety belt and loops appropriately. NA-D asked R5 if she was awake and proceeded to raise the arms. R5 stood at approximately 135 degrees, never coming to a full stand. NA-D grabbed the back of R5's pants during transfer to toilet. R5 was allowed some privacy, but remaining by door of bathroom. Staff re-entered bathroom to assist resident with cares. Safety belts were placed, R5 was raised using the lift, however, never came to a full stand. Staff transferred R5 to bed. During observation on 7/8/26 at 10:47 a.m. NA-B and NA-C entered R5's room with the EZ stand, sanitized hands and donned gloves. Staff placed harness, safety straps and loops appropriately. Placed R5's hands appropriately to hang on. NA-C encouraged R5 to stand and to "feel the pressure on [R5's] feet". R5 stood at approximately 135 degrees, never coming to a full stand. R5 was allowed privacy, but staff remained by the bathroom door. Staff re-entered, raised R5 and encouraged her to stand. However, R5 never came to a full stand, raising to approximately 135 degrees. R5 was placed in wheelchair. During interview on 7/8/26 at 10:59 a.m., NA-B stated the resident's Kardex hung in the closet for reference on how to care for each resident. NA-B stated R5 did not stand up straight. She felt it was a safe transfer because there were 2 staff assisting with the transfer. During interview on 7/8/26 at 11:05 a.m. RN Case Manager (RN)-A stated she expected a resident stood straight up when transferred with the EZ stand. The staff encouraged resident to stand-up. Staff were expected to sit residents back down and try again if they did not. Further, she expected staff to notify her when a resident was no longer doing so. RN-A was unaware of any concerns related to R5 transferring safely when using the EZ stand. Facility policy was requested but none provided.			F0689	Continued from page 8 all residents who require a mechanical standing lift will be reassessed to ensure that is the most appropriate intervention for transfer assistance. The facility interviewed contracted physical therapist to determine what the clinical standard is for degrees of standing to be considered a full stand. As per physical therapist, there is not a generalized standard of practice, each resident's degree of standing will be different. The facility has reviewed the manufacturer's recommendations for lift use and clinical indications. No reference of full stand or degrees of standing is mentioned in manufacturer's literature. The facility does not have a policy specific to transferring safety, however, the facility policy entitled "Mechanical Lift Use" was supplied to MDH for review. The policy will be reviewed and revised if needed. Staff who are responsible for completing transfers and assessing transfer needs will be re-educated to their responsibility to this regulation with enhanced focus on notification to RN if changes in resident's ability to safely transfer are noted and the expectation for ongoing assessment of resident clinical need. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring assessment is completed if there is a change in residents' ability to transfer safely in a standing mechanical lift daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4)			F0700	The facility does attempt to use appropriate alternatives prior to installing a side or bedrail. The facility does ensure correct installation, use and maintenance of bed rails. The facility does assess		08/24/2026

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F0700 SS = D	Continued from page 9 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and attempt alternatives prior to use of bed rails for 2 of 6 residents (R55, R16) reviewed for bed rails. Findings include: R55's comprehensive minimum data set (MDS) dated 6/1/26 indicated R55 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and arthritis. Section P of the MDS which covers restraints and alarms indicated R55 did not use bedrails. During observation and interview on 7/6/26 at 10:24 a.m., R55's bed was noted to have half-length bed rails attached to the top portion of the right and left side of the bed. R55 stated they had been there since her admission, and she did not routinely use them. R55's medical record was reviewed and lacked an assessment, or consent and education for the use of bedrails. R16's quarterly MDS assessment dated 6/1/26			F0700	Continued from page 9 the resident for risk of entrapment, review the risks and benefits of bed rail use with the resident/ representative and obtain informed consent and follow the manufacturer's recommendations for installing and maintaining side rails. The facility does recognize that for R55 and R16 there was not a documented assessment, consent or education in place. Regarding R55 and R16, a bedrail assessment will be completed to determine if bedrails are appropriate to be used. If not, the bed rails will be removed, and care plans will be updated accordingly. If bed rails are to remain in place, education and consent will be completed with resident/representative. Regarding all other residents who may be affected by the deficient practice, an audit of all residents who have bedrails in place will be completed to ensure there is an assessment, education and consent completed. The facility will create a specific consent form related to bed/side rail use to ensure resident's/representatives are aware of risks and benefits and best able to make an informed decision related to their use. Staff who are responsible for completing bed rail education and assessment will be re-educated to their responsibility to this regulation with enhanced focus on the importance of the completion and accuracy of bedrail use assessments education and consent. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring completion of bed rail assessments, education and consent daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026

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F0700 SS = D	Continued from page 10 indicated R16 was cognitively intact and had the following diagnoses: coronary artery disease, heart failure, and high blood pressure. Section P of the MDS which covers restraints and alarms indicated R16 did not use bedrails. During observation and interview on 7/6/26 at 2:13 p.m., R16's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R15 stated he did not use them and could not recall how long they had been on his bed. R16's medical record was reviewed and lacked an assessment, consent and education for the use of bedrails. During interview on 07/09/2026 at 4:51 p.m., Director of Nursing (DON) stated a resident who used bedrails required an assessment for appropriateness, a physician's order, consent and education provided to the resident or their representative. Further, bedrails needed to be compatible with the bed and installed by maintenance staff. DON confirmed R55 and R16 had not had a bedrail assessment prior to the installation of bedrails. DON stated she expected nursing staff to complete a bedrail assessment prior to initiating bedrails. It was important to ensure the bedrails did not restrain the residents in any way, and to ensure residents safety. A policy titled Side-Rail Use with a last review date of 2/2026 indicated the purpose of bedrails was to promote resident independence at the highest possible level for turning, repositioning and mobility in bed while ensuring resident safety and compliance with regulatory standards. The policy stated bedrails were only used when clinically indicated to support resident mobility, positioning and comfort and never as a restraint, and are based on individual assessments.			F0700			08/24/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			F0755	The facility does establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. The facility recognizes that the page of the narcotic book for R150 had an error in transcription of the Ativan order and did not match the bubble packed card or the order in the eMAR. Regarding R150, the order for Ativan was confirmed and the narcotic book was corrected to reflect the		08/24/2026

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F0755 SS = D	Continued from page 11 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to transcribe orders according to standards of practice for medication management for 1 of 5 (R150) residents reviewed for unnecessary medications. Findings include: R150's undated faceheet indicated they were admitted on 7/1/26, and had the following diagnoses: restlessness and agitation, pain, palliative care, and a frontotemporal neurocognitive disorder. R150's clinical physician orders dated 7-9-26, indicated the following order: Ativan 0.5mg solutabs- Give 0.25mg by mouth every 4 hrs as needed for restlessness R150's corresponding narcotic book page associated with the Ativan order, showed the following: Ativan 5mg three times a day (TID) q4hr PRN R150's bubble pack card for Ativan listed the following:			F0755	Continued from page 11 accurate order for Ativan dose. Confirmation was completed and the order in the eMAR and on the bubble packed medication card were correct and R150 did receive the intended dose of Ativan at all times. Regarding all other residents who may be affected by this practice, an audit of all controlled/narcotics will be completed to ensure the card, narcotic count book and eMAR order are the same. Staff who are responsible for transcribing and administering controlled/ narcotic medications will be re-educated to their responsibility to this regulation with enhanced focus on the importance of accuracy in all order transcriptions and monitoring during medication administration that all areas listing the orders match. If there is notation of them not all matching, efforts must be made to clarify the correct/intended order and to correct the error immediately. If there is a change in direction during course of use of the medication, staff may utilize direction change stickers to indicate the change. The facility does not have a policy specific to medication transcription. The facility practice is to follow regulatory agencies' guidance including those of CMS and DEA in accordance with currently accepted professional principles. To ensure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring medication bubble cards, narcotic count books and eMAR directions all match daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026

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F0755 SS = D	Continued from page 12 Lorazepam (Ativan) 0.25mg solutab-dissolve 1 tablet (0.25mg) by mouth three times a day AND dissolve 1 tablet by mouth every 4 hours as needed. The pharmacy card did not include a sticker or any other connotation which would have indicated the different tablet strength which was listed in the EMAR and not on the card. The undated index page for the above listed narcotic book listed the following: R150-Lorazepam 0.25mg- entered on 7-1-26. On 7/9/26 at 1:40p.m. during an observation of medication storage in a medication cart, the narcotic drawer contained a card for R150's Ativan 0.25milligrams (MG) by mouth (PO). Page 111 of the corresponding narcotic book listed Ativan 5mg every (q) 4 hours (HR) as needed (PRN). The electronic medication administration record (EMAR) listed 0.5MG solutabs-give 0.25mg PO q4hr PRN. The licensed practical nurse (LPN)-B confirmed all the transcribed locations for the same order did not match and should have. On 7/9/26 at 1:50p.m., LPN-B stated the facility process for receiving and transcribing new narcotics was for the nurse or trained medical aide (TMA) to receive them and verify they have the correct medication, enter it in the narcotic book and verify with two nurses. Furthermore, when they completed a narcotic count, one staff would have the narcotic book, and one staff would have the medication cards. LPN-B stated they go by the index, the staff with the book would refer to the page listed on the medication card, and the person with the medication card would count the number of tablets and ensure they matched. On 7/9/26 at 2:50 p.m., the pharmacist (PHARM) confirmed all three areas regarding the above listed order, narcotic book, and the card should all match, and if there was a change in dose or tablet strength, the card should have had a sticker or another connotation to denote the change, however, it did not. The PHARM stated their expectation was for staff to be comparing the name/strength/dose of the medication during narcotic counts and during medication administration, and the importance of completing those checks to reduce the likelihood of medication errors. On 7/9/26 at 4:51p.m., the director of nursing (DON) stated their expectation was staff entered orders			F0755			08/24/2026

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NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH , SAUK RAPIDS, Minnesota, 56379			
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F0755 SS = D	Continued from page 13 received from the pharmacy, two nurses counted the medications and ensured they were correct and matched. Then write the correct directions for use in the narcotic book and were to be given a number from the index. Additionally, the DON stated they expect the staff members compared all areas listed above during narcotic count and medication administration, to ensure the resident received the correct medication, therapeutic dose, and to prevent diversion of medications. A policy for medication transcription was requested, however none was provided.			F0755			08/24/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure medications were labeled with an opened-on date as well as an expiration date for 1 of 4 medication carts (500 wing cart) reviewed for medication storage and labeling. Findings include:			F0761	The facility does ensure that drugs and other biologicals used in the facility are labeled in accordance with currently accepted professional principles. The facility does recognize that on 7/9/26 one Lantus pen did not have an open date or use by date noted and a box with 2 bottles of Systane eye drops had one bottle with an open date but no written expiration date and one without an open date or written expiration date. In regard to the Systane eye drops; upon follow up review with consultant pharmacist it is confirmed that Systane artificial tear eye drops do not require a reduced open time and that it is appropriate to use the manufacturer's labeled expiration date as the use by date. The bottles were inspected and both bottles did have the manufacturer's expiration date on them. One bottle's expiration date was located under the pharmacy label with resident identifiers on it. The other bottle had the expiration date visible. These bottles therefore would not require an open date in this situation as long as they were used by the manufacture's expiration date, which is this situation, had not passed. In regard to the Lantus insulin pen, the facility referred to the received receipt to determine when the insulin had entered the facility. That date was used as the open date as the pen could not have been opened prior to the facility receiving it. The pen remained within the allotted open timeframe with use of the received date. The facility obtained and supplied all mediation carts with a supply of labeling stickers to document open dates. Regarding all others who may be affected by this, all medication carts will be audited to ensure all medications that require open have them in place		08/24/2026

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F0761 SS = D	Continued from page 14 On 07/09/2026 at 1:50 p.m., during review of the 500 wing medication cart with licensed practical nurse (LPN-A) the following was observed: 1 Lantus insulin pen with no expiration date noted. A box containing 2 bottles of Systane eye drops: bottle 1 indicated an open date of 6/1/26, but lacked an expiration date. Bottle 2 lacked both an opened on and expiration date. LPN-A stated when new medications were delivered the nurse who received the medications was to place an opened-on/Expired sticker on the medication and when the medication was first used that date, as well as the expiration date was written on the sticker. LPN-A opened medication cart to demonstrate the process, however, could not find any of the stickers needed for proper labeling. LPN-A stated without the opened-on or expiration date staff wouldn't know how long a medication was opened and whether or not it was safe to use. Further, LPN-A stated eyedrops expired in 28 days after opening, and the eyedrops dated 6/1/26 were past expiration. During interview on 07/09/2026 at 4:51 p.m., Director of Nursing (DON) stated she expected when staff checked in medications from pharmacy, they should place an opened-on and expires-on sticker to medications such as eye drops, insulin, nasal sprays, and inhalers. DON stated it was important to have this information on the medications to make sure the medication was safe to use and given appropriately, and still within its therapeutic level to prevent infections and to prevent a resident from receiving a non-therapeutic dose. A policy related to medication labeling and storage was requested but not provided.			F0761	Continued from page 14 and if any do not, they will be disposed of. Staff who are responsible for medication administration and labeling will be re-educated to their responsibility to this regulation with enhanced education on the importance of labeling open dates to ensure residents receive medications safely and as per professional standards. The facility will create a policy to include appropriate guidance on labeling of medications that require open dates that are outside of the listed manufacturer expiration dates as well as guidance on the appropriate actions to take if a medication is found to not have a listed date. To assure ongoing compliance of the regulation, the facility quality team/designee will conduct routine audits ensuring medication that requires additional labeling of open dates daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 7/6/26 through 7/9/26, a standard recertification survey (S5269041-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT IN compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H52693146C/2984280			20000			07/30/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota Department of Health

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20000	Continued from page 1 H52693148C/2633020 H52693147C/2574238 The facility is enrolled in ePOC, 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, the facility must acknowledge receipt of the electronic documents.		20000			07/30/2026	
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 2 of 6 resident reviewed for bedrails. Findings include: R55's comprehensive minimum data set (MDS) dated 6/1/26 indicated R55 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and arthritis. Section P of the MDS which covers restraints and alarms indicated R55 did not use bedrails. During observation and interview on 7/6/26 at 10:24 a.m., R55's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R55 stated they had been there since her admission. R55's medical record was reviewed and did not indicate the use of bedrails. R16's quarterly MDS assessment dated 6/1/26 indicated R16 was cognitively intact and had the following diagnoses: coronary artery disease, heart failure, and high blood pressure. Section P of the MDS which covers restraints and alarms indicated R16 did not use bedrails. During observation and interview on 7/6/26 at 2:13 p.m., R16's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R15 stated he did not use them for		20550	corrected		08/24/2026	

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20550	Continued from page 2 positioning. R16's medical record was reviewed and did not indicate the use of bedrails. During interview on 7/9/26 at 4:51 p.m., director of nursing (DON) stated she expected the MDS assessment to be accurately completed and to include all necessary information pertaining to the resident's current health conditions. DON stated it was important to have the assessments be accurate as it drives the resident plan of care and ensures the resident received appropriate care. DON went on to state the MDS assessments also drive reimbursement and if incorrect the facility would not receive proper reimbursement. A policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, Director of Nursing, or designee could review policy and procedures and educated staff. Audits could be completed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550			08/24/2026	
21525	Pharmacist Service Consultation CFR(s): MN Rule 4658.1305 A.B.C A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to transcribe orders according to standards of practice for medication management for 1 of 5 (R150) residents reviewed for unnecessary		21525	corrected		08/24/2026	

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21525	Continued from page 3 medications. Findings include: R150's undated faceheet indicated they were admitted on 7/1/26, and had the following diagnoses: restlessness and agitation, pain, palliative care, and a frontotemporal neurocognitive disorder. R150's clinical physician orders dated 7-9-26, indicated the following order: Ativan 0.5mg solutabs- Give 0.25mg by mouth every 4 hrs as needed for restlessness R150's corresponding narcotic book page associated with the Ativan order, showed the following: Ativan 5mg three times a day (TID) q4hr PRN R150's bubble pack card for Ativan listed the following: Lorazepam (Ativan) 0.25mg solutab-dissolve 1 tablet (0.25mg) by mouth three times a day AND dissolve 1 tablet by mouth every 4 hours as needed. The pharmacy card did not include a sticker or any other connotation which would have indicated the different tablet strength which was listed in the EMAR and not on the card. The undated index page for the above listed narcotic book listed the following: R150-Lorazepam 0.25mg- entered on 7-1-26. On 7/9/26 at 1:40p.m. during an observation of medication storage in a medication cart, the narcotic drawer contained a card for R150's Ativan 0.25milligrams (MG) by mouth (PO). Page 111 of the corresponding narcotic book listed Ativan 5mg every (q) 4 hours (HR) as needed (PRN). The electronic medication administration record (EMAR) listed 0.5MG solutabs-give 0.25mg PO q4hr PRN. The licensed practical nurse (LPN)-B confirmed all the transcribed locations for the same order did not match and should have. On 7/9/26 at 1:50p.m., LPN-B stated the facility process for receiving and transcribing new narcotics was for the nurse or trained medical aide (TMA) to receive them and verify they have the correct medication, enter it in the narcotic book and verify			21525			08/24/2026

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21525	Continued from page 4 with two nurses. Furthermore, when they completed a narcotic count, one staff would have the narcotic book, and one staff would have the medication cards. LPN-B stated they go by the index, the staff with the book would refer to the page listed on the medication card, and the person with the medication card would count the number of tablets and ensure they matched. On 7/9/26 at 2:50 p.m., the pharmacist (PHARM) confirmed all three areas regarding the above listed order, narcotic book, and the card should all match, and if there was a change in dose or tablet strength, the card should have had a sticker or another connotation to denote the change, however, it did not. The PHARM stated their expectation was for staff to be comparing the name/strength/dose of the medication during narcotic counts and during medication administration, and the importance of completing those checks to reduce the likelihood of medication errors. On 7/9/26 at 4:51p.m., the director of nursing (DON) stated their expectation was staff entered orders received from the pharmacy, two nurses counted the medications and ensured they were correct and matched. Then write the correct directions for use in the narcotic book and were to be given a number from the index. Additionally, the DON stated they expect the staff members compared all areas listed above during narcotic count and medication administration, to ensure the resident received the correct medication, therapeutic dose, and to prevent diversion of medications. A policy for medication transcription was requested, however none was provided. SUGGESTED METHOD OF CORRECTION: The administrator, Director of Nursing, or designee could review policy and procedures and educated staff. Audits could be completed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21525			08/24/2026
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written			21565	corrected		08/24/2026

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21565	Continued from page 5 order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 2 of 2 residents (R2, R69) reviewed for medication administration. Findings include: R69's comprehensive MDS assessment dated 4/15/26 indicated R69 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and renal insufficiency. R69's self-administration of medication inquiry form signed by R69 on 4/15/26 indicated R69 did not want to self-administer medications either independently or after set-up by facility staff. During observation and interview on 7/6/26 at 11:04 a.m., a bottle of Nystatin powder with a pharmacy label containing R69's name was observed on the dresser. R69's orders reviewed on 7/8/26 lacked an order for self-administration of medication. R2's quarterly minimum data set (MDS) assessment dated 6/1/26, indicated R2 was cognitively intact and had the following diagnoses: heart failure, high blood pressure, end stage renal disease (ESRD) and diabetes. R2's self-administration of medication inquiry form signed by R2 on 8/28/25 indicated R2 did not want to self-administer medications either independently or after set-up by facility staff. During observation and interview on 7/6/26 at 3:32 p.m., a bottle of antifungal powder with a pharmacy label containing R2's name was observed on the bedside table in R2's room. R2's orders reviewed 7/8/26 lacked an order for self-administration of medication. During interview on 07/09/2026 at 7:28 a.m., licensed practical nurse (LPN-A) stated medications could be left at the bedside only if they have the doctors order to leave them and they have been assessed as safe to self-administer.			21565			08/24/2026

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21565	Continued from page 6 During interview on 7/9/26 at 4:51 p.m., Director of Nursing (DON) confirmed R69 and R2 did not have a SAM assessment and stated her expectation for SAM was residents were assessed and had a physician's order before a SAM was put in place or medications be left at bedside. DON went on to state it was important for residents to be assessed to ensure the 5 rights of medication administration were being followed, important for staff to know what medications the resident is taking and to prevent another resident gaining access to medications. A policy for self-administration of medications was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, Director of Nursing, or designee could review policy and procedures and educated staff. Audits could be completed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21565			08/24/2026	
21800	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute144.651 Subd. 4 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.		21800	corrected		08/24/2026	

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21800	Continued from page 7 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was displayed for residents, visitors, and staff to review. This had the potential to affect all residents currently residing in the facility, as well as all staff and visitors. Findings include: On 7/8/26 at 8:47 a.m., it was observed that RBOR poster was displayed in a locked glass case in a small common area near the entrance and was dated 1/16. On 7/8/26 at 12:02 p.m., director of Social Services confirmed the poster was outdated and a new one needed to be ordered. A facility policy was requested but none provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of Social Services, or designee could ensure residents and staff are educated about current resident rights and all copies displayed or given to residents/representative were up to date. Audits could be conducted to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21800			08/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH , SAUK RAPIDS, Minnesota, 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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on 07/08/2026. 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: 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			K0000			07/30/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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K0000 Bldg. 01	Continued from page 1 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 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 138 at the time of the survey.			K0000			07/30/2026

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K0000 Bldg. 01	Continued from page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			07/30/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/08/2026 at 11:44 AM, it was revealed by observation that all 7 neighborhood residential stoves are not equipped with a timer with a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the VP of Environmental Services Director verified these deficient findings at the time of discovery.			K0324	The facility does protect cooking equipment in accordance with NFPA 96, standard for ventilation control and fire protection of commercial cooking operations. Regarding the stoves on 7 households, three of the 7 households do not have a stove located on them. The remaining 4 household stoves will have a timer installed to ensure a 120-minute capacity to automatically deactivate the cooktop or range independent of staff action. Those households include Sunny Lake, ACE headwaters, Memory Lane and Canary Creek. Any future instillation of stoves within a resident household will have a timer with a 120- minute capacity. Re-education to staff who are responsible for installation and maintaining facility stoves within resident households will be re-educated with an enhanced focus on the importance of a way for stoves to deactivate independent of staff action and the use of the 120- minute timers that must be in place. To ensure ongoing compliance of the regulation, the VP of Environmental services/designee will conduct routine audits ensuring all stoves within households have the 120- minute timer installed daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026

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K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1.On 07/08/2026 at 11:30 AM, it was revealed by observation that there were multiple wires on the sprinkler pipe in Fan Room #1. 2.On 07/08/2026 at 11:40 AM, it was revealed by observation that there was a cable wrapped around the sprinkler pipe in the boiler room. 3.On 07/08/2026 at 11:55 AM, it was revealed by observation that there were multiple wires on the sprinkler pipe in Room B13. 4.On 07/08/2026 at 12:00 PM, it was revealed by observation that was a pneumatic line braced to the sprinkler pipe in Room B15.			K0351	The facility does ensure that it is protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the installation of Sprinkler Systems. Regarding the sprinkler heads and piping in the fan room, B13 and B15; cables wrapped around sprinkler piping in Fan Room #1, the boiler room, and B13 will be rerouted so they are not touching the sprinkler piping. The pneumatic line in Room B15 will be routed so it is not touching the sprinkler pipe. Regarding any other sprinkler heads and piping an audit of the building will be completed to ensure no wiring is on those sprinkler heads/piping. Re-education for staff who are responsible for maintaining the sprinkler system will be completed with an enhanced focus on the importance of keeping all sprinkler heads and piping free from any wires. Future cable installations will be inspected by the Maintenance Supervisor or VP of environmental services/designee to ensure compliance. To ensure ongoing compliance of the regulation, the VP of Environmental services/designee will conduct routine audits ensuring all sprinkler heads/piping remain free of wires/cables daily x1 week, weekly x 2 weeks, monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility Quality Assurance Meetings. Date of completion for this correction is Aug 24, 2026		08/24/2026

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K0351 SS = F Bldg. 01	Continued from page 4			K0351			08/24/2026
K0921 SS = F Bldg. 01	An interview with the VP of Environmental Services Director verified these deficient findings at the time of discovery. Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/08/2026 at 10:45 AM, it was revealed that the facility failed to provide documentation on the electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable			K0921	the date has been changed to the date waiver was submitted.		08/11/2026

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K0921 SS = F Bldg. 01	Continued from page 5 suction units, and other electrical medical equipment was present at the facility was inspected and maintained. An interview with the VP of Environmental Services verified this deficient finding at the time of discovery.			K0921			08/11/2026