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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5SFQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**
2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/14/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 09/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245393

September 24, 2015

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, Minnesota 55971

Dear Mr. Lindh:

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

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

Effective September 8, 2015 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 14, 2015

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, Minnesota 55971

RE: Project Number S5393024

Dear Mr. Lindh:

On August 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 30, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 14, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 8, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 8, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 30, 2015, effective September 8, 2015 and therefore remedies outlined in our letter to you dated August 13, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245393	A. Building B. Wing	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/08/2015**
ID Prefix **F0287** Reg. # **483.20(f)** LSC	Correction Completed **08/13/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/08/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/08/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/19/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	09/14/2015	10160	09/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/30/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245393	A. Building B. Wing **01 - MAIN BUILDING 01**	9/8/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **09/04/2015**	ID Prefix	Correction Completed **09/04/2015**	ID Prefix	Correction Completed **09/04/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0038		LSC K0050	
ID Prefix	Correction Completed **09/04/2015**	ID Prefix	Correction Completed **09/04/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0062		LSC K0147		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	09/14/2015	10160	09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/30/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5SFQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**
2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 13, 2015

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, Minnesota 55971

RE: Project Number S5393024

Dear Mr. Lindh:

On July 30, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 8, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 8, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 form will be used as verification of compliance. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 30, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the most recent survey results were available to the residents who resided at the facility. This had the potential to effect 69 out of 69 residents. Findings include:	F 167	Corrective Action: Good Shepherd Lutheran Home respects the residents¿ right to examine the results of the most recent survey of our facility conducted by the Federal or State surveyors and any plan of corrections in effect with respect to the facility. Good	7/31/15

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

Electronically Signed | 08/21/2015

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

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	245393	A. BUILDING _____ B. WING _____	07/30/2015

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GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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F 167	Continued From page 1 During an observation on the initial tour on 7/27/15 at 1:15 p.m. annual survey results that hung on a bulletin board outside the administrators' office were dated 7/11/2013. The 5/30/2015 survey with citations was not located in the area for resident access. During an interview on 7/27/15, at 7:15 p.m. the director of nursing (DON) verified the survey results were from 2013 and stated the 2014 survey results should have been posted. On 7/30/15 at 1:30 p.m. DON stated the facility did not have a policy pertaining to posting of survey results.	F 167	Shepherd Lutheran Home¿s most recent survey results were made available to all residents who reside at in the facility and are located in the main lobby. Identification: All current and future residents residing in the facility will have the most recent survey results available to them. Measures: Facilities most recent survey results will be made available to all residents who reside at Good Shepherd Lutheran Home. DON will post results when they are made available by the Minnesota Department of Health. Monitoring: Administrator will review and ensure placement of the most recent survey results on a monthly basis. Survey results will be reviewed during the next QA committee meeting. Responsible Person: Director of Nursing monitored by facility Administrator.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		9/8/15

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F 242	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R58) observed for activity was provided a choice of activity. Findings include: R58 was admitted to the facility on 6/12/12, with diagnosis that included heart failure and renal failure, according to facility admission record. The facility identified R58 on the annual Minimum Data Set (MDS), an assessment dated 6/18/15, to have moderate cognitive impairment, no behaviors, mood of feeling tired, activity preferences importance included keeping up with the news and doing things with a group were somewhat important to resident, locomotion on and off unit with supervision, and received no therapy. According to 14 day MDS dated 7/9/15, occupational therapy was started on 6/26/15, and physical therapy started 6/28/15. Document review of R58's care plan with revision date of 7/2/15, revealed a focus of altered feelings of well-being and resident was spending more time in the lobby area and near the puzzles to visit with others. Staff interventions included: "Offer me choices throughout my cares/routines. Offer me praise for time out of my room and socializing with others." R58's care plan with revision date of 9/22/14,	F 242	Corrective Action: Good Shepherd Lutheran Services respects each individual resident¿s right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care; their right to interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. R58¿s activity preferences were reviewed. Therapy was contacted and informed of his preferences. R 58¿s therapy schedule was revised to allow him to attend activities of his choice. Identification: Good Shepherd Lutheran Services strives to make our nursing facility more resident centered and homelike. All current residents receiving therapy were identified. Each resident receiving therapy was interviewed and therapy was informed of their activity preferences in order to develop a schedule that meets their individual needs. Measures: Therapy department was instructed to develop each individual therapy session time based around the residents activity preferences and at no time remove them from an activity or prevent them from attending an activity to go to a therapy	

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F 242	Continued From page 3 read, "I will need encouragement and instruction to play some of the games. I enjoy sitting and watching what takes place in the lobby and visiting with others." Staff interventions read, "Explain to me, the importance of social interaction, leisure activity time. Encourage my participation by telling what is going to take place so I can decide if it is something I want to do." During observation on 7/28/15, at 9:25 a.m., R58 was dressed neatly and sat on the edge of bed. During interview at that time, physical therapy aide (PTA)-A who had entered the room and stated it was time for therapy. R58 replied wanted to attend the group activity in the lobby at 9:30 a.m. PTA-A stated, "You are scheduled for therapy at 9:30 [a.m.]." "They will be disappointed if you did not come." R58 replied, "But I don't know, I wanted to go to the lobby for activity where a lady reads the paper, does puzzles." Following this conversation PTA-A pushed R58 in wheelchair to physical therapy room. On 7/28/15, at 9:34 a.m., activity aide (AA)-A had been interviewed and stated R58 "usually comes to the morning activity," and R58 "really likes this activity." During observations at that time, AA-A read news in lobby, visited about canning and chocolate candy. During interview on 7/28/15, at 9:39 a.m., therapy aide (TA)-A stated was responsible for scheduling therapy. TA-A stated, "sometimes we rearrange things," "usually try to work around activities," and "could have rescheduled" in regards to R58's therapy times. TA-A stated R58 usually had therapy later in day. TA-A stated that day the therapist was present for only a couple of hours so R58 was scheduled in the morning. During	F 242	session. In the event a resident is attending an activity during their scheduled therapy time, their therapy sessions will then be rescheduled to ensure their therapy needs are also met. Monitoring: During Plan of Corrections inservice, staff will be informed of each resident¿s right to attend activities of their choice and instructed to inform the Director of Nursing in the event the resident¿s preference is not honored. Resident¿s currently receiving therapy services will be assessed to ensure their personal activity choices are being honored weekly x 4 weeks then monthly x 2 months by the Quality Improvement Coordinator. Survey results will be reviewed during the next QA meeting. Responsible Person: All staff including therapy department monitored by Quality Improvement Coordinator and Director of Nursing.	

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F 242	Continued From page 4	F 242		

observations at that time, R58 was observed in the therapy room seated on a stationary bike pedaling with both feet.

During interview on 7/28/15, at 9:44 a.m., PTA-A stated, "[R58 was] scheduled for 9:30 [a.m.]" PTA-A stated R58 "Should have been aware of the schedule" as nursing and resident were notified yesterday of schedule. PTA-A stated he was aware R58 wanted to go to group activity at 9:30 a.m., was scheduled for therapy and "it is difficult to rearrange therapy schedule."

During interview on 7/28/15, at 9:49 a.m., director of nursing stated she expected R58 be provided choice of activity and to have therapy rescheduled. Director of nursing stated the choice of activity was part of facility culture change.

During interview on 7/28/15, at 10:35 a.m., R58 was asked how he felt when he was not allowed to attend the group activity. R58 stated therapy was "so bossy." R58 stated when did not want to go to therapy, they are "pretty bossy" and take me to therapy anyway.

Document review of facility Culture Change Journey: New Ways of Caring not dated read, "Goal with a new admit: resident changes their address but keeps their daily routines." "Return the focus of control to the residents: Staff change and slow their routines to the routines of the residents rather than expecting them to change to facility/staff routines. Residents have choices about sleeping, eating, having fun, and keeping clean, staff support continence for as long as possible, promote self-care and mobility, promote quality end-of-life care."

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F 242	Continued From page 5 Document review of facility employee handbook, not dated, page four: Culture Change read, "Residents should always be asked for their choice of food, beverage, activities, mealtime etc." During interview on 7/28/15, at 1:58 p.m., director of nursing verified culture change policy and employee handbook directed residents had choices about sleeping, eating, having fun.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide services in accordance with the plan of care and physician orders for 3 of 3 residents (R48, R46, R54) reviewed for activities of daily living. Finding include: R48 had diagnoses that included dementia, stroke, and diabetes as found on the doctors notes dated 7/8/15. R48 was observed on 7/27/15 1:00 p.m. sitting in the wheelchair in the lobby. R48's feet were dangling, no footrests were on the wheelchair. R48 had gripper socks on her feet, but no shoes.	F 282	Corrective Action: R48¿s Care plan was reviewed and updated to reflect current abilities. It was identified that she had a decline in her walking ability related to a sore toe after her podiatry visit and had been wearing gripper socks instead of her shoes. During that time she had been refusing to ambulate. Her toe has since healed and she has resumed ambulating with staff assist. R46¿s care plan was reviewed and found to be accurate and appropriate to have staff assess R46¿s skin on a daily basis. Staff were re-educated on R46¿s delicate	9/8/15

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F 282	Continued From page 6 On 7/27/15 at 5:30 a.m. R48 was observed in the dining room for the supper meal and again R48 wore gripper socks but no shoes. The care plan dated 5/25/15 indicated R48 was to wear black shoes, walk twice a day, one staff to ambulate 50 to 100 feet in the morning daily. The Bedside Kardex Report provided 7/29/15 indicated R48 was to be walked daily. The physician's orders dated 7/18/14 noted R48 was to walk with wheeled walker and supervision to meals. Nursing assistant ADL (activity of daily living) charting was reviewed for 6/28/15 to 7/28/15. The documentation indicated R48 was not walked daily but only 19 of 30 days and was not walked to meals. During an interview on 7/29/15 at 7:20 a.m. the nursing assistant (NA)-C stated R48 was to walk every day in the hallway, but would not do so. R46 had been observed on 7/28/15, at 9:12 a.m. R46 was observed seated in her wheelchair in a common area of the facility. R46 was observed to have a red and purplish colored bruise on the top of her left forearm. R46's care plan interventions dated 12/31/12 included, "staff will help to inspect my skin daily for any redness, irritation or breakdown...SKIN INSPECTION: Due to my decreased mobility staff should inspect my skin daily for breakdown." R46's NAR [nursing assistant registered] Bath Day Worksheets were reviewed for the month of July 2015 and revealed no documentation of bruising to R46's left forearm. R46's nurse progress notes were reviewed from 7/1/15 to 7/31/15 and revealed no documentation related to the bruise on R46's left forearm.	F 282	skin and increased risk for bruising and injury. TAR was updated to include monitoring of bruise on left forearm daily for changes until resolved along with an ongoing weekly comprehensive skin assessment evaluation. R54¿s skin was reassessed on 7/28/15. A progress note was added regarding the bruising on his left elbow from his fall. TAR was updated with weekly skin assessment. Identification: Each resident using a wheelchair was reassessed for their need for foot rests to ensure their feet were supported. Weekly Skin assessments will be reviewed during the mandatory Plan of Corrections inservice on 8/27/15. Bruising and non-pressure related skin breakdown will be addressed. A template was developed for licensed nurses to document a weekly skin progress note on all residents. Monitoring: Resident Care Plans will be reviewed three per day over the course of the next month for accuracy. Care Plans will be updated as needed with changes reported during daily review, weekly skin assessment and newly revised Physical Device Assessment for wheelchair positioning by the appropriate Case Manager. Case Managers will also assess for further updates required during each resident¿s quarterly review based on assessments/MDS/CAA data. Quality Improvement Coordinator will collect	

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F 282	Continued From page 7 R46's treatment administration record for July 2015 was reviewed and revealed the bruise on R46's left forearm was not being monitored for healing. On 7/29/2015 11:27 a.m. nursing assistant (NA)-C stated she last worked with R46 on Monday (7/27/15) and did not recall seeing the bruise on R46's forearm. NA-C stated she looked for bruises when doing cares for residents daily and stated on a residents bath day, nursing assistants documented on the bath sheet identified skin concerns. NA-C stated when a bruise was identified the nurse was informed for follow-up. On 07/29/15 11:00 a.m. registered nurse (RN)-B verified R46 had a bruise on the top of her left forearm. RN-B stated there had been no documentation of bruising identified on the bath sheets dated 7-18-15 or 7-25-15 or in the nurse progress notes. RN-B stated nursing assistants were to monitor skin daily during cares. RN-B stated when a bruise was identified a nurse was to follow up on the bruise and assess the area. If a resident was unable to explain the bruise staff were to complete an unexplained bruise report and complete an incident report. RN-B stated nursing would start a treatment on the TAR to monitor for healing of the bruise. R46's progress note dated 7/30/15 read, "Noted light purple bruise on left forearm, that is fading it measures L [length] 3.5 cm [centimeters] x [times] W [width] 2.5 cm at widest part. Is irregular shaped bruise...TAR [treatment administration record] to monitor bruise changes..."	F 282	monthly review forms daily x 1 month and compare with Care Plan updates. Results will be reviewed by Director of Nursing to determine further monitoring schedule. Weekly skin progress notes will be monitored weekly x 4 weeks then q 2 weeks x2 months by the Quality Improvement Coordinator. Results will be reviewed by QA committee and Director of Nursing. Responsible Person: Licensed Nurses, Case Managers monitored by Quality Improvement Coordinator and Director of Nursing.	

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F 282	Continued From page 8 On 07/30/15 at 2:05 p.m. RN-B verified the facility failed to follow the care plan for identification of R46's bruise during the daily skin checks. R54 had been observed on 7/27/15, at 6:44 p.m. R54 had a fistula for dialysis in the left antecubital space and three bruises that surrounded the left elbow area. The largest bruise was the size of a baseball and the smallest one was the size of a quarter. R54 stated, "I bumped it yesterday." It was not evident in the medical record the facility had identified the bruises until it was brought to the facility's attention on 7/28/15, at 3:42 p.m. by this surveyor. R54 was admitted to the facility on 5/16/12 according to the facility admission record with diagnoses that included but not limited to end stage renal failure and diabetes type II. R54's annual Minimum Data Set (MDS) dated 5/20/15 indicated R54 received dialysis, had no cognitive impairment with a Brief Interview for Mental Status score of 14 and was independent for all activities of daily living except required set up assistance from staff in the areas of eating and personal hygiene. R54's electronic care plan provided by the facility on 7/29/15 the care plan directed staff to "monitor/document/report to MD [medical doctor] PRN [as needed] changes in skin status: appearance, color, wound healing, s/sx [signs/symptoms] of infection, wound size, stage ....observe for redness, open areas, scratches, cuts, bruises, and report changes to nurse ..." R54's treatment administration record (TAR) did not indicate bruises had been identified in the past two days. R54's nursing progress notes did not reflect identification of the bruises on the left arm in the past two days.	F 282		

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F 282	Continued From page 9 During an interview on 7/29/15, at 8:50 a.m. the director of nursing (DON) stated daily monitoring was not documented in the medical record for R54's bruse. On 7/30/15 the director of nursing provided a copy of the Minnesota Administrative Rules 4658.0405 and stated this was the policy the nursing home used for care planning. The Rules indicated that a "Comprehensive plan of care must be used by all personnel involved in the care of the resident."	F 282		
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a	F 287		8/13/15

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F 287	Continued From page 10 facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure timely submission of a discharge Minimum Data Set (MDS) for 1 of 16 residents (R88) reviewed for discharge MDS. Findings include: R88 was admitted to the facility on 4/25/15 according to the facility admission record and was discharged from the facility on 5/2/15. During an admission record review on 7/28/15, at 1:00 p.m. it was discovered the discharge Minimum Data Set (MDS) with an assessment	F 287	Corrective Action: R 88¿s discharge Minimum Data Set reviewed and found to be completed, was locked and submitted to CMS. Identification: Good Shepherd Lutheran Home understands and acknowledges the requirement to encode and electronically transmit MDS data for each resident in the facility. All resident discharged from Good Shepherd Lutheran Home within the past year were reviewed to ensure each discharge MDS had been submitted to	

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F 287	Continued From page 11 reference date (ARD) of 5/2/15 had not ever been submitted. During an interview on 7/28/15, at 1:37 p.m. licensed practical nurse (LPN)-B verified the discharge MDS had not been submitted. Stated the discharge MDS should have been submitted by 5/15/15. LPN-B explained at the time, the admission MDS had not yet been accepted so the discharge MDS could not be signed and submitted. Stated it was an oversight. During an interview on 7/30/15, at 1:35 p.m. registered nurse (RN)-B stated the case managers were responsible for completing, signing, and locking the MDS's and the director of nursing (DON) was responsible for monitoring the progress and completion of the MDS and was solely responsible for the MDS submissions. During an interview on 7/30/15, at 1:45 p.m. DON verified she had been person responsible for the MDS submissions and explained she had been the person responsible for ensuring the MDS's were signed and completed. DON explained she had submitted MDS's once per week on Mondays unless someone needed an MDS submitted earlier. DON further explained, if the admission MDS had not been submitted, the case manager would not have been able to sign and lock the discharge MDS. DON stated the case manager probably forgot to go back into the MDS program to sign it after admission MDS had been submitted. DON stated she had not reminded the case manager to go back in and sign the discharge MDS. DON indicated there was not an auditing system in place to ensure the timely submission of the MDS's, stated "I am the checks and balances."	F 287	CMS. Measures: Point Click Care Admit/Discharge report will be printed off and compared to MDS Submission Batch prior to exporting to CMS to ensure all Discharge data is submitted as required. Monitoring: Director of Nursing will review validation report and compare with discharge report and MDS schedules for accuracy weekly. Results will be reviewed with the Case Managers and QA Committee. Responsible Person: Case Managers monitored by and the Director of Nursing or designee.	

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F 287	Continued From page 12 CMS Submission Report MDS 3.0 NH Final Validation Report indicated the discharge MDS dated 5/2/15 was late and had been submitted on 7/28/2015. A policy was requested and not received.	F 287		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility failed to evaluate wheelchair positioning for 2 of 2 residents (R1, R48) in the sample who utilized wheelchairs and failed to identify non-pressure related skin injuries for 2 of 3 residents (R46, R54) reviewed with non-pressure related skin conditions. Findings include: LACK of WHEELCHAIR POSITIONING: R1 was admitted to the facility on 8/6/84, and had diagnosis that included osteoporosis, dementia,and schizophrenia, according to facility admission record. R1 was identified on the annual Minimum Data	F 309	Corrective Action: Good Shepherd Lutheran Services strives to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. In regards to wheelchair positioning, R1 was reassessed by Occupational Therapy on 7/30/15 and foot rests with padding were applied. R48¿s wheelchair positioning was assessed by Occupational Therapy on 7/29/15. R48¿s w/ch was modified (lowered), bilateral elevating leg rests with calf pad was applied to her w/ch.	9/8/15

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F 309	Continued From page 13 Set (MDS), an assessment dated 6/2/15, to have short and long term memory problem, moderately impaired decision making, required extensive assistance of two staff for activities of daily living, and received restorative therapy range of motion, no occupational therapy and no physical therapy. Document review of R1's care plan dated 7/2/05, identified a focus of mobility assistance related to anxiety, schizophrenia, dementia, osteoporosis, poor judgement, unsteady, refused to walk. Staff interventions included unable to walk, if in wheelchair, needs staff assistance, total assist of one staff for wheelchair mobility, refused to work with physical therapy, reposition every two hours and offload for one minute at that time. Document review of facility nursing assistant assignment sheet printed 7/30/15, revealed locomotion on and off the unit was initialed by staff three times a day. Document review of facility occupational therapy (OT) consult dated 6/23/14, identified plan in place for range of motion exercises to extremities, no positioning devices in bed, wheelchair, or splints or orthotics. The consult lacked evaluation of wheelchair position. During observations on 7/27/15, at 6:47 p.m., licensed practical nurse (LPN)-F pushed R1 in wheelchair to R1's room. R1's feet did not touch the floor and there were no leg/feet supports. Observations at 6:50 p.m., revealed LPN-F pushed R1 in wheelchair back to lobby. R1's feet did not touch the floor and there were no leg/feet rests. During observations on 7/29/15, at 10:57 a.m.,	F 309	R46¿s care plan was reviewed and found to be accurate and appropriate to have staff assess R46¿s skin on a daily basis. Staff were re-educated on R46¿s delicate skin and increased risk for bruising and injury. TAR was updated to include monitoring of bruise on left forearm daily for changes until resolved along with an ongoing weekly comprehensive skin assessment evaluation. R54¿s skin was reassessed on 7/28/15. A progress note was added regarding the bruising on his left elbow from his fall. TAR was updated with weekly skin assessment. Identification: Each resident using a wheelchair was reassessed for their need for foot rests to ensure their feet were supported. Weekly Skin assessments will be reviewed during the mandatory Plan of Corrections inservice on 8/27/15. Bruising and non-pressure related skin breakdown will be addressed. A template was developed for licensed nurses to document a weekly skin progress note on all residents. Physical Device Assessment was revised to aide in assessing residents wheelchair positioning needs on a routine basis. Measures: Occupational Therapy will continue to visually assess residents wheelchair positioning on a monthly basis. Physical Device Assessment which is completed upon admission, with a significant change, hospital return, quarterly and prn was	

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F 309	Continued From page 14 nursing assistant (NA)-A and NA-B completed morning cares and transferred R1 to wheelchair. NA-B pushed R1 in wheelchair from R1's room to the activity room, feet dangled without leg/feet supports. Observations revealed no evidence of wheelchair foot rests in R1's room. During interview on 7/29/15, at 11:20 a.m., LPN-A stated R1 could place feet on the floor. Observations at that time revealed R1 sat in wheelchair with knees lifted upward and feet did not touch the floor. Observations on 7/29/15, at 11:28 a.m., NA-B assisted R1 to eat in the activity room. Feet were observed off the floor. Observations on 7/29/15, at 11:41 a.m., R1 was done eating and NA-B pushed wheelchair to lobby, feet dangled with no leg/feet supports. During interview on 7/29/15, at 11:43 a.m., NA-B stated R1 did not use wheelchair foot rests. NA-B stated did not know why there were no wheelchair foot rests. During interview on 7/29/15, at 11:57 a.m., LPN-A verified R1's feet dangled and did not touch the floor. LPN-A stated did not know why R1 lacked wheelchair foot rests. During interview on 7/29/15, at 12:15 p.m., registered nurse (RN)-A verified R1 did not use wheelchair foot rests. RN-A stated R1 made frequent body movements while in wheelchair, would not be able to keep feet on wheelchair foot rests, and would injure self. RN-A verified OT consult dated 6/23/14, did not include assessment for wheelchair foot rests. RN-A	F 309	revised to include wheelchair positioning. Type of w/ch used, hip and knee positioning, ability to propel with feet and use of foot rest was added to the assessment. Staff will be educated during Plan of Corrections inservice on proper wheelchair positioning and the risk of pressure related skin breakdown if a resident¿s feet are not properly supported and instructed to inform the Nurse/Case Manager of need for alterations to establish proper positioning. Staff will also be educated on non-pressure related injuries to monitor along with revised procedure for assessing and monitoring. Monitoring: Newly revised Physical Device Assessments will be implemented for accuracy and ongoing monitoring. Results will be reviewed by the QA committed and Director of Nursing. Weekly skin progress notes will be monitored weekly x 4 weeks then q 2 weeks x2 months by the Quality Improvement Coordinator. Results will be reviewed by QA committee and Director of Nursing. Responsible Person: Direct care staff, Licensed Nurses, Case Managers monitored by Quality Improvement Coordinator and Director of Nursing.	

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F 309	Continued From page 15 verified no evidence of OT evaluation of wheelchair position. During observations on 7/30/15, at 9:11 a.m., occupational therapist registered (OTR) and registered nurse-A (RN-A) were in R1's room, while OTR evaluated wheelchair position. Two wheelchair foot rests were in place with pads on the leg rests and pads for the feet. OTR stated had evaluated resident position one year ago and "everything was midline then." OTR stated she would have looked at wheelchair position at that time, although it was not documented. OTR stated R1 had been positioned in wheelchair with padded foot rests for 45 minutes at that time with no restlessness. R1 appeared calm. OTR stated without foot rests, pressure on back of knees may cause inadequate weight distribution. OTR stated she conducted a monthly walk through the facility dining room to observe residents wheelchair positions. OTR stated R1 may not have been present. OTR and RN-A stated R1 did not propel wheelchair with feet. OTR and RN-A verified R1 sat in wheelchair without leg supports, feet dangled and did not touch the floor. RN-A stated yesterday afternoon she saw R1 in wheelchair with feet touching the floor. RN-A verified R1's feet dangled due to R1 pulled up knees. Document review of OT evaluation completed on 7/30/15, with following recommendations: Positioning-resident in narrow adult 16 inch wheelchair with 2 inch foam gel cushion, hips centered and to the back, feet do not touch floor per nursing, so foot rests (elevating with calf pad) added. Resident would benefit from OT to modify/adapt wheelchair environment to maximize wheelchair tolerance, skin and joint	F 309		

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F 309	Continued From page 16 integrity, toward safe oral intake and socialization(mobility dependent). Although requested, no wheelchair position policy was provided. R48 was observed on 7/27/15 at 1:00 p.m. sitting in the wheelchair in the lobby. The wheelchair had a 4 inch cushion on the seat and no foot rests. Her feet dangled about 12 inches above the floor. On 7/27/15 at 5:30 p.m. while at the dining room table her feet continued to dangle without support. On 7/28/15 R48 was observed again at the dining room table to have her feet dangle without support while sitting in the wheelchair. On 7/29/15 at 8:45 a.m. R48 was again observed to be in the wheelchair with feet dangling and unsupported. NA-D house manager was observed to move R48 in wheelchair and not foot rests were noted. The physician visit notes dated 7/8/15 noted R48 to have diagnoses that included dementia, type 2 diabetes, history of stroke and a history of lower extremity blood clot. R48's care plan dated 5/25/15 was reviewed and indicated the wheelchair was to be positioned for self -transfers and the wheelchair was to have a wedge cushion for positioning. LPN-B a case manager was interviewed on 7/29/15 at 8:50 a.m. and stated R48 did not have footrests because she would self-transfer. LPN-B stated that occupational therapy (OT) was responsible for wheelchair positioning. On 7/29/15 at 9:02 a.m. the occupational therapist (OTR) and the therapy aid (TA)-A were interviewed. OTR said that R48 had not received	F 309		

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services from occupational therapy since 2011 and had not had a recent referral for services. OTR stated OT was responsible for wheelchair positioning and that it was not good for the resident to have feet dangle. With feet dangling above the ground it would not be safe for a resident to transfer independently.
NON-PRESSURE RELATED SKIN ISSUES:

R46 had been observed on 7/28/15, at 9:12 a.m. R46 was observed seated in her wheelchair in a common area of the facility. R46 was observed to have a red and purplish colored bruise on the top of her left forearm.

R46's quarterly minimum data set (MDS) assessment dated 6/16/15 indicated R46 required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and locomotion on/off the unit. The MDS indicated R46 had severely impaired decision making skills for daily living and long and short term memory problems.

R46's care plan interventions dated 12/31/12 included, "Staff will help to inspect my skin daily for any redness, irritation or breakdown...SKIN INSPECTION: Due to my decreased mobility staff should inspect my skin daily for breakdown."

R46's NAR [nursing assistant registered] Bath Day Worksheets were reviewed for the month of July 2015 and revealed no documentation of bruising to R46's left forearm.

R46's nurse progress notes were reviewed from 7/1/15 to 7/31/15 and revealed no documentation related to the bruise on R46's left forearm.

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R46's treatment administration record for July 2015 was reviewed and revealed the bruise on R46's left forearm was not being monitored for healing.

On 7/29/2015 11:27 a.m. NA-C stated she last worked with R46 on Monday 7/27/15 and did not recall seeing the bruise on R46's forearm. NA-C stated she looked for bruises when doing cares for residents daily and stated on a residents bath day, nursing assistants documented on the bath sheet identified skin concerns. NA-C stated when a bruise was identified the nurse was informed for follow-up.

On 07/29/2015 11:00 a.m. RN-B verified R46 had a bruise on the top of her left forearm. RN-B stated there had been no documentation of bruising identified on the bath sheets dated 7-18-15 or 7-25-15 or in the nurse progress notes. RN-B stated nursing assistants were to monitor skin daily during cares. RN-B stated when a bruise was identified a nurse was to follow up on the bruise and assess the area. If a resident was unable to explain the bruise staff were to complete an unexplained bruise report and complete an incident report. RN-B stated nursing would start a treatment on the treatment administration record (TAR) to monitor for healing of the bruise.

R46's progress note dated 7/30/15 read, "Noted light purple bruise on left forearm, that is fading it measures L [length] 3.5 cm [centimeters] x [times] W [width] 2.5 cm at widest part. Is irregular shaped bruise...TAR to monitor bruise changes..."

On 07/29/2015 8:31 a.m. DON stated residents'

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skin was monitored visually during cares and a complete skin assessment was done each week on bath day. The DON stated she would expect staff to document the size and location of bruising when noticed and monitor the bruising for healing.

R54 had been observed on 7/27/15, at 6:44 p.m. R54 had a fistula for dialysis in the left antecubital space and three bruises that surrounded the left elbow area. The largest bruise was the size of a baseball and the smallest one was the size of a quarter. R54 stated, "I bumped it yesterday." It was not evident in the medical records the facility had identified the bruises until it was brought to the facility's attention on 7/28/15, at 3:42 p.m.

R54 was admitted to the facility on 5/16/12 according to the facility admission record with diagnoses that included but not limited to end stage renal failure and diabetes type II.

R54's annual Minimum Data Set (MDS) dated 5/20/15 indicated R54 received dialysis, had no cognitive impairment with a Brief Interview for Mental Status score of 14 and was independent for all activities of daily living except required set up assistance from staff in the areas of eating and personal hygiene.

R54's electronic physician order's included Aspirin 81 milligrams (mg) by mouth once per day which has side affect of decreasing clotting increasing chance of bruising.

R54's electronic care plan provided by the facility on 7/29/15 did not identify R54's risk for bruising and did not identify left elbow bruises. The care plan directed staff to "monitor/document/report to MD [medical doctor] PRN [as needed] changes in skin status: appearance, color, wound healing, s/sx [signs/symptoms] of infection, wound size, stage ....observe for redness, open areas, scratches, cuts, bruises, and report changes to

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F 309	Continued From page 20 nurse ..." R54's TAR indicated routine monitoring of the left arm fistula was checked on all three shifts on 7/26/15 and was checked on all three shifts on 7/27/15. Despite the six times the left arm was checked, it was not evident the bruises had been identified or reported. R54's nursing progress notes did not reflect identification of the bruises on the left arm. During an interview on 7/28/15, at 3:42 p.m. LPN-G verified the bruises on R54's elbow, R54 then told the LPN he had fallen by his car on Sunday (7/26/15). LPN stated she had not been aware the bruises or the fall. LPN-G explained when skin checks were performed by NA's when they provided cares, then they would report to the nurse, the nurse would fill out an incident report, report it to the case manager, and then investigated. LPN-G further stated bruises are measured, entered into the medical record, and monitored every day. LPN-G stated the everyday monitoring was not documented in the medical record, nurses would write progress notes on any changes observed. During an interview on 7/29/15, at 8:50 a.m. the director of nursing (DON) said the bruising should have been documented and follow-up on to see if they resolve. Facility policy Bruise and Injury Policy, Procedure, and Investigation Form, included the following direction: "Nursing staff are required to actively search resident skin surfaces for any skin problems including bruises or injury during nursing cares". The policy directed staff to "Follow written and photo documentation procedures for any skin problem identified." The policy provided did not include documentation procedures, lacked instruction on risk assessment, follow-up care, and monitoring.	F 309		

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F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 review, the facility failed to ensure hazardous chemicals were inaccessible to residents who wonder and were cognitively impaired. This had the potential to affect 4 residents identified by the facility to be cognitively impaired and wandering; and failed to ensure a mobility device was used per manufacturer instructions to reduce the risk of injury for 1 of 1 resident (R62) observed to be pushed while seated in a four wheeled walker. Findings include: LACK OF CHEMICALS SECURED FROM COGNITIVELY IMPAIRED RESIDENT ACCESS: During an observation on the initial tour on 7/27/15, at 1:03 p.m. the door to the west shower room was unlocked; 2 full gallon jugs of Turbo Clean, and a jug of Cid-A-L II were found to be on the floor under a chair next to the bathtub. In addition, a spray bottle that contained a disinfectant was hanging from a water pipe on the wall next to the tub. The Material Safety Data Sheet (MSDS) for Turbo Clean last issued on 7/22/15 indicated the effects of exposure could cause, acute mild irritation of	F 323	Corrective Action: The safety of those residing at Good Shepherd Lutheran Home is a top priority. The doors to each Spa room are to be locked at all times to ensure residents are not exposed to hazardous chemicals and to guarantee chemicals are inaccessible to residents who are cognitively impaired and wander. All of the chemicals used to disinfect and sanitize the whirlpool spa were moved to a locked cabinet. The nursing assistant that wheeled R62 seated in her four-wheeled walker was re-educated on the manufactures guidelines that state the wheeled walker is not to be used as a wheelchair for safety reasons. Identification: Current and future residents with cognitive impairment that wander have been identified. Staff were re-educated on requirement for the Spa room doors to remain locked from the outside at all times for the safety of our residents.	9/8/15

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F 323	Continued From page 22 sensitive skin and mucous membranes, in large quantities could cause nausea and vomiting, and may cause chest discomfort and coughing. The MSDS further advised not to get into eyes and to not induce vomiting if consumed (caustic material). The MSDS for Cid-A-L II indicated a high hazardous warning with a score of 3 and advised chemical could cause severe skin/eye irritation. The MSDS warned "eye contact causes irritation and chemical burns, vapor may cause drowsiness, nausea, loss of motor skills, or disorientation" and directed to consult a physician immediately if swallowed. The MSDS advised the use of goggles or a full face shield, adequate ventilation, impervious gloves, and to use respiratory protection as a good practice. During an interview on 7/27/15, at approximately 1:30 p.m. nursing assistant (NA)-I verified the door to the west shower room had been open and verified the chemicals were on the floor. NA-I stated, the chemicals were not supposed to be on the floor, they were supposed to be off the floor. NA-I then moved the chemicals to the other side of the tub and placed the chemicals on platform approximately the height and size of a pallet. NA-I further stated the door to the shower room was supposed to be locked because of the chemical storage. NA-I did not know why the shower door had been unlocked. During an interview on 7/29/15, at 8:59 a.m. the director of nursing (DON) explained no chemicals should be stored in the shower room out in the open. DON further explained the chemicals should have been stored in the cabinet in the shower room and then the shower room locked. DON stated the shower rooms are locked because of storage of chemicals. During an interview on 7/30/15, at 1:55 p.m. DON	F 323	Current and future residents that use four wheeled walkers with a seat have been identified. Staff working with these residents were instructed that at no time should their walker be used for transportation from one location to another. Measures: Maintenance director assessed the lock on the spa room doors. Each lock will be replaced to only allow access by staff with a key while allowing exiting from the inside unobstructed. Chemicals used to disinfect and sanitize will remain in locked cabinets going forward. Staff will be re-educated on proper storage of hazardous chemicals during mandatory inservice. Staff were re-educated on the manufactures guidelines for the proper use of four wheeled walkers. Staff were instructed that at no time should residents be pushed while seated on their walker to avoid a tip-over resulting in injury. Monitoring: Maintenance department to stock chemicals in the locked cabinets as supply runs low. Quality Improvement Coordinator will check that all chemicals are in locked cabinets and check doors to the Spa rooms to ensure automatic locks are in proper working order and on a weekly basis x 1 month. All staff to assist in observing for any staff	

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F 323	Continued From page 23 indicated there had been four residents who had been in the facility at time who were cognitively impaired that wondered. A facility policy on the storage of chemicals was asked for and not provided. IMPROPER USE OF WALKER: R62's quarterly Minimum Data Set (MDS) dated 6/11/15, identified R62 had intact cognition, and required supervision with staff assistance for transfers and ambulation. During observation on 7/29/15, at 7:36 a.m. nursing assistant (NA)-F pushed R62 down the hallway towards the tub room while R62 was seated on a purple Guardian Envoy 480 four-wheeled walker (a device used for ambulation). R62 had clothing in her hands, and was not holding onto the device for security. When interviewed on 7/29/15, at 8:07 a.m. NA-F stated R62 liked to hold her clothes for her morning bath and "just prefers" to be pushed in her four-wheeled walker on her bath days. Further, NA-F stated she was "not sure" if the four-wheeled walker manufacturer recommended the device be used in that way, or if R62 had been assessed for safety when using the device in that way. During interview on 7/29/15, at 8:27 a.m. licensed practical nurse (LPN)-B stated residents should not be pushed on their walkers as they were "not to be used as a wheelchair." Further, LPN-B stated using the device in that way was not safe to do. When interviewed on 7/29/15, at 11:30 a.m.	F 323	found to be using wheeled walkers in an unsafe manor and instructed to report to Nurse or Director of Nursing immediately . Responsible Person: Maintenance staff monitored by Quality Improvement Coordinator All staff monitored by Nurses and Director of Nursing	

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F 323	Continued From page 24 registered nurse (RN)-A stated R62 should not have been pushed down the hallway while she was seated on her four-wheeled walker, "That would be unsafe." An undated Guardian Select Envoy 480 Rolling Walker User Instructions manual read, "Do not use this walker as a wheelchair; doing so may result in a tip-over, resulting in injury."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/8/15

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F 329	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to establish parameters for use and identify non-pharmalogical interventions for an as needed anxiety medication for 1 of 5 residents (R9) reviewed for unnecessary medications; and failed to provide a physicians justification for use of two anti-depressant (duplicate therapy) medications for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings Include: R9 was admitted to the facility on 10/6/14 according to the admission record with diagnoses including: acute chronic systolic heart failure, chronic airway obstruction and dementia without behavioral disturbance. R9 was started on hospice services on 7-17-15. R9's physician order sheets signed and dated 7-28-15 revealed that R9 had orders for the following psychotropic medication: Lorazepam Solution (antianxiety medication) 2 MG[milligrams]/ML[milliliters] Give 0.25 ml sublingually every 4 hours as needed for anxiety and restlessness. However, there were no individualized symptom parameters identified that directed staff when to administer the PRN Lorazepam to R9. R9's Medication Administration Record revealed: On 7/27/15 and 7/28/15 - Lorazepam Solution 0.25 ml was administered for anxiety and restlessness. There was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the	F 329	Corrective Action: The goal of Good Shepherd Lutheran Home staff is that each resident¿s drug regime will be free from unnecessary drugs. The resident¿s drug regime is reviewed by staff, physician/nurse practitioner (MD/NP), and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. R9¿s prn lorazepam was reviewed by Hospice on 7/30/15. MAR was updated to include specific indications for use of the prn and direction to attempt non-pharmacological interventions first. Staff educated on updates. R40 seen Dr. Modjeski on 8/19/15 for review of her medications specifically her Celexa and Wellbutrin. Current status was reviewed and MD noted ¿did well with prior reduction. Decrease Wellbutrin to 50mg po qd¿. Identification: All resident receiving prn psychotropic medications were reviewed for specific target behavior parameters on the MAR to direct staff when the medication is to be administered along with instruction to attempt and document non-pharmacological interventions prior to administration. Staff re-educated on	

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F 329	Continued From page 26 Lorazepam Solution to R9. R9's nurses' notes were reviewed from 7/1/15 to 7/28/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted and there was no documentation hospice has been consulted prior to the administration of the PRN Lorazepam. On 07/30/2015 9:56 a.m. licensed practical nurse (LPN)-D stated when giving prn Lorazepam non-pharmacological interventions should be attempted prior to the administration of the medication and documented in point click care. LPN-D verified there were no individual symptom parameters in place for the use of the prn lorazepam for R9. On 07/30/2015 10:30 a.m. the director of nursing (DON) stated she would expect staff to try other interventions prior to the administration of the PRN Lorazepam. The DON stated staff should document the behavior symptoms and the non-pharmacological interventions attempted prior to the administration of the medication in point click care. The DON verified individual symptom parameters were not in place for the use of the prn lorazepam for R9. The Medication Administration Record policy updated 7-15-09 read, "...c. Non-pharmacological interventions are to be attempted prior to the use of prn medications if appropriate. Examples: ice, behavior modification interventions, repositioning, ambulation, increased fluids etc. d...PRN psychotropic: will have indications/DX on when to administer..." LACK OF JUSTIFICATION FOR USE OF TWO ANTIDEPRESSANTS:	F 329	procedure regarding documenting non-pharmacological interventions attempted prior to the use of prn psychotropic medications. All current residents receiving an antidepressant were reviewed for medical justification. Those found to be taking more than one antidepressant were reviewed again by Dr. Modjeski for justification or medication change. Monitoring: During month end change over [staff comparing previous month MAR with upcoming month MAR for accuracy] staff will monitor prn psychotropic medication orders for specific target behavior parameter along with instruction to attempt/document non-pharmacological interventions that are attempted prior to administration. Documentation will be reviewed on a weekly basis x one month then prn thereafter depending on results of previous audits to ensure proper documentation of non-pharmacological interventions are being attempted prior to administration. Case Managers will inform Director of Nursing when a resident is prescribed more than one antidepressant. Director of Nursing will review for proper documentation to justify use monthly x 3 months and prn thereafter depending on results of previous audits. Results will be reviewed with QA committee. Responsible Person:	

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F 329	Continued From page 27 R40's annual Minimum Data Set (MDS) dated 6/11/15, identified R40 had moderate cognitive impairment, and took an antidepressant (a psychotropic medication used to alleviate depression) on a daily basis. R40's signed physician orders dated 7/22/15, included the following three psychoactive medications: "Citalopram Hydrobromide [Celexa an antidepressant] Tablet 20 mg [milligrams]...by mouth in the morning related to DEPRESSIVE DISORDER..." Celexa has been given daily for over 17 months. Wellbutrin [an antidepressant] Tablet 100 mg ...by mouth in the morning related to DEPRESSIVE DISORDER..." Wellbutrin was stared January 2014. "RisperDAL [an antipsychotic medication] Tablet 0.5 mg...by mouth every 48 hours..." R40's Care Area Assessment (CAA) Worksheet dated 6/14/15, identified R40 was taking antipsychotic and antidepressant medication, and that her "chronic health problems are being treated." The identified "adverse consequences of ANTIDEPRESSANTS exhibited by this resident [R40]" were identified as, "Anxiety", and "Increased risk for falls." Further, the CAA identified, "Resident is on a low dose of Risperdal, Celexa [citalopram] and Wellbutrin. Appropriate to continue use; appropriate treatment for Dx..." R40's medical record was reviewed and the following progress notes by R40's physician on the following dates: 6/24/15 which read, R40 seen "for a routine	F 329	Licensed Nurse, Case Manager monitored by Director of Nursing or designee.	

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visit", and R40 "offers no complaints." R40's physician identified an "ASSESSMENT/PLAN" which included, "Major depressive disorder, stable on citalopram, Wellbutrin, and takes Risperdal every other day. She does follow with [psychologist] in psychiatry."
6/4/15 which read, R40's "ASSESSMENT/PLAN" continued, "Mood Disorder with anxiety...Continue followup with psychiatry. The patient [R40] has been benefiting from low-dose Risperdal for treatment of depression with psychosis."
4/22/15 which read, R40 was seen by her Psychiatrist who identified, "...has been treated with Wellbutrin and Celexa for depression and Risperdal for 'odd behaviors."...These behaviors have been under control with a very small dose of Risperdal, namely 0.5 mg once every other day...it therefore seems wise to continue her medication at this very low dose because of the benefit from it..." Further, the note identified, "Prescribed medications are Celexa 20 mg per day, Risperdal 0.5 mg every other day, and Wellbutrin 100 mg per day."
4/21/15 which read, R40 was identified as "doing well" by nursing staff, and had a tapering of her Risperdal on 2/23/15 that was unsuccessful as R40's behaviors returned. The physician identified an "ASSESSMENT/PLAN" including, "Major depressive disorder. The patient [R40] is currently on citalopram, Wellbutrin, and we as Risperdal every other day. She has done well on these medications and did not respond well to removal of the Risperdal where her behaviors returned, so we will continue with this every other day dosing and she will follow up with [physician-A] tomorrow."
2/17/15 which read, R40 was identified by nursing as "doing well", and further identified an "ASSESSMENT/PLAN" which included, "We will

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F 329	Continued From page 29 discontinue the Risperdal at this time. Continue Wellbutrin and citalopram." 10/22/14 which read, R40 was seen by her psychiatrist who identified, "I discussed the patient's situation with the nurse who indicates that on the current regimen of medications...she is doing a good deal better than before. There is a reduction of odd behaviors and a reduction in agitation...we will continue her medications unchanged." 1/22/14 which read, R40 was seen by her psychiatrist who identified, "This patient was last seen by myself in 2010. In the interval she has been gradually reduced in her dosage of Wellbutrin which was finally discontinued and Celexa which was reduced and Risperdal which was discontinued. However, these medications, namely the Celexa and Risperdal have subsequently been restarted to combat the regression in the patient's behavior...subsequently restarted on two of her meds and currently at the time of this consultation was taking Celexa 20 mg per day and Risperdal 0.5 mg at bedtime...The nurse who knows her well says that her dementia over the last four years does not seemed to have changed in any significant way but the behaviors have fluctuated as noted above...We will proceed to manage the situation by restarting Wellbutrin and continuing other meds unchanged." None of R40's physician/psychiatrist progress notes reviewed provided any physician justification for the continued use of both the Wellbutrin and Celexa for more than 17 months. R40's Behavior Monitoring records dated January 2015 to July 2015, were reviewed and identified the use of her "Anti-Depressant" medication with symptoms of "Persistent sad, anxious, or 'empty'	F 329		

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mood';"feeling guilty, worthless, helpless";"decreased energy, fatigue, being 'slowed down'";"restlessness, irritability";"feeling hopeless, pessimistic";"difficulty concentrating [sic], remembering, making decisions..." and;"persistent physical symptoms that do not respond to trt [treatment]..." However, the only recorded behavior for past six months read, "Resident [R40] hit male staff member in the face when male staff was helping to transfer..."

When interviewed on 7/29/15, at 11:30 a.m. registered nurse (RN)-A stated R40 had behaviors when taken off the Risperdal, and sustained several failed attempts to discontinue it in the past. R40's antidepressant medications were prescribed to target certain behaviors including "sad mood, irritability, decreased energy, [and] feeling hopeless." R40's Risperdal had last been decreased in February 2015 (5 months prior) and that was the last time any of R40's psychotropic medications had been reduced, including the Celexa and Wellbutrin. R40's Celexa had been increased on 1/15/14 for "feeling awfully tired", and the Wellbutrin was added to her regimen on 1/22/14 (7 days later) for being "less active and somnolent." RN-A stated R40 had not had an attempted dose reduction in her antidepressant medication since January 2014 because "she has maintained and done well on this regimen." RN-A stated she was unable to locate any medical justification for the addition of R40's Wellbutrin to her medication regimen, adding it was added because "years ago" R40 was on it and seemed to do well by what RN-A knew "by history."

During interview on 7/30/15, at 1:35 p.m. the director of nursing (DON) stated she expected

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F 329	Continued From page 31 the physician(s) to take everything into consideration before ordering medications, and for them to provide justification including expected outcomes and parameters for continued use of psychotropic medications in order to justify those medications.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were provided in accordance with current physician orders for 2 of 10 residents (R67, R40) observed to receive medication during the survey. This resulted in a facility medication error rate of 8.0% (percent). Findings include: R67's quarterly Minimum Data Set (MDS) dated 6/17/15, identified R67 had severe cognitive impairment. R67's signed physician orders dated 7/22/15, identified an order for, "Simvastatin Tablet [medication used to treat high cholesterol] 20 mg [milligrams] Give 1 tablet by mouth at bedtime..." During observation of medication administration on 7/27/15, at 4:56 p.m. R67 was seated in the dining room, waiting for his supper meal.	F 332	Corrective Action: It is the intent and standard of Good Shepherd Lutheran Home to ensure that residents are free of medication errors to the highest extent possible. The facility administers medications in accordance with manufacture guidelines, accepted protocols and practices consistent with accepted standards of nursing practice. Upon review of the most recent survey findings, it was determined that the noted medication errors were isolated individual errors and not standards of practice as outlined in our facilities Pharmaceutical Services Policy and Procedures. The individuals involved were counseled and re-educated on facility policy and procedure as well as acceptable medication administration practices. Identification: Good Shepherd¿s Pharmaceutical	9/8/15

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F 332	Continued From page 32 Licensed practical nurse (LPN)-E prepared R67's medications at a mobile cart outside the dining room, including his simvastatin, for a total of four pills and administered them to R67. LPN-E stated R67 would "prefer" to take the simvastatin now with his other medications, and she had been giving it to him this way (at supper time) for "a little while." At 5:08 p.m. LPN-E reviewed R67's current signed physician orders and stated it had been ordered to be given at bedtime as the medication works better then. Further, LPN-E stated R67 should have been given the medication at bedtime as ordered by the physician, "Technically it is an error." R40's annual MDS dated 6/11/15, identified R40 had moderate cognitive impairment. R40's signed physician orders dated 7/22/15, identified an order for, "Artificial Tear Solution [lubricating eye drop medication] Solution [sic] Instill 2 drop in both eyes every morning and at bedtime..." During observation of medication administration on 7/27/15, at 6:55 p.m. LPN-F removed the package of artificial tears from a mobile cart in the hallway outside R40's room and provided it to the surveyor for review. The medication label identified, Artifi [artificial] Tears Sol [solution] Instill 1 drop in both eyes twice daily." LPN-F stated the label "is in error" and applied gloves to instill the eye drops to R40. R40 was laying in bed, and LPN-F pulled down on the lower eye lid to instill the drops. LPN-F instilled three drops into each eye, and provided R40 a tissue to hold underneath her eyes. LPN-F stated she "ended up" instilling three drops into each eye because the drops come out of the bottle quickly. Further,	F 332	Services Policies and Procedures outlining medication administration policies and procedures was reviewed and found to be accurate to ensure residents residing in the facility receive all medications as ordered by their provider. To ensure medications administration practices are consistent with our facilities policies and procedures, all nurses and TMA¿s responsible for medication administration will be re-educated on the necessity to follow medication administration orders in accordance with facility policy and physician¿s order/direction. Special emphasis will be on eye medication administration with a skill competency requirement. Re-education and competency will be done during the Mandatory Plan of Corrections inservice Monitoring: RN Staff Development Coordinator will perform random medication administration audits observing 3 nurses/trained medication aides each week x 2 months focusing on staff compliance with facility policies and procedures then twice a month x 1 month then monthly x 2 month. Results of audit will be reviewed as they are completed for further monitoring and education. All medication errors will be investigated and tracked in an effort to identify potentially modifiable contributing factors. Audit results will be reviewed with the Director of Nursing and QA committee. Responsible Person:	

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F 332	Continued From page 33 LPN-F stated, "I made a mistake." When interviewed on 7/29/15, at 12:42 p.m. the director of nursing (DON) stated the nursing staff should have obtained a different order for R67's simvastatin if they were administering it earlier in the day, and it would be considered an error of administration being given at a different time than the physician had ordered. The DON stated if a resident receives too many eye drops, it would also be considered a medication error. Further, nurses are expected to "follow the orders" from the physician. An undated facility Pharmaceutical Services policy identified, "Medications shall be administered as prescribed", and directed staff to, "Administer medications in accordance with written orders of the attending physician."	F 332	Licensed Nurses and Trained Medication Aides monitored by the Staff Development Coordinator and Director of Nursing.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the consulting pharmacist	F 428	Corrective Action: The goal of Good Shepherd Lutheran	8/19/15

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	245393	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 34 identified the lack of medical justification for use of two antidepressant (a psychotropic medication used to alleviate depression) medication (duplicate therapy) started 17 months ago for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings include: R40's annual Minimum Data Set (MDS) dated 6/11/15, identified R40 had moderate cognitive impairment, and took an antidepressant (a psychotropic medication used to alleviate depression) on a daily basis. R40's signed physician orders dated 7/22/15, read, "Citalopram Hydrobromide [an antidepressant] Tablet 20 mg [milligrams]...by mouth in the morning related to DEPRESSIVE DISORDER..." and; "RisperDAL [an antipsychotic medication] Tablet 0.5 mg...by mouth every 48 hours..." and; " Wellbutrin [an antidepressant] Tablet 100 mg ...by mouth in the morning related to DEPRESSIVE DISORDER..." R40's Care Area Assessment (CAA) Worksheet dated 6/14/15, identified R40 was taking antipsychotic and antidepressant medication, and that her "chronic health problems are being treated." The identified "adverse consequences of ANTIDEPRESSANTS exhibited by this resident [R40]" were identified as, "Anxiety", and "Increased risk for falls." Further, the CAA identified, "Resident is on a low dose of Risperdal, Celexa [citalopram] and Wellbutrin. Appropriate to continue use; appropriate treatment for Dx..." The CAA did not identify any medical justification for the use of dual	F 428	Home is to maintain the resident¿s highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist routinely reports irregularities to the Director of Nursing and Case Manager. These recommendations are then reviewed by the physician/NP as indicated. The Pharmacy Consultants were notified of the regulatory findings regarding lack of medical justification for the use of two antidepressants. Identification: All current residents receiving an antidepressant were reviewed for medical justification. Those found to be taking more than one antidepressant were reviewed again by Dr. Modjeski for justification or medication change. Monitoring: Pharmacy Consultants instructed to more closely monitor resident¿s medications for duel therapies along with medical justification for those medications. Case Managers reviewing monthly recommendations will monitor for Pharmacy Consultant recommendations on residents receiving duel therapies and will review with the provider as indicated. Findings will be reviewed at the Quality Assurance Committee meeting. Responsible Person: Case Managers and Director of Nursing	

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F 428	Continued From page 35 antidepressant medications nor any input from R40's physician or psychiatrist. R40's physician notes dated 6/24/15 included, R40 seen "for a routine visit", and R40 "offers no complaints." R40's physician identified an "ASSESSMENT/PLAN" which included, "Major depressive disorder, stable on citalopram, Wellbutrin, and takes Risperdal every other day. She does follow with [psychologist] in psychiatry." Physician notes dated 6/4/15, 4/22/15, 4/21/15, 2/17/15, 10/22/14, 1/22/14 were reviewed and no physician justification for the use of two antidepressants had been found. When interviewed on 7/29/15, at 11:30 a.m. registered nurse (RN)-A stated R40 had behaviors when taken off the Risperdal, and sustained several failed attempts to discontinue it in the past. R40's antidepressant medications were prescribed to target certain behaviors including "sad mood, irritability, decreased energy, [and] feeling hopeless." R40's Risperdal had last been decreased in February 2015 (5 months prior) and that was the last time any of R40's psychotropic medications had been reduced, including the Celexa and Wellbutrin. R40's Celexa had been increased on 1/15/14 for "feeling awfully tired", and the Wellbutrin was added to her regimen on 1/22/14 (7 days later) for being "less active and somnolent." RN-A stated R40 had not had an attempted dose reduction in her antidepressant medication since January 2014 because "she has maintained and done well on this regimen." RN-A stated she was unable to locate any medical justification for the addition of R40's Wellbutrin to her medication regimen, adding it was added because "years ago" R40 was on it and seemed to do well by what RN-A	F 428	will monitor Pharmacy Consultant monthly reviews for recommendations regarding medical justifications for continued use of antidepressants.	

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F 428	Continued From page 36	F 428		

knew "by history."

The consulting pharmacist monthly reviews were reviewed from 12/4/14 to 6/27/15 and no recommendation in regards to the justification for use of two antidepressant medications used had been found. However, progress note authored by consultant pharmacist dated 1/29/15 read, "No new medications/changes...No recent symptoms reported...I suggest avoiding GDR [gradual dose reduction] of antidepressant [there are two antidepressants], but it is time to address possible GDR of risperidone...please consider and note if now is not in the best interest of her status." Also consulting pharmacist progress note dated 6/27/15 read, "No systemic meds changed...Continues Wellbutrin...have discussed further tapering of psychotropic medications, especially the risperidone...is noted by provider to continue in the best interest of her quality of life...Please have provider note the plan for not tapering the risperidone in their note as I have noted above or consider further tapering..." Further, the physician documented, "Pt [patient] has better quality of life[,] decreased behaviors [with] this medication regimen." The physician did not document a risk versus benefit of being on dual antidepressant medication despite the increased risk of side effects, or any current plan for attempt at reduction of the medication.

During interview on 7/30/15, at 10:36 a.m. the consulting pharmacist (CP) stated the on-going discussion for R40 had been centered around her use of Risperdal and tapering it down. It had been a "reasonable amount of time" since her last dose reduction, and the Wellbutrin should be decreased, "I don't know there is evidence they have tried to taper that enough." It was "rather

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F 428	Continued From page 37 sudden" to start the Wellbutrin after increasing the Celexa in January 2014, and the CP added he expected the physicians to document in their notes "more about why the drug seems necessary." During interview on 7/30/15, at 1:35 p.m. the director of nursing (DON) stated she expected the physician(s) to "take everything into consideration" before ordering medications, and for them to provide justification including expected outcomes and parameters for continued use of psychotropic medications "in order to justify those medications." Further, the DON stated the consulting pharmacist should have identified the irregularity so it could have been corrected.	F 428		

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K 000	INITIAL COMMENTS FIRE SAFETY 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 FORM 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2015

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Shepherd Lutheran Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1982, an addition was constructed and was determined to be of Type II(111) construction, with a partial basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinklered. The facility has full corridor smoke detection, spaces open to the corridors and resident sleep rooms that is monitored for automatic fire department notification. Good Shepherd Lutheran Home has elected to use the following Categorical Waivers - Doors, Combustible decorations on walls, doors and	K 000		

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K 000	Continued From page 2 ceilings, Extinguishing Requirements and Capacity of Means of Egress. The facility has a capacity of 75 beds and had a census of 71 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour fire rated construction at building separation wall in accordance with 2000 - NFPA 101, sections 19.1.1.4.1. The deficient practice could affect all 71 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM on 07/30/2015, observation revealed, that the 2 hour fire rated building separation wall between the nursing home and assisted living has a open penetration around several cables above the lay	K 011	Maintenance staff will fill the open penetration around several cables in the building seperation wall between the nursing home and assisted living per Fire Marshal orders.	9/4/15

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K 011	Continued From page 3 in ceiling. This deficient practice was confirmed by the facility maintenance staff (R) at the time of discovery.	K 011		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 . The deficient practice could affect all 20 out of 71 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM on 07/30/2015, observation revealed, that the daycare and "B" wing required exit discharges has more than 1/2" elevation change to public way. NOTE: Make sure all sidewalks are checked for this deficiency. This deficient practice was confirmed by the	K 038	Good Shepherd has contracted with Bunke Construction LLC to replace cement sections of daycare and "B" wing exit discharges that have more than 1/2 " elevation change to public way. Maintenance Director Duane Franzwa has also assessed other areas of the grounds and will have Bunke Construction replace additional areas that may become a concern.	9/4/15

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K 038	Continued From page 4 facility maintenance staff (R) at the time of discovery.	K 038		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 71 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM on 07/30/2015, the review of the fire drill documentation for the past 12 months (August 2014 to July 2015) revealed that the drills for the following shifts were completed, but did not sufficiently vary the times that the drills were conducted: Day: 1125, 1000, 1020 and 1010 hours	K 050	Good Shepherd will conduct fire drills once per shift per quarter for all staff under varying times and conditions. The next planned fire drill will be in September at approximately 1430 hours. Future drills will also be conducted under varying times and conditions. Duane Franzwa will assure that the drills are performed per requirements by 2000 NFPA 101, Section 19.7.1.2	9/4/15

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K 050	Continued From page 5 Evening: 2100, 1600, 2030 and 1545 hours This deficient practice was confirmed by the facility maintenance staff (R) at the time of discovery.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-3.2. This deficient practice could affect all 71 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM on 07/30/2015, observation revealed that the dry fire sprinkler system water gauges have a hand written date of 3/09 on them. There was no documentation stating the gauges have been calibrated or replaced in the past 5 years. This deficient practice was confirmed by the facility maintenance staff (R) at the time of discovery.	K 062	Good Shepherd has contracted with Summit Fire Protection to evaluate the water gauges on the dry sprinkler system and have them calibrated or replaced. Duane Franzwa will assure this work is performed.	9/4/15
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		9/4/15

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K 147 SS=D	Continued From page 6 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70 and 2007 MSFC. The deficient practice could affect 15 out of 71 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM on 07/30/2015, observation revealed, that the following was found: 1. The circuit breaker panels are block in rooms # G13 and # G14 2. In resident room # W1, refrigerator plugged into power strip 3. Employee Break room has the wall air conditioner plugged into power strip NOTE: Check the entire facility for these deficiencies These deficient practices were confirmed by the facility maintenance staff (R) at the time of discovery.	K 147	Good Shepherd will assure that: 1. The circuit breaker panels in rooms # G13 and # G14 are not blocked. Items will be removed to create a clear path to the breaker panels. 2. In resident room # W1 the refrigerator has been unplugged from the power strip. 3. The wall air conditioner in the employee break room no longer is plugged in to the power strip. The cord has been replaced and plugs in directly to the outlet on the wall. Duane Franzwa, Good Shepherd Maintenance , will assess any other such concerns throughout the facility and make changes as needed to meet the requirements of 2000 NFPA 101 -19.5.1, 9.1.2, 1999 NFPA 70 and 2007 MSFC. Plan of Correction Submitted by Tom Lindh Good Shepherd Lutheran Home Administrator 8/19/2015	

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K 147	Continued From page 7 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147		