Electronically Delivered

April 15, 2024

Licensee
Good Shepherd Assisted Living
330 13th Street North
Sauk Rapids, MN 56379

RE: Project Number(s) SL20282015

Dear Licensee:

On March 28, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 4, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

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January 19, 2024

Licensee
Good Shepherd Assisted Living
330 13th Street North
Sauk Rapids, MN 56379

RE: Project Number(s) SL20282015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each

matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20282	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ASSISTED LIVING	330 13TH STREET NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20282015 On January 2, 2024, through January 4, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 53 residents; 14 receiving services under the Assisted Living license. An immediate correction order was identified on January 2, 2024, issued for SL20282015, tag identification 0470. On January 2, 2024, the immediacy of correction order 0470 was removed, however, noncompliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents, were in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 470		

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0 470	Continued From page 2 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license with a capacity of 57 residents, with a current census of 53 residents, 14 of whom received assisted living services. During the entrance conference on January 2, 2024, at 10:25 a.m., licensed assisted living director (LALD)-B stated each day, the licensee had two unlicensed personnel (ULP) who worked from 6:00 a.m. through 2:00 p.m., one ULP who worked from 6:00 a.m. through 11:00 a.m., one ULP from 2:00 p.m. through 10:00 p.m., one ULP from 2:00 p.m. through 10:30 p.m., and one ULP from 10:30 p.m. through 6:00 a.m. LALD-B stated the night ULP provided services to the whole campus including four buildings, two of which were assisted living facilities with separate health facility identification (HFID) numbers, and two of which were comprehensive home care licenses designated as a United States Department of Housing and Urban Development (HUD) building. These services included rounds in each building every two hours. LALD-B stated all four buildings were attached by hallways. The licensee's Direct-Care Staffing Plan, revised October 12, 2023, noted "Between the hours of 10:00 p.m. and 6:00 a.m. there will be direct-care staff able to respond to a resident's request for assistance with health and safety needs within a	0 470		

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0 470	Continued From page 3 reasonable amount of time. These staff will be located in the building or an attached building, in order to respond within a reasonable amount of time." It also noted "1 HHA [home health aid] will always be available from 2200 [10:00 p.m.] - 0630 [6:30 a.m.] (NOC [night] Shift)." On January 2, 2024, at 1:05 p.m., LALD-B stated night staff provide simple services, including medication administration, toileting, laundry, and safety checks to residents in all four buildings. LALD-B provided a list of services and chores for the night shift, which indicated 13 residents residing in the licensee's building received services on the night shift including toileting, equipment check, behavioral intervention for anxiety, property destruction, self-injurious behavior, verbal aggression, and laundry. In an attached assisted living facility, the same night staff provided services for 22 residents including behavioral interventions including verbal aggression, wandering, anxiety and orientation assistance, lymphedema pump, reminders, equipment check, medication administration, weight, vital signs, oxygen reading, and laundry. In two attached comprehensive home care licensed/HUD building, the same night staff provided services for eight residents including laundry services, and behavioral interventions for anxiety and verbal aggression. On January 2, 2024, at 1:55 p.m., LALD-B stated she was not aware of the licensee having a waiver for utilizing staff from other buildings with separate licenses on the overnight shift. The licensee's Staffing Plan and Daily Schedule policy dated August 2021 indicated the staffing plan would provide qualified direct-care staff sufficient to meet the residents' needs 24 hours a	0 470		

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0 470	Continued From page 4 day, 7 days a week and would be adequate to address each residents' needs as identified in the service plan and assisted living contract, each resident's acuity level as determined by the most recent assessment, and ability to meet the residents' scheduled and reasonable unforeseeable unscheduled needs given the physical layout of the facility premises. The policy also indicated from the hours of 10:00 p.m. to 6:00 a.m., direct-care staff would respond to a resident request for assistance with health or safety needs within a reasonable amount of time. Per Minnesota Statutes 2022, Chapter 144G, Assisted Living, 144G.08, Subd. 4a. Assisted living facility campus means: (1) a single building having two or more addresses, located on the same property with a single property identification number; (2) two or more buildings, each with a separate address, located on the same property with a single property identification number; or (3) two or more buildings at different addresses, located on properties with different property identification numbers, that share a portion of a legal property boundary. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor review on January 2, 2024, however, noncompliance remains at a scope and level of level three, widespread (l).	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 5 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance	0 550		

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0 550	Continued From page 6 procedure to include the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances, as required. During a tour of the facility on January 2, 2024, at 11:14 a.m., with assisted living director (LALD)-B, the surveyor observed a white board in the common area, near the entrance, that included several postings for residents. There was no grievance procedure posted in this area. On January 2, 2024, at 1:10 p.m., LALD-B stated the grievance procedure was not posted in the common area of the facility, and should be. The licensee's Grievance/Complaint policy, revised January 27, 2023, indicated each resident and/or resident representative would receive written notice of the facility's process for receiving and resolving complaints, which would include the name, telephone number and email contact information for the staff person(s) responsible for handling grievances; however, the policy did not indicate the grievance procedure would be posted in a conspicuous place, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 7 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, and edema. R1's Service Plan, dated February 3, 2023, noted services including recording oxygen percentage daily, dressing daily, medication administration four times daily, scheduled services one time a week, and scheduled services two times per week.	0 630		

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0 630	Continued From page 8 R1's IAPP dated November 21, 2023, failed to include: - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2's diagnoses included back pain due to injury, cerebrovascular accident (stroke), and osteoporosis of multiple sites. R2's Service Plan, dated July 20, 2023, indicated R2 received services including assistance with dressing, bathing, medication set-up, monthly vital sign monitoring, safety checks, side rail checks, housekeeping, laundry, and listed three "scheduled services" one day per week, and one "scheduled service" daily. R2's IAPP dated November 27, 2023, failed to include: - the person's risk of abusing other vulnerable adults; - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; and - risk of self-abuse. On January 4, 2024, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated she had recently become aware of the need to click an extra button in the electronic record system to include this information, but it had not been completed. The licensee's Individual Abuse Protection Plans policy, dated May 23, 2023, indicated the IAPP would include: - individualized review or assessment of the	0 630		

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0 630	Continued From page 9 resident's susceptibility to be abused by another individual, including other vulnerable adults; - the resident's risk of abusing other vulnerable adults; - specific measures to minimize the risk of abuse to that person and other vulnerable adults; and - measure to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 10 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 3, 2024, at 11:10 a.m., licensed assisted living director (LALD)-B and assisted living director in residency (ALDIR)-C provided documentation on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation	0 810		

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	20282	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD ASSISTED LIVING	330 13TH STREET NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 indicated the fire safety and evacuation plan did not include specific staff instruction for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. The documentation provided showed drills completed in April, July, and November in 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2).	0 910		

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0 910	Continued From page 12 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written contract with the following required content: -the contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility; -the contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: -the facility and contracted service provider when applicable; -the licensee of the facility; -the managing agent of the facility, if applicable; and -the authorized agent for the facility. R1 R1's (facility name) Assisted Living Contract, signed by R1 on August 2, 2021, indicated the names of a prior licensed assisted living director (LALD) and authorized agent, with the telephone numbers listed. It lacked the physical mailing address as required. R2 R2's (facility name) Assisted Living Contract, signed by R2 on January 23, 2023, indicated the facility's authorized agent was LALD-B and included the contact telephone number; however, did not include the authorized agent's physical	0 910		

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0 910	Continued From page 13 mailing address, as required. On January 4, 2024, at 11:50 a.m., licensed assisted living director (LALD)-B stated the contract lacked the above required information and stated R1's contract was an older version and needed to be updated. LALD-B also stated the current contract was the same contract received by all residents living in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers	0 940		

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0 940	Continued From page 14 provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2's records lacked a written contract to include: - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; and	0 940		

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0 940	Continued From page 15 - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. R1 R1's diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, and edema. R1's Service Plan, dated February 3, 2023, noted services including recording oxygen percentage daily, dressing daily, medication administration four times daily, "scheduled services" one time a week, and "scheduled services" two times per week. R1's (facility name) Assisted Living Contract was signed by R1 on August 2, 2021. R2 R2's diagnoses included back pain due to injury, cerebrovascular accident (stroke), and osteoporosis of multiple sites. R2's Service Plan, dated July 20, 2023, indicated R2 received services including assistance with dressing, bathing, medication set-up, monthly vital sign monitoring, safety checks, side rail checks, housekeeping, laundry, and listed three "scheduled services" one day per week, and one "scheduled service" daily. R2's (facility name) Assisted Living Contract was signed by R2 on January 23, 2023. On January 4, 2024, at 11:50 a.m., licensed assisted living director (LALD)-B stated the contract lacked the above required information	0 940		

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0 940	Continued From page 16 and stated the contract was the same contract received by all residents living in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 950 SS=A	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated	0 950		

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0 950	Continued From page 17 representative. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident identified or declined a designated a representative as required, for one of two residents (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnoses included back pain due to injury, cerebrovascular accident (stroke), and osteoporosis of multiple sites. On January 3, 2024, at 10:23 a.m., the surveyor observed while licensed practical nurse (LPN)-D performed medication set-up for R2, in R2's apartment. R2 was ambulating, with a walker, from the bathroom to a recliner, and asking questions about treatment of a newly discovered open wound on her left ankle. R2's Service Plan, dated July 20, 2023, indicated R2 received services including assistance with dressing, bathing, medication set-up, monthly vital sign monitoring, safety checks, side rail checks, housekeeping, laundry, and listed three "scheduled services" one day per week, and one "scheduled service" daily.	0 950		

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0 950	Continued From page 18 R2's record included the required verbatim notice on a separate document from the contract, notifying the resident of the Right to Designate a Representative for Certain Purposes. R2's (facility name) Assisted Living Contract was signed by R2 on January 23, 2023. On page 10, number 29, the contract included a box for the resident to check and initial if the resident declined to identify a designated representative, and a box to check and initial if the resident chose to identify a designated representative with provided space for the name and contact information of the designated representative. This area was blank on R2's contract. On January 4, 2024, at 11:22 p.m., licensed assisted living director (LALD)-B stated the licensee should have ensured R2 understood she could identify or decline to identify a designated representative, and should have verified this area was completed by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains,	01060		

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01060	Continued From page 19 at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for	01060		

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01060	Continued From page 20 one of one resident (R1) hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. R1's diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, and edema. R1's Service Plan dated February 3, 2023, noted services including recording oxygen percentage	01060		

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01060	Continued From page 21 daily, dressing daily, medication administration four times daily, scheduled services one time a week, and scheduled services two times per week. R1's Resident Notes indicated on October 16, 2023, R1 was being admitted to the hospital with low oxygen saturation rates. R1's Resident Notes dated October 18, 2023, indicated R1 returned to his apartment from the hospital. On January 4, 2024, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated they were aware of the need to do the emergency relocation but did not do it for R1. CNS-A stated they had this task added to their calendars to get better at doing this required task. The licensee's Contract Termination policy, dated August 2021, noted in the event of an emergency relocation, the facility must provide a written notice to include the reason for the relocation, the name and contact information for the location to which the resident had been relocated and any new service provider, contact information for the OOLTC, if known and applicable, the approximate date or range of dates in which the resident was expected to return to the facility, or a statement that the return date was not currently known, and a statement that if the facility refused to provide housing or services after the relocation, the resident had the right to appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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01610	Continued From page 22	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01610		

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01610	Continued From page 23 The findings include: R2 was admitted for services on January 18, 2023. R2's diagnoses included back pain due to injury, cerebrovascular accident (stroke), and osteoporosis of multiple sites. On January 3, 2024, at 10:23 a.m., the surveyor observed while licensed practical nurse (LPN)-D performed medication set-up for R2, in R2's apartment. R2 was ambulating, with a walker, from the bathroom to a recliner, and asking questions about treatment of a newly discovered open wound on her left ankle. R2's Service Plan, dated July 20, 2023, indicated R2 received services including assistance with dressing, bathing, medication set-up, monthly vital sign monitoring, safety checks, side rail checks, housekeeping, laundry, and listed three "scheduled services" one day per week, and one "scheduled service" daily. R2's record included an Admission Assessment, dated February 21, 2023, or 34 days after R2's admission date, not prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moves in, whichever was earlier, as required. On January 4, 2024, at 11:24 a.m., clinical nurse supervisor (CNS)-A stated R2's assessment was not completed timely, and stated they had been trying to get better at completing assessments per the required guidelines. The licensee's Initial and On-going Nursing	01610		

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01610	Continued From page 24 Assessment of Clients policy, revised August, 2021, indicated a RN would coordinate the comprehensive nursing assessments of the resident's physical, mental, and cognitive needs, as required, to include a pre-admission assessment, 14 day assessment, and ongoing assessment no less than every 90 days, and change in resident condition. The policy did not specify the required initial assessment time frame. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620		

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	20282	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 25 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services, for one of two residents (R2) as required, and failed to ensure the RN completed a comprehensive reassessment after a change of condition for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: 14-DAY ASSESSMENT R2 R2 was admitted for services on January 18, 2023. R2's diagnoses included back pain due to injury, cerebrovascular accident (stroke), and osteoporosis of multiple sites. On January 3, 2024, at 10:23 a.m., the surveyor	01620		

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GOOD SHEPHERD ASSISTED LIVING	330 13TH STREET NORTH SAUK RAPIDS, MN 56379

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01620	Continued From page 26 observed while licensed practical nurse (LPN)-D performed medication set-up for R2, in R2's apartment. R2 was ambulating, with a walker, from the bathroom to a recliner, and asking questions about treatment of a newly discovered open wound on her left ankle. R2's Service Plan, dated July 20, 2023, indicated R2 received services including assistance with dressing, bathing, medication set-up, monthly vital sign monitoring, safety checks, side rail checks, housekeeping, laundry, and listed three "scheduled services" one day per week, and one "scheduled service" daily. R2's record included an Assessment by Date, identified as the 14 day assessment, dated March 22, 2023, or 63 days after R2's initiation of services, instead of no more than 14 days after the initiation of services, as required. On January 4, 2024, at 11:24 a.m., clinical nurse supervisor (CNS)-A stated R2's 14 day assessment was not completed timely, and stated they had been trying to get better at completing assessments per the required guidelines. COMPREHENSIVE REASSESSMENT AFTER A CHANGE IN CONDITION R1 R1's diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, and edema. R1's Service Plan dated February 3, 2023, noted services including recording oxygen percentage daily, dressing daily, medication administration four times daily, scheduled services one time a	01620		

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01620	Continued From page 27 week, and scheduled services two times per week. R1's Resident Notes indicated on October 16, 2023, R1 was admitted to the hospital with low oxygen saturation rates. R1's Resident Notes dated October 18, 2023, indicated R1 returned to his apartment from the hospital. On January 4, 2024, at 11:15 a.m., CNS-A stated R1 returned from the hospital with oxygen and there was a change in condition, but no reassessment had been completed. CNS-A stated she would typically do an assessment and a note upon return from the hospital unless there was a change in condition as there was in this case, and should have completed a comprehensive reassessment for R1. The licensee's Initial and On-Going Nursing Assessment of Clients policy, dated August 2021, indicated a RN would coordinate the comprehensive nursing assessments of the resident's physical, mental, and cognitive needs, as required, to include a pre-admission assessment, 14 day assessment, and ongoing assessment no less than every 90 days, and change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 28 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a	01650		

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01650	Continued From page 29 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, and edema. R1's Service Plan dated February 3, 2023, noted services including recording oxygen percentage daily, dressing daily, medication administration four times daily, scheduled services one time a week, and scheduled services two times per week. The service plan lacked: - a description of the services to be provided; and - identification of and information as to who had authority to sign for the resident in an emergency. R2 R2's diagnoses included back pain due to injury, cerebrovascular accident (stroke), and osteoporosis of multiple sites. R2's Service Plan, dated July 20, 2023, indicated R2 received services including assistance with dressing, bathing, medication set-up, monthly vital sign monitoring, safety checks, side rail checks, housekeeping, laundry, and listed three "scheduled services" one day per week, and one "scheduled service" daily. The service plan lacked: - a description of the services to be provided. On January 4, 2024, at 11:15 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they utilized an electronic medical record software program, and	01650		

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01650	Continued From page 30 because they were unsure how to include specific services, they indicated "scheduled services" on the service plan as a generic term that included services such as picking up laundry from or delivering laundry to the resident's room, therefore, used the generic term. LALD-B stated the service plan lacked a description of the services to be provided. CNS-A stated for R1, the oxygen management included refilling the portable tank twice daily and changing the tubing per manufacturer directions, and this was not included on the service plan. The licensee's Contents of Service Plans policy, dated August, 2021, indicated services plans would include a description of the services to be provided, and a contingency plan that included the identification of and information on who had the authority to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01920 SS=C	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was	01920		

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01920	Continued From page 31 disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures included the required verbiage to investigate any known loss or unaccounted prescription drugs, as required. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 2, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management services to their residents. The licensee's Loss or Spillage of Medications policy, dated June 2019, indicated when loss or a spillage of any medication occurred, notation must be made in the resident's medication record. If the loss or spillage was of a controlled medication, the notation about the loss or spillage	01920		

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01920	Continued From page 32 must be documented and the nurse notified. The policy lacked the required content to include the notation must be signed by the person responsible for the spillage. On January 4, 2024, at 11:20 a.m., LALD-B stated the policy lacked the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01920		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	03090		

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03090	Continued From page 33 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a tour of the facility on January 2, 2024, at 11:14 a.m., the surveyors observed outside the front entrance and just inside the front entrance of the assisted living facility. There was no required posting for notification of electronic monitoring devices. Licensed assisted living director (LALD)-B stated there was no posting available at the main entrance related to the statutory language for electronic monitoring, and stated, "It should be posted out there." The licensee's Electronic Monitoring policy, dated August 2021, indicated the facility shall post a sign at each entrance accessible to visitors that states, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

MDH Environmental Health Division
Food, Pools & Lodging Section
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/02/24*
Time: 10:12:31
Report: 1046241001

Food and Beverage Establishment Inspection Report

Location:
Good Shepherd Assisted Living
330 13th Street North
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0038606
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202526525
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

THE KITCHEN IS NOT USED IN THIS ESTABLISHMENT FOR COOKING OR SERVING. RESIDENTS WALK TO THE COMPREHENSIVE HOME CARE LICENSED BUILDING TO OBTAIN BREAKFAST AND DINNER. LUNCH IS DELIVERED TO THEIR ROOMS. THE BUILDING WHERE FOOD IS COOKED AND SERVED WAS RECENTLY SURVEYED.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MDH Environmental Health Division inspection report number 1046241001 of 01/02/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Nicole Larrison
Public Health Sanitarian 1
St. Cloud District Office
320-472-0042
nicole.larrison@state.mn.us