Electronically Delivered

July 29, 2024

Licensee
Good Shepherd Homes Inc
1211 4th Avenue North
Sauk Rapids, MN 56379

RE: Project Number(s) SL25644015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 3, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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 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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Amy Hyers, Evaluation Regional Operations Manager
State Evaluation Team
Email: amy.hyers@state.mn.us
Telephone: 651-443-2878 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25644	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD HOMES INC	1211 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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: SL25644015-0 On July 1, 2024, through July 3, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 58 residents; 20 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 1, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 2 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included required documented competencies for one of two unlicensed personnel ((ULP)-I) who provided treatment administration for residents. 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 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:	0 650		

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0 650	Continued From page 3 ULP-I was hired by the licensee on October 5, 2023, to provide direct care services to residents of the licensee. On July 2, 2024, at 8:40 a.m., the surveyor observed ULP-I provide services for residents including medication administration and application of pneumatic compression leg pumps. ULP-I's personnel record contained a form titled, Assisted Living Sign off Sheet dated October 5, 2023, through October 11, 2023. The sign off form indicated a registered nurse (RN) trained ULP-I on lymphedema pumps, Circaid Juxalite leg wraps, and intermittent sequential circulation pumps, however lacked evidence ULP-I returned demonstration for the RN to ensure competency on the treatments. On July 2, 2024, at approximately 8:40 a.m., ULP-I stated a registered nurse observed them perform multiple tasks including leg pumps, application of compression stockings, and medication administration to ensure they were competent in performing the procedures. On July 3, 2024, at approximately 11:25 a.m., RN-D confirmed ULP-I had no evidence of competency for applying leg pumps/leg wraps in their employee record and stated it should be there. RN-D stated the licensee lacked any systematic method for maintenance of employee files which lead to the missing competency. Licensee's policy Training Documentation dated as revised August 2021, indicated the licensee would maintain a record of staff training and competency.	0 650		

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0 650	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 5 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 the residents). The findings include: The licensee's Emergency Manual for Assisted Living binder last reviewed on June 14, 2023, included the following content: -emergency preparedness plan review and update last completed on June 14, 2023; -missing resident plan review and update last completed on October 9, 2023; -communication plan review and update last completed on June 13, 2023; and -communication plan referenced attached lists of names/contact information for staff, residents' physicians, Federal, State, tribal, regional, and local emergency preparedness staff (lists were not attached). The licensee's emergency preparedness plan lacked the following required content: -emergency preparedness plan reviewed and updated annually; -missing resident plan reviewed and updated quarterly; -communication plan reviewed and updated annually; and -names/contact information for staff, residents' physicians, Federal, State, tribal, regional, and local emergency preparedness staff.	0 680		

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0 680	Continued From page 6 On July 3, 2024, at 12:17 p.m., licensed assisted living director in residence (LALDIR)-B stated the emergency preparedness plan had not been updated since June 2023. LALDIR-B stated the licensee wanted to include information about other emergencies, such as Narcan use, but had not yet updated the plan to do so. LALDIR-B stated the missing resident plan, and the communication plan did not have more recent updates either. LALDIR-B stated another license owned by the same owner had a survey at the end of 2023 and the licensee went through the emergency preparedness plan at that time to make corrections, but the lists of contact information must not have been added back in. LALDIR-B stated the emergency preparedness plan was a work in progress. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." The licensee's Emergency and Disaster Preparedness policy dated August 2021, indicated the licensee developed and implemented an emergency preparedness plan based on facility-based and community-based risk assessments using an all-hazards approach. The policy indicated the emergency preparedness plan, communication plan, and policies/procedures would be reviewed and updated at least annually. The policy also	0 680		

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0 680	Continued From page 7 indicated the communication plan would be complete and address the elements listed in Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 8 by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. 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 July 01, 2024, survey staff toured the facility with maintenance engineer (ME)-G and building maintenance staff (BM)-H. BM-H tested the smoke alarms in multiple apartments. Upon testing, it was found that the smoke alarms in the following locations were not interconnected in apartments #319, #314, #312, #305, #304, #218, #213, #211, #208, #202, #119, #116, #105, #102. These deficient conditions were visually verified by ME-G and BM-H accompanying on the tour. During interview on July 01, 2024, at 2:00 p.m., ME-G stated that none of the apartments in the building had interconnected smoke alarms because they did not know that the smoke alarms had to be interconnected inside the apartments. ME-G stated they would figure out how to get them interconnected.	0 780		

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0 780	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition 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). Findings include:	0 800		

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0 800	Continued From page 10 On July 01, 2024, survey staff toured the facility with maintenance engineer (ME)-G and building maintenance staff (BM)-H. It was observed that the trash chute door on the second floor did not shut and latch on its own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. It was observed that multiple fire-rated doors in the facility did not close completely and positively latch. Fire-rated doors to egress stairs and high-hazard spaces should close and positively latch to maintain the fire resistance integrity of the rated assembly. Fire-Rated Doors: 1. Third floor laundry room door 2. Third floor central stair door 3. Second floor south stairwell door. During interview on July 01, 2024, ME-G stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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	0 810		

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0 810	Continued From page 11 (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 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all 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	0 810		

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0 810	Continued From page 12 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 July 01, 2024, licensed assisted living director in residence (LALDIR)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Apartment Evacuation", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included instructions for staff to evacuate the building, but the plan failed to include procedures for how staff are to evacuate residents. The FSEP included assessment documentation of the residents who lived in the building that would need assistance during an emergency evacuation but did not include instructions to staff on how to provide assistance for movement, evacuation, or relocation. During an interview on July 01, 2024, at 2:00 p.m., LALDIR-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to	0 810		

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	25644	A. BUILDING: _____ B. WING _____	07/03/2024

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0 810	Continued From page 13 provide training to employees on the FSEP upon hire and at least twice per year. LALDIR-B was unable to provide documentation showing any training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. During an interview on July 01, 2024, at 2:00 p.m., LALDIR-B stated they provided training at orientation, during the fire drills, and through a fire safety training offered by a third-party online software that could not be modified to include the facility-specific fire safety plans. Survey staff explained to LALDIR-B that the training should be separate from the drills and should cover the specific evacuation plan for the facility. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated that drills were completed on 04/06/2023, 11/13/2023, 1/29/2024, 2/20/2024, 4/11/2024, 5/21/2024, and 6/26/2024. During an interview on July 01, 2024, at 2:00 p.m., LALDIR-B stated there were no records of any additional evacuation drills completed at the facility in 2023, 2022, or 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	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	01060		

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01060	Continued From page 14 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, 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	01060		

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01060	Continued From page 15 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 to the resident, legal representative, and designated representative for three of three residents (R2, R3, R4). 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: R2 R2's Service Plan (Waiver) - Addendum to Contract dated May 14, 2024, indicated R2 received the following services: bathing, behavior management, dressing, grooming, housekeeping, leg wraps, laundry, medication administration, meals, vital signs, toileting, and emergency assistance. R2's progress note dated, June 3, 2024, at 7:18 a.m., indicated R2 was admitted to the hospital on June 1, 2024, for nausea, vomiting, shortness of breath, and lightheadedness. R2's progress note indicated R2 was receiving intravenous (IV) antibiotics for treatment of pneumonia or atelectasis (a partial or full collapse of a lung due to blockage or pressure).	01060		

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01060	Continued From page 16 R2's progress note dated, June 3, 2024, at 8:36 a.m., indicated R2 would likely stay in the hospital "a few days" per the hospital social worker. R2's progress note dated, June 3, 2024, at 10:01 a.m., indicated R2 would be discharged from the hospital at 2:30 p.m. and returning to the facility. R2's record lacked a written notice with the required statutory content provided to resident, resident's representative, and designated representative of emergency relocation. R3 R3's Service Plan (Waiver) - Addendum to Contract dated May 9, 2024, indicated R3 received the following services: bathing-shower three times weekly, BI- orientation (behavioral intervention) assist twice daily, grooming twice daily, light housekeeping weekly, Juxtalite leg wraps twice daily, laundry- two loads weekly, meal tray delivery service daily, menu selection assistance weekly, monitor for Covid symptoms daily, oxygen assistance weekly, vital signs monthly, unspecified "reminder" twice daily, safety check twice daily, side rail check weekly, supervision by the LPN for leg wraps every 90 days, Tek Tone (pendant call system) monthly, and therapeutic exercise daily. R3's progress note dated June 19, 2024, at 9:32 a.m., titled, Fall indicated R3 was transported to the emergency room following a fall and R3's son was aware. R3's progress note dated June 19, 2024, at 11:46 a.m., titled, Emergency Relocation indicated R3 was transferred to an acute hospital and provided the reason for the transfer was fall and altered mental status. The note included the name and	01060		

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01060	Continued From page 17 phone number of the hospital and indicated the estimated length of stay was unknown. The progress note did not identify to whom the notification was provided, if anyone. R3's undated Emergency Relocation Notification printed on July 3, 2024, during the survey, indicated R3 was transferred to an acute hospital and provided the reason for the transfer was fall and altered mental status. The document included the name and phone number of the hospital and indicated the estimated length of stay was unknown. The document included the generic statutory requirements for notification but did not identify to whom the emergency relocation notification was provided, if anyone. R3's progress note titled, Hospital Return dated June 24, 2024, at 3:54 p.m., indicated R3 returned from the hospital that day. R4 R4's Service Plan (Waiver) - Addendum to Contract dated June 7, 2024, indicated R4 received the following services: light housekeeping weekly, laundry- two loads weekly, medication administration four times daily, monitor for Covid symptoms daily, vital signs monthly, unspecified "reminder" three times daily, and Tek Tone monthly. R4's progress note dated June 4, 2024, at 7:25 p.m., titled, Emergency Relocation Notification indicated R4 was transferred to an acute hospital and provided the reason for the transfer was for IV antibiotics due to acute kidney injury and concerning lab work. The note included the name and phone number of the hospital and indicated the estimated length of stay was unknown. The progress note did not identify to whom the	01060		

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01060	Continued From page 18 notification was provided, if anyone. R4's progress note dated June 5, 2024, at 11:18 a.m., indicated clinical nurse supervisor (CNS)-E collaborated with the social worker from the hospital, and R4 was likely going to be in the hospital for "a few more days". R4's progress note dated June 7, 2024, at 11:19 a.m., indicated R4 returned from the hospital that day. On July 3, 2024, at 11:25 a.m., registered nurse (RN)-D stated she was unsure why an emergency relocation notice was not completed for R2. RN-D stated based on the information in R3 and R4's progress notes, she did not have a clear answer on if or how the residents, residents' representatives, and designated representatives were notified of the emergency relocations. RN-D stated either the RN, or the licensed practical nurse (LPN) was responsible for entering a note in the resident's record about emergency relocation notices and stated the note should indicate who notifications were provided to. The licensee's undated Notification of Emergency Relocation policy indicated the following information would be included in a notification of emergency relocation: -resident name; -date of emergency relocation; -location of emergency relocation and contact information for service provider; -reason for emergency relocation; -estimated length of stay; -notice that an emergency relocation is not notice of service termination and the resident has a right to return; -information on how to appeal a contract	01060		

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01060	Continued From page 19 termination; -who notification was made to; and -contact information for the OOLTC, Office of the Ombudsmen for Mental Health and Developmental Disabilities, and Office of Administrative Hearings. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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 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.	01620		

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01620	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a change in condition assessment following residents' hospitalizations for two of three residents ((R)2, R4) and ongoing nursing assessments not to exceed every 90-days thereafter for two of three residents (R2, R4). 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: R2 R2's Service Plan (Waiver) - Addendum to Contract dated May 14, 2024, indicated R2 received the following services: bathing, behavior management, dressing, grooming, housekeeping, leg wraps, laundry, medication administration, meals, vital signs, toileting, and emergency assistance. R2's progress note dated, June 3, 2024, at 7:18 a.m., indicated R2 was admitted to the hospital on June 1, 2024, for nausea, vomiting, shortness of breath, and lightheadedness. R2's progress note indicated R2 was receiving intravenous (IV) antibiotics for treatment of pneumonia or atelectasis (a partial or full collapse of a lung due	01620		

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01620	Continued From page 21 to blockage or pressure). R2's progress note dated, June 3, 2024, at 8:36 a.m., indicated R2 would likely stay in the hospital "a few days" per the hospital social worker. R2's progress note dated, June 3, 2024, at 10:01 a.m., indicated R2 would be discharged from the hospital at 2:30 p.m. and returning to the facility. R2's medical record contained the following RN assessments: -admission assessment dated November 1, 2023; -14-day assessment dated November 16, 2023; -90-day assessment dated February 13, 2024; -hospital return assessment dated February 20, 2024; and -90-day assessment dated May 24, 2024. R2's medical record lacked a RN assessment upon return from the hospital on June 3, 2024. In addition, R2's assessment dated May 24, 2024, was 94 days after the assessment dated February 20, 2024. R4 R4's Service Plan (Waiver) - Addendum to Contract dated June 7, 2024, indicated R4 received the following services: light housekeeping weekly, laundry- two loads weekly, medication administration four times daily, monitor for Covid symptoms daily, vital signs monthly, unspecified "reminder" three times daily, and Tek Tone monthly. R4's progress note dated June 4, 2024, at 7:25 p.m., titled, Emergency Relocation Notification indicated R4 was transferred to an acute hospital and provided the reason for the transfer was for IV antibiotics due to acute kidney injury and	01620		

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01620	Continued From page 22 concerning lab work. The note included the name and phone number of the hospital and indicated the estimated length of stay was unknown. R4's progress note dated June 5, 2024, at 11:18 a.m., indicated clinical nurse supervisor (CNS)-E collaborated with social worker from hospital, and R4 was likely going to be in the hospital for "a few more days". R4's progress note dated June 7, 2024, at 11:19 a.m., indicated R4 returned from the hospital that day. R4's medical record contained the following RN assessments: -admission assessment dated January 18, 2024; -14-day assessment dated February 2, 2024; -hospital return assessment dated March 21, 2024; and -90-day assessment dated June 26, 2024. R4's medical record lacked a RN assessment upon return from the hospital on June 7, 2024. In addition, R4's assessment dated February 2, 2024, was 15 days after the assessment dated January 18, 2024, and R4's June 26, 2024, assessment was 97 days after the assessment dated March 21, 2024. On July 1, 2024, at 11:17 a.m., RN-D stated a change in condition assessment would be completed after a hospitalization, emergency room visit, or fall. On July 3, 2023, at 11:23 a.m., RN-D stated a hospitalization should trigger a change in condition assessment. RN-D stated she did not know why R2 or R4 did not have a change in condition assessment completed after their	01620		

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01620	Continued From page 23 hospital returns dated June 3, 2024, and June 7, 2024, respectively. RN-D stated clinical nurse supervisor (CNS)-E was responsible for completing the assessments and RN-D deferred to her. RN-D stated assessments were occasionally completed late. RN-D stated Rtask (the electronic medical record system) populates the assessment due dates on a separate screen for the nurses. RN-D stated she did not believe late assessments were a systemic issue but did occasionally happen if the RN had a number of changes in condition assessments or county customized living tools for reimbursement to complete. The licensee's Initial and On-Going Nursing Assessment of Clients policy dated August 2021, indicated nursing assessments were completed by the RN based on the required assessment schedule and as needed based on resident condition. The policy indicated ongoing assessments would be completed periodically but "no less than" every 90-days (statute 144G.70, Subdivision 2 (c-e) indicated assessments cannot exceed 90 calendar days from the date of the last assessment). The policy further stated, "the frequency between assessments not to exceed 90 days from the date of the last assessment." The policy stated the RN would reassess the resident if the resident had a change in condition but did not indicate what situations would constitute a change in condition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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01650	Continued From page 24	01650		
01650 SS=F	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, 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 the service plan included the fee for services for all services received for five of five residents (R1, R2, R3, R4, R5) with records reviewed.	01650		

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01650	Continued From page 25 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 Service Plan signed April 6, 2022, indicated R1 received the following services: bathing-whirlpool twice weekly, dressing twice daily, light housekeeping weekly, laundry- two loads weekly, medication set up every 14 days, record vital signs daily, TED (compression) stockings twice daily, and unspecified "scheduled services" one day per week (noted twice). R1's service plan included a section titled "Estimated Monthly Total" which indicated, "Your Waiver Service Agreement, as sent to you by your Care Coordinator, details the rates for the services allowed by Medical Assistance. Please refer to your Service Agreement or your Care Coordinator for a final rate for all services listed above. In the event Resident no longer qualifies for Medical Assistance, Resident is aware that they are responsible to pay the Private Pay fees for the same services as detailed in the attached fee schedule." R1's service plan included at attachment titled Assisted Living & Supportive Housing Rates dated August 1, 2021. The rate form included ala-carte pricing for specified services, however, the ala-carte options did not match up with each	01650		

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	25644	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD HOMES INC	1211 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 26 of the services identified, and did not identify which prices were being charged to R1 for the following: - R1 had a service of bathing-whirlpool twice weekly, however the rate form only included a monthly price for whirlpool baths once weekly; - R1 had unspecified "scheduled services", however, the rate form did not include this category or a price. R2 R2's Service Plan signed May 14, 2024, indicated R2 received the following services: bathing, behavior management, dressing, grooming, housekeeping, leg wraps, laundry, medication administration, meals, vital signs, toileting, and emergency assistance. R2's service plan included a section titled "Estimated Monthly Total" which indicated, "Your Waiver Service Agreement, as sent to you by your Care Coordinator, details the rates for the services allowed by Medical Assistance. Please refer to your Service Agreement or your Care Coordinator for a final rate for all services listed above. In the event Resident no longer qualifies for Medical Assistance, Resident is aware that they are responsible to pay the Private Pay fees for the same services as detailed in the attached fee schedule." R2's service plan included at attachment titled Assisted Living & Supportive Housing Rates dated August 1, 2021. The rate form included ala-carte pricing for specified services, however, the ala-carte options did not match up with each of the services identified, and did not identify which prices were being charged to R2 for the following: - R2 had a service of bathing-shower two	01650		

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	25644	A. BUILDING: _____ B. WING _____	07/03/2024

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01650	Continued From page 27 times weekly, however the rate form only included a monthly price for showers once weekly. - R2 had an unspecified service of BI-verbal aggression, however the rate form did not include this category or a price. - R2 had a service for the treatment of Juxtalite leg wraps twice daily. The rate form included a Delegated HHA (home health aide) Services section which identified price categories for the following: delegated treatments one task/one time, delegated treatments one task 1-2 times weekly, delegated treatments simple 1 time daily, delegated treatment simple 2 times daily, delegated treatment complex 1 time daily, delegated treatment complex two times daily, and Ted/Compression Socks (on/off) daily. R2's service plan did not identify whether R2's Juxtalite leg wraps were a simple or complex treatment. - R2 had a service for monitor for Covid symptoms daily, however the rate form did not include this category or a price. - R2 had a service for miscellaneous household tasks daily, however the rate form did not include this category or a price. - R2 had a service of supervision by the LPN for leg wraps every 90 days. The rate form included a nursing services section which identified price categories for the following: nursing service- special needs- standard, nursing service- special needs- complex, nurse visit- time (per 15 minutes), however R2's service plan did not identify whether the LPN supervision of R2's leg wraps was standard, complex, or would be charged by increments of time. - R2 had a service of toileting six times daily, however the rate form only included toileting services which identified price categories for the following: one time daily, one to two times daily, three to four times daily, and every two hours.	01650		

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	25644	A. BUILDING: _____ B. WING _____	07/03/2024

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01650	Continued From page 28 R3 R3's Service Plan signed May 9, 2024, indicated R3 received the following services: bathing-shower three times weekly, BI-orientation (behavioral intervention) assist twice daily, grooming twice daily, light housekeeping weekly, Juxtalite leg wraps twice daily, laundry-two loads weekly, meal tray delivery service daily, menu selection assistance weekly, monitor for Covid symptoms daily, oxygen assistance weekly, vital signs monthly, unspecified "reminder" twice daily, safety check twice daily, side rail check weekly, supervision by the LPN for leg wraps every 90 days, Tek Tone (pendant call system) monthly, and therapeutic exercise daily. R3's service plan included a section titled, "Estimated Monthly Total" which indicated, "Your Waiver Service Agreement, as sent to you by your Care Coordinator, details the rates for the services allowed by Medical Assistance. Please refer to your Service Agreement or your Care Coordinator for a final rate for all services listed above. In the event Resident no longer qualifies for Medical Assistance, Resident is aware that they are responsible to pay the Private Pay fees for the same services as detailed in the attached fee schedule." R3's service plan included at attachment titled Assisted Living & Supportive Housing Rates dated August 1, 2021. The rate form included ala-carte pricing for specified services, however, the ala-carte options did not match up with each of the services identified, and did not identify which prices were being charged to R3 for the following: - R3 had a service of bathing-shower three times weekly, however the rate form only included a monthly price for showers once weekly;	01650		

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	25644	A. BUILDING: _____ B. WING _____	07/03/2024

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01650	Continued From page 29 - R3 had an unspecified service of BI-orientation, however the rate form did not include this category or a price. - R3 had a service for the treatment of Juxtalite leg wraps twice daily. The rate form included a Delegated HHA (home health aide) Services section which identified price categories for the following: delegated treatments one task/one time, delegated treatments one task 1-2 times weekly, delegated treatments simple 1 time daily, delegated treatment simple 2 times daily, delegated treatment complex 1 time daily, delegated treatment complex two times daily, and Ted/Compression Socks (on/off) daily. R3's service plan did not identify whether R3's Juxtalite leg wraps were a simple or complex treatment. - R3 had a service for menu selection weekly, however the rate form did not include this category or a price. - R3 had a service for monitor for Covid symptoms daily, however the rate form did not include this category or a price. - R3 had a service for oxygen assistance weekly, however the rate form only included options for oxygen assistance once daily, up to four times daily, or greater than five times daily. - R3 had a service for unspecified "reminders" twice daily, however the rate form only included options for reminders per occurrence, once weekly, once daily, or three times daily. - R3 had a service of safety check twice daily, however the rate form did not include this category or a price. - R3 had a service of side rail check weekly, however the rate form did not include this category or a price. - R3 had a service of supervision by the LPN for leg wraps every 90 days. The rate form included a nursing services section which	01650		

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01650	Continued From page 30 identified price categories for the following: nursing service- special needs- standard, nursing service- special needs- complex, nurse visit- time (per 15 minutes), however R3's service plan did not identify whether the LPN supervision of R3's leg wraps was standard, complex, or would be charged by increments of time. - R3 had a service of therapeutic exercise daily, however the rate form did not include this category or a price. R4 R4's Service Plan signed June 7, 2024, indicated R4 received the following services: light housekeeping weekly, laundry- two loads weekly, medication administration four times daily, monitor for Covid symptoms daily, vital signs monthly, unspecified "reminder" three times daily, and Tek Tone monthly. R4's service plan included a section titled, "Estimated Monthly Total" which indicated "Your Waiver Service Agreement, as sent to you by your Care Coordinator, details the rates for the services allowed by Medical Assistance. Please refer to your Service Agreement or your Care Coordinator for a final rate for all services listed above. In the event Resident no longer qualifies for Medical Assistance, Resident is aware that they are responsible to pay the Private Pay fees for the same services as detailed in the attached fee schedule." R4's service plan included at attachment titled, Assisted Living & Supportive Housing Rates dated August 1, 2021. The rate form included ala-carte pricing for specified services, however, the ala-carte options did not match up with each of the services identified, and did not identify which prices were being charged to R4 for the	01650		

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01650	Continued From page 31 following: - R4 had a service for monitor for Covid symptoms daily, however the rate form did not include this category or a price. R5 R5's Service Plan signed January 30, 2024, indicated R5 received the following services: bathing-shower two times weekly, BI- anxiety (behavioral intervention) assist three times daily, BI- orientation assist three times daily, CPAP (continuous positive airway pressure) assist daily, light housekeeping weekly, Juxtalite leg wraps twice daily, laundry- two days a week, medication administration four times daily, miscellaneous household tasks daily, monitor for Covid symptoms daily, vital signs monthly, record weight daily, side rail check weekly, and Tek Tone monthly. R5's service plan included a section titled, "Estimated Monthly Total" which indicated, "Your Waiver Service Agreement, as sent to you by your Care Coordinator, details the rates for the services allowed by Medical Assistance. Please refer to your Service Agreement or your Care Coordinator for a final rate for all services listed above. In the event Resident no longer qualifies for Medical Assistance, Resident is aware that they are responsible to pay the Private Pay fees for the same services as detailed in the attached fee schedule." R5's service plan included at attachment titled, Assisted Living & Supportive Housing Rates dated August 1, 2021. The rate form included ala-carte pricing for specified services, however, the ala-carte options did not match up with each of the services identified, and did not identify which prices were being charged to R5 for the	01650		

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01650	Continued From page 32 following: - R5 had a service of bathing-shower two times weekly, however the rate form only included a monthly price for showers once weekly; - R5 had an unspecified service of BI-anxiety, however the rate form did not include this category or a price. - R5 had an unspecified service of BI-orientation, however the rate form did not include this category or a price. - R5 had a service for the treatment of Juxtalite leg wraps twice daily. The rate form included a Delegated HHA (home health aide) Services section which identified price categories for the following: delegated treatments one task/one time, delegated treatments one task 1-2 times weekly, delegated treatments simple 1 time daily, delegated treatment simple 2 times daily, delegated treatment complex 1 time daily, delegated treatment complex two times daily, and Ted/Compression Socks (on/off) daily. R5's service plan did not identify whether R5's Juxtalite leg wraps were a simple or complex treatment. - R5 had a service for monitor for Covid symptoms daily, however the rate form did not include this category or a price. - R5 had a service of side rail check weekly, however the rate form did not include this category or a price. On July 3, 2024, at approximately 11:30 a.m., registered nurse (RN)-D stated they agreed fees for services was confusing and stated usually the business office personnel and county case workers navigated the communication with the resident or responsible party about what the resident's monthly rate would be. On July 3, 2024, at 12: 17 p.m., licensed assisted living director in residency (LALDIR)-B stated the	01650		

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01650	Continued From page 33 licensee had already noted the fees for services was a problem for the licensee and they were actively working on it. LALDIR-B stated they agreed the fees for all services were not apparent within the fee document. The licensee's policy titled Contents of Service Plans dated as revised August 2021 indicated service plans would include the fees for services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

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01730	Continued From page 34 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for one of two residents (R4) with records reviewed. 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 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: R4's Service Plan signed June 7, 2024, indicated	01730		

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01730	Continued From page 35 R4 received the following services: light housekeeping weekly, laundry- two loads weekly, medication administration four times daily, monitor for Covid symptoms daily, vital signs monthly, unspecified "reminder" three times daily, and Tek Tone monthly. R4's Individualized Medication Management Plan dated June 26, 2024, lacked documentation of identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis. On July 3, 2024, at approximately 11:30 a.m., registered nurse (RN)-D reviewed R4's medication record including R4's individualized medication management plan, R4's June 2024 medication administration record, and R4's assessment dated June 26, 2024. RN-D stated the documents did not identify persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis, although they were unsure why the information was not there. The licensee's policy titled Documentation of Medication, Treatment and Therapy Management Services dated as revised October 2022 indicated the RN will document the services the resident will receive on the resident's individualized medication management plan to include actions to request and obtain needed refills for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01910	Continued From page 36	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately document in the resident's record regarding the disposition of medication to include all the required content for one of two discharged residents (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 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).	01910		

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01910	Continued From page 37 The findings include: R1 was discharged from the licensee on April 15, 2024, for a higher level of care. R1's Service Plan signed April 6, 2022, indicated R1 received medication set up services from the licensee every 14-days. R1's Discharge Summary dated April 15, 2024, indicated R1's medications were given to the nurses of the new facility for continuation of care. R1's Medication Disposition record signed May 2, 2024, indicated the licensee disposed of R1's medications through a means of "Use of pharmaceutical drop box". R1's record lacked an accurate medication disposition record with required content to include: - to whom the medications were given. On July 3, 2024, at approximately 11:30 a.m., registered nurse (RN)-D stated R1 was still a resident at the other facility (where RN-D was the current clinical nurse supervisor), but she did not recall if R1's medications were sent with them during the move. RN-D confirmed the discrepancy between R1's records and stated the medication disposition should have been done within 24 hours of R1's discharge to ensure accurate documentation. The licensee's policy titled Disposition of Medications Policy dated as revised August 2021 indicated, "Staff will document in the resident's electronic record to which [sic] the medications were given, the time and date, the name of each	01910		

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01910	Continued From page 38 medication and the amount of medication remaining." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *07/01/24*
Time: 11:33:51
Report: 1037241136

Food and Beverage Establishment Inspection Report

Location:
Good Shepherd Homes Inc
1211 4th Avenue North
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0038021
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202588681
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.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
PROVIDE A QUATERNARY AMMONIUM TEST KIT FOR MEASURING THE SANITIZING SOLUTION.
Comply By: 07/15/24

Surface and Equipment Sanitizers

Hot Water: = 166 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: GRAPE JUICE
Violation Issued: No

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

ALL FOOD IS STORED AND PREPARED IN THE LICENSED KITCHEN LOCATED IN THE SHEPHERD OAKS BUILDING, LICENSE 10085.
FOODS ARE SENT OVER ON A CART TO THE SERVING KITCHEN AT THE TIME OF SERVICE. ALL FOODS ARE CONSUMED OR DISCARDED AT THE TIME OF DELIVERY FROM THE

Type: Full
Date: *07/01/24*
Time: 11:33:51
Report: 1037241136
Good Shepherd Homes Inc

Food and Beverage Establishment Inspection Report

LICENSED KITCHEN.
DISCUSSED ORDER, BARE HAND CONTACT, AND PROCEDURES FOR SERVING WITH HAILEY.
NO COOLING IS COMPLETED IN THE SERVING KITCHEN.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1037241136 of 07/01/24.

Certified Food Protection Manager: JILL M ORTON

Certification Number: 19876 Expires: 02/01/26

Inspection report reviewed with person in charge and emailed.

Signed:_____
HAILEY

Signed: Michelle L Hovanes
Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us