DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 3, 2023

Licensee
Good Shepherd Cottages
307 11th Street North
Sauk Rapids, MN 56379

RE: Project Number(s) SL23241015

Dear Licensee:

On April 27, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 10, 2023, 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,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

Electronically Delivered

March 29, 2023

Licensee
Good Shepherd Cottages
307 11th Street North
Sauk Rapids, MN 56379

RE: Project Number(s) SL23241015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 10, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00
St - 0 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

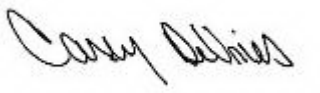
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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 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: SL23241015-0 On March 6, 2023, through March 8, 2023, 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 31 residents, all of whom received services under the provider's Assisted Living with Dementia license. On March 7, 2023, at 6:45 p.m., immediate correction order 2310 was issued. The immediacy was removed on March 8, 2023, at 10:30 a.m. On March 8, 2023, at approximately 11:00 a.m., immediate correction order 2320 was issued. The immediacy was removed on March 8, 2023, at 12:20 p.m.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
0 480	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 had the potential to affect all 31 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 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 included document titled, Food and Beverage Establishment Inspection Report dated March 6, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
0 510	Continued From page 2 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene for one of three employees (unlicensed personnel (ULP-D). 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: On March 7, 2023, at 7:40 a.m., the evaluator observed ULP-D apply gloves to assist R2 with incontinence cares and preparation for the day. ULP-D assisted R2 onto the toilet, removed a soiled incontinence brief, assisted R2 with dressing, grooming, oral cares, placed soiled laundry in a clothes hamper and made R2's bed. ULP-D left the room, entered the hallway to talk with hospice staff, entered and exited a	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
0 510	Continued From page 3 medication room, returned to R2's room, assisted R2 off the toilet, placed a gait belt on R2 and transferred R2 to a wheelchair. ULP-D removed a garbage bag from R2's garbage can, removed gloves and handed the garbage bag to ULP-G. ULP-D transported R2 to the dining room table in the wheelchair. ULP-D did not change gloves, perform hand washing or use hand sanitizer throughout the process of assisting R2. ULP-D's training record indicated ULP-D completed infection control, donning/doffing and hand washing training on the following dates: - May 28, 2022; - July 20, 2021; and - July 23, 2021. On March 7, 2023, at 9:25 a.m., assistant administrator/licensed practical nurse (LPN)-A stated staff completed computerized infection control training at orientation and annually. The licensee's 4-1 Hand Hygiene policy dated August 1, 2021, indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
0 680	Continued From page 4 (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 31 residents receiving services under the assisted living with dementia care license. 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
0 680	Continued From page 5 failure that has affected or has potential to affect a large portion or all the residents). The findings include: On March 6, 2023, at approximately 11:30 a.m., during tour with assistant administrator/licensed practical nurse (LPN)-A, the evaluator observed licensee lacked a prominently posted emergency preparedness plan. On March 7, 2023, at 8:43 a.m., the evaluator requested to review licensee's emergency preparedness plan. The evaluator and LPN-A walked to a locked cleaning closet where LPN-A removed and provided to the evaluator a red emergency preparedness binder. The licensee's Emergency Preparedness Procedures binder was last reviewed December 2, 2022. The emergency preparedness plan lacked: - posting an emergency disaster plan prominently, and - emergency plan testing/annual testing requirements. On March 8, 2023, at 8:32 a.m., LPN-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include the noted content. The licensee's 7-3 Emergency and Disaster Preparedness policy dated, August 2021, indicated the facility trained staff on hire, annually, and conducted exercises to test the emergency preparedness plan at least twice per year in compliance with 42 C.F.R. 483.73 (d) (2). No further information was provided.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
0 680	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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 7 This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide the required documentation of employee and resident training on fire safety and 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). Findings include: A record review and interview were conducted on March 06, 2023, at approximately 1:45 p.m. with assistant administrator/licensed practical nurse (LPN)-A on the fire safety and evacuation training, and evacuation drills for the facility. Record review showed unavailable documentation for training on the fire safety and evacuation plan upon initial hire and twice per year. During interview, LPN-A stated that the licensee policy is to train employees on fire safety and evacuation upon initial hire and annually after that but had no documentation to back this up. Record review showed unavailable documentation for annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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 8 include movement, evacuation, or relocation as required by statute. LPN-A stated there was a policy on resident training for fire safety and evacuation, but one was not provided at the time of the interview. Record review of the unavailable documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, LPN-A stated that licensee has not conducted the required amount of evacuation drills for the employees to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01290	Continued From page 9 licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living with dementia care license for two of two licensed nurses (licensed practical nurse (LPN)-E), clinical nurse supervisor/registered nurse (CNS/RN)-B) and two of two unlicensed personnel (ULP)-C, ULP-D). 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: CNS/RN-B CNS/RN-B was hired on August 20, 2018, under the former comprehensive license and began providing assisted living services to the licensee's residents on August 1, 2021. On March 6, 2023, at 10:23 a.m., during the entrance conference, CNS/RN-B stated she conducted the assessments for all residents of the licensee. CNS/RN-B's employee record contained a background study clearance, affiliated with the former comprehensive license, dated August 30, 2018. LPN-E LPN-E was hired on October 7, 2013, under the former comprehensive license and began providing assisted living services to the licensee's	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01290	Continued From page 10 residents on August 1, 2021. On March 6, 7 and 8, 2023, throughout the day, the evaluator observed LPN-E providing direct care and supervision to residents and staff of the licensee. LPN-E's employee record contained a background study clearance, affiliated with the former comprehensive license, dated September 30, 2013. ULP-C ULP-C was hired on September 30, 2022. On March 6, 2023, at 12:53 p.m., the evaluator observed ULP-C administer medications to R3. ULP-C's employee record contained a background study clearance, affiliated with the licensee's former comprehensive license, dated October 4, 2022. ULP-D ULP-D was hired on February 11, 2008, under the licensee's former comprehensive license and began providing assisted living services to the licensee's residents on August 1, 2021. On March 6, 2023, at 1:27 p.m., the evaluator observed ULP-D administer medications to R1. ULP-D's employee record contained a background study clearance, affiliated with the licensee's former comprehensive license, dated February 6, 2008. CNS/RN-B, LPN-E, ULP-C and ULP-D's employee records lacked evidence of a current, cleared background studies affiliated with the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01290	Continued From page 11 licensee's current assisted living with dementia care license, effective August 1, 2021. On March 7, 2023, at 12:15 p.m., the evaluator reviewed and verified with assistant administrator/licensed practical nurse (LPN)-A through Department of Human Services NetStudy Roster, CNS/RN-B, LPN-E, ULP-C and ULP-D did not have a cleared background study affiliated with the licensee's name or license number. On March 7, 2023, at 12:15 p.m., assistant administrator/licensed practical nurse (LPN)-A stated the background checks had been done upon hire through the parent company's human resources, however, were not affiliated with the licensee's assisted living with dementia care license. The licensee's Background Checks policy, revised July 11, 2013, indicated in accordance with regulation, it was policy of licensee to conduct a background check on current employees and prospective employees. The policy did not address employees meeting assisted living licensure requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01500	Continued From page 12	01500		

provision of assisted living services. The annual training must include:
(1) training on reporting of maltreatment of vulnerable adults under section 626.557;
(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;
(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;
(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and
(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.
(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01500	Continued From page 13 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of four employees (unlicensed personnel (ULP)-D). 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: ULP-D began employment on February 11, 2008, under licensee's former comprehensive license and began providing direct resident cares under the assisted living with dementia care license on August 1, 2021. ULP-D's record lacked evidence annual training was completed as required in the following areas:	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01500	Continued From page 14 - review of the licensee's policies and procedures. On March 7, 2023, at 9:25 a.m., assistant administrator/licensed practical nurse (LPN)-A verified ULP-D's record did not meet annual training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01610 SS=E	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 a registered nurse (RN) conducted an initial assessment for	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01610	Continued From page 15 two of two residents (R1, R2) prior to initiation of services. 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: R1 R1 was admitted for services on February 21, 2023. R1's diagnoses included Alzheimer's disease (a brain disorder causing memory problems, thinking and behavior), chronic heart failure (heart disease that affects pumping actions to the heart muscles), GERD (chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, a tube connecting the mouth and stomach). On March 6, 2023, at 1:27 p.m., the evaluator observed unlicensed personnel (ULP)-D administer afternoon medications to R1. R1's admission assessment completed by the RN was dated March 3, 2023. The assessment was not completed prior to initiation of services on February 21, 2022. R2 R2 was admitted for services on July 7, 2022.	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01610	Continued From page 16 R2's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). On March 7, 2023, at 7:40 a.m. the evaluator observed ULP-D perform morning cares on R2. R2's admission assessment completed by the RN was dated July 14, 2022. The assessment was not completed prior to initiation of services on July 7, 2022. On March 7, 2023, at 10:56 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-B verified R1 and R2's admission assessment required prior to the start of services was not completed. CNS/RN-B stated, "being the only RN during COVID-19 for 31 residents, I got behind on assessments". The licensee's 1-6 Initial and On-Going Nursing Assessment of Residents policy indicated a RN would complete the comprehensive nursing assessments for resident's physical, mental and cognitive needs at a pre-admission assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=F	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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01620	Continued From page 17 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days after the initiation of services for four of five residents (R1, R2, R5, R7) and failed to ensure the RN conducted ongoing resident assessment, not to exceed 90 calendar days from the date of the last assessment for four of five residents (R2, R3, R5, R7). 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01620	Continued From page 18 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 was admitted for services on February 21, 2023. R1's diagnosis included Alzheimer's disease (a brain disorder causing memory problems, thinking and behavior), chronic heart failure (heart disease that affects pumping actions to the heart muscles), GERD (chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, a tube connecting the mouth and stomach). R1's unsigned service plan effective February 21, 2023, indicated R1 received assistance with grooming, housekeeping, laundry, medication administration, orientation assist, verbal aggression, and anxiety assist. On March 6, 2023, at 1:27 p.m., the evaluator observed unlicensed personnel (ULP)-D administer afternoon medications to R1. R1's record included a completed Admission Assessment dated March 2, 2023, ten days after the start of services and lacked a 14-day assessment. R2 R2 was admitted for services on July 7, 2022. R2's diagnoses included dementia (a group of symptoms that affects memory, thinking and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01620	Continued From page 19 interferes with daily life), and atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). R2's Service Plan and Agreement signed February 7, 2023, indicated R2 received assistance with bathing, transfers, dressing, grooming, eating assistance, hearing aids, repositioning, toileting, and medication assistance. On March 7, 2023, at 7:40 a.m. the evaluator observed ULP-D perform morning cares on R2. R2's record included one assessment, an Admission Assessment dated July 14, 2022, seven days after the start of services. R2's record lacked a 14-day assessment and all required 90-day assessments. R3 R3's diagnoses included dementia and chronic obstructive pulmonary disease (respiratory symptoms of breathlessness and cough). R3's service plan dated July 6, 2022, indicated the resident received services which included medication administration, bathing, hygiene/grooming, dressing, toileting, laundry, and housekeeping. On March 6, 2023, at 12:53 p.m., the evaluator observed ULP-C administer R3 her scheduled afternoon medication. R3's record indicated the most recent 90-day assessment was completed on July 18, 2022. R3's record lacked all required 90-day assessments after July 18, 2022.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01620	Continued From page 20 R5 R5's diagnoses included Parkinson's disease, hypertension, history of falls, and arterial ischemic stroke. R5's service plan signed February 5, 2023, indicated the resident received services which included medication administration, orientation assistance, bathing, hygiene/grooming, dressing, toileting, and laundry. On March 7, 2023, at 7:42 a.m., the evaluator observed ULP-F administer R5's morning medication. R5's record included an admission assessment completed on November 18, 2022, and an assessment completed on March 6, 2023 (day of survey entry). R5's record lacked a 14-day and a 90-day assessment. R7 R7's diagnoses included dementia due to Parkinson's disease, hallucinations, chronic kidney disease stage 3 (CKD3), and major depression. R7's service plan signed February 24, 2023, indicated the resident received services which included medication administration, orientation assistance, repetitive behavior, bathing, hygiene/grooming, dressing, toileting, and laundry. On March 7, 2023, at 1:42 p.m., the evaluator observed ULP-F administer R7's afternoon medication.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
01620	Continued From page 21 R7's record included an admission assessment completed on December 17, 2021, an assessment completed on March 9, 2022, and most recent on March 6, 2023 (day of survey entry). R7's record lacked a 14-day, and all required 90-day assessments. On March 7, 2023, at 10:56 a.m., clinical nurse supervisor (CNS/RN)-B stated the assessments listed in Rtask (a computer software program) were the completed assessments and verified R1, R2, R3, R5 and R7 lacked the required assessments. CNS/RN-B stated, "being the only RN during COVID-19 for 31 residents, I got behind on assessments". The licensee's 1-6 Initial and On-Going Nursing Assessment of Residents policy indicated a RN would complete the comprehensive nursing assessments for resident's physical, mental and cognitive needs at pre-admission assessment, 14-day assessment, ongoing assessment completed periodically but no less than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02110	Continued From page 22 (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives for five of five residents (R1, R2, R3, R5, R7).	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02110	Continued From page 23 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 is 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 of the residents). The findings include: The facility held a current Assisted Living with Dementia Care license. R1 R1 was admitted for services on February 21, 2023. R1's diagnoses included Alzheimer's disease (a brain disorder causing memory problems, thinking and behavior), chronic heart failure (heart disease that affects pumping actions to the heart muscles), GERD (chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, a tube connecting the mouth and stomach). R2 R2's was admitted for services on July 7, 2022. R2's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). R3 R3 was admitted for services on October 10, 2018.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02110	Continued From page 24 R3's diagnoses included dementia and chronic obstructive pulmonary disease (respiratory symptoms of breathlessness and cough). R5 R5 was admitted for services on August 20, 2021. R5's diagnoses included Parkinson's disease, hypertension, history of falls and arterial ischemic stroke. R7 R7 was admitted for services on December 8, 2021. R7's diagnoses included Parkinson's disease due to dementia, hallucinations, and history of falls. On March 7, 2023, at 8:52 a.m., assistant administrator/licensed practical nurse (LPN)-A stated the licensee had recently completed the required dementia care policies and procedures, however, licensee had not provided the policies to residents and/or the resident's legal and designated representatives. LPN-A stated previously the policies and procedures had not been included with the admission packages, however, the admission packages would now contain the updated policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02310	Continued From page 25 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards with assistive devices (consumer bed rails), for three of five residents (R2, R3, R5). This resulted in an immediate correction order on March 7, 2023, at 6:45 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, 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 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 diagnoses included dementia, and atrial fibrillation (abnormal heart rhythm). R2's Assessment dated July 14, 2022, indicated R2 required some help to sit up and getting in and out of bed, they were able to safely transfer independently as desired, at times with staff to assist as needed using gait belt.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02310	Continued From page 26 R2's Service plan dated February 7, 2023, indicated R2 received services which included assistance with bathing/showering, medication management, eating assistance, dressing, grooming, toileting, TED stockings, repositioning, housekeeping, and laundry. On March 7, 2023, at 7:40 a.m., evaluator observed R2 in bed with a Halo Safety Ring (consumer bedrail), with one pole bolted to the left side of R2's hospital bed. The device had a circular top with bars within the circle. At the time of the observation, unlicensed personnel (ULP)-D, stated R2 utilized consumer bedrail for assistance getting in and out of the bed. With assistance of ULP-D, R2 was moved from lying to sitting position, assisted from sitting to standing with a use of a gait belt. At no time in the observation, was R2 observed to use the Halo to assist with the bed mobility or to get out of bed. R2 was assisted by ULP-D to walk to the bathroom using a gait belt and walker. ULP-D was observed to call for assistance of second ULP (ULP-G) to assist R2 get off the toilet from sitting to standing. R2 was assisted to a wheelchair for transportation to the dining room. R2's clinical record lacked evidence the Halo Safety Ring was identified, the Consumer Product Safety Commission (CSPC) was referenced for potential recall and assessed for safety, including review of risks and benefits of using the Halo Safety Ring. R3 R3's diagnoses included dementia and chronic obstructive pulmonary disease (respiratory symptoms of breathlessness and cough). R3's Assessment dated July 18, 2022, indicated R3 required extensive assistance of one staff with	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02310	Continued From page 27 mobility and gait belt for transfers. The assessment identified R3 required staff assistance with positioning and transferring in and out of bed with use of a hospital bedrail. The assessment indicated the risk versus benefits were reviewed with the resident. R3's Service plan dated July 6, 2022, indicated R3 received services which included assistance with toileting, oxygen, medication management and "side rail check" once a week. On March 7, 2023, at 3:04 p.m., clinical nurse supervisor (CNS) and evaluator observed a Halo Safety Ring, with one pole bolted to the metal side of the hospital bed and a circular top with bars within the circle. The device was attached to the left side of R2's bed. At the time of the observation, R3 was observed to be seated in a recliner. R3 stated they used the bedrail to get up in bed. CNS was observed to grab the Halo Safety Ring, the device moved freely side to side. CNS stated Midwest Medical installed the Halo Safety Ring and verified the device was loose. R3's assessment identified risks versus benefits were reviewed with R3, the clinical record lacked evidence the licensee referred to CSPC to check for potential recall of the Halo Safety Ring. Comfort Company Halo Safety Ring model: 77121 complete halo ALC, manufacturer guidelines dated December 4, 2017, identified risks included serious injury or death could result if not properly installed. Improper installation creates risk of entrapment. The guidelines further stated, "Proper patient (resident) assessment and monitoring, and proper maintenance and use of the equipment is required to reduce the risk of entrapment."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02310	Continued From page 28 R5 R5's diagnoses included Parkinson's, hypertension (high blood pressure), and history of falls. R5's Assessment dated November 18, 2022, indicated R5 was independent with repositioning with use of the "partial bedrail" for assisting mobility in and out of bed. R5's Service plan dated February 5, 2023, indicated R5 received services which included orientation assistance, "siderail checks," assistance with bathing/showering, medication management, behavioral management, toileting, dressing, grooming, housekeeping, and laundry. On March 7, 2023, at 3:07 p.m., CNS and evaluator observed Confidence Point U-bar shaped siderail that had one bar with a "U" closed shaped handle at the top. The device was strapped around the metal hospital bed frame with a black strap. CNS was observed to grab the top of R5's bedrail, the device moved feely back and forth. CNS verified the device was loose. On March 7, 2023, at 10:56 a.m., CNS-B stated she was behind on assessments, and stated they were unaware of bedrail on R2's bed. On March 7, 2023, at 5:40 p.m., ULP-H stated siderail checks were performed weekly ensuring siderails are secure and to notify the nurse if they are loose. 7610 Instructions Confidence Bed Handle V 1.0, undated, manufacturer guidelines identified, "Improper installation of this product significantly increases the risk of entrapment." On March 7, 2023, at 2:52 p.m., CNS stated each	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02310	Continued From page 29	02310		

manufacture for all bedrails were in a binder located in CNS's office. CNS stated the manufacture guidelines and the recalls should be checked at each 90 day assessment. CNS stated Halo bedrails were installed by Midwest Medical, and stated the u-bar bedrail was installed by the CNS. CNS stated they did not check CSPC for device recall.

The licensee's Assessing Bed Assistive Devices policy, dated August 2021, noted when a resident utilized a side rail on a bed, the licensee would assess the use, educate the resident or representative about the risk and benefits of the side rails, and verify the side rail in use was a safe design and utilized consistent with the manufacturer's directions. In addition, it noted the facility would determine as safe by meeting all the requirements below:
- The side rails was used consistent with manufacturer's directions;
- The side rails were installed securely and maintained in good operating condition, be aware of wobbly rails; and
- If the side rail (hospital bed design) was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment, to mean side rail zones 1, 2 and 3 must not exceed 4.75".

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02310	Continued From page 30	02310		

incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:
- Purpose and intention of the bed rail;
- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;
- The resident's bed rail use/need assessment;
- Risk vs. benefits discussion (individualized to each resident's risks);
- The resident's preferences;
- Installation and use according to manufacturer's guidelines;
- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and
- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".
Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.

The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02310	Continued From page 31 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of this order was removed on March 8, 2023, at 10:30 a.m. The scope and level remain the same.	02310		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents received health care and other assisted living services to adequately provide services to residents, for two residents with falls (R5, R7). This resulted in an immediate correction order issued March 8, 2023, at approximately 11:00 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02320	Continued From page 32 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: R5 R5's diagnoses included Parkinson's disease, ischemic stroke, and history of falls. R5's Service Plan Agreement dated February 5, 2023, indicated R5 required assistance with dressing, grooming, orientation assistance, toileting, bathing, medication administration, meals, and housekeeping. R5's Incident Summary Report dated January 1, 2023, through March 7, 2023, indicated R5 had thirteen (13) falls from January 1, 2023, through March 7, 2023. Incident reports completed by staff indicated injury resulted from the falls on the following dates and times: - January 3, 2023 - unwitnessed fall, "hit head, had fall in bathroom, got up by self and was dizzy" - January 5, 2023 - unwitnessed fall, "abrasion to left shoulder" - January 16, 2023 - unwitnessed fall, "complaints of pain in tail bone" - January 26, 2023 - unwitnessed fall, "resident was on her side behind the door laying on the floor with a bloody nose" - January 30, 2023, - witnessed fall, "abrasion and red mark on left side of face" - February 7, 2023 - unwitnessed fall, "resident offering complaints of sore groin" - February 8, 2023 - unwitnessed fall, "resident fell when ambulating in hallway. Was found sitting	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02320	Continued From page 33	02320		

on her bottom. Resident hit wall when fallen. Sore back."; and
- February 11, 2023 - unwitnessed fall, "suspected head trauma. Small bump to back of head."

R5's progress notes did not address a fall on January 3, 2023.

On January 5, 2023, at 8:15 p.m., a licensed practical nurse (LPN) wrote, "ambulating into her bathroom and lost balance falling in bathroom doorway. Bumped against a chest of drawers by bathroom door leaving three (3) small round raised spots on back of left upper arm. Looked like 3 mosquito bites. Reports pain to left arm bumps, but none other".

On January 16, 2023, at 7:16 p.m., a LPN wrote in R5's progress notes, "found her sitting on the bathroom floor talking to her daughter on the phone. Two person assist to standing. Ambulated with one person assist to recliner without any difficulty. Complained of tailbone pain". Progress notes indicated R5 had complaints of pain on January 17, 2023, and January 18, 2023, following the fall.

On January 26, 2023, at 10:33 p.m., an on-call registered nurse (RN) wrote "she then walked quickly to her apartment door without her walker to unlock the door for staff. On her way to the door she fell and hit her face. Her nose is bloody, starting to swell, and bruise".

R5's Incident Summary Report included falls on February 7, 2023, and February 8, 2023. The falls were not included in R5's progress notes.

On February 12, 2023, at 10:51 a.m., an LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02320	Continued From page 34 wrote, "Writer notified by RN of recent fall. Has a quarter-size bump to lower area back of head. Writer obtained ice pack for resident to apply per her request. Had no other complaints. Writer reminded resident to push tektone pendent for any falls or if needing assistance getting something not within reach. Writer noted sign on wall with tektone reminder. Oncall/onsite nursing updated via snap message". The incident reports indicated a LPN documented and reviewed the incidents, however, R5's progress notes lacked documentation the clinical nurse supervisor/registered nurse (CNS/RN)-B conducted a follow up assessment with falls resulting in injury and/or a change in condition. On March 7, 2023, at 4:30 p.m., the evaluator reviewed assessments for R5 completed on November 18, 2022, and March 6, 2023 (day of survey entry), R5's assessments remain unchanged and did not address new interventions to prevent falls. R7 R7's diagnoses included Parkinson's due to dementia, hallucinations, and history of falls. R7's Service Plan Agreement dated February 24, 2023, indicated R7 required assistance with dressing, bathing, toileting, medication administration, meals, and housekeeping. R7's Assessments dated March 9, 2022, and March 6, 2023, indicated R7 had memory loss, was confused at times, was frequently unsteady, independent with ambulation and transfers and was a high risk for falls. R7's Incident Summary Report dated January 1,	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02320	Continued From page 35 2023, through March 7, 2023, indicated R7 had forty-eight (48) falls from January 1, 2023, through March 7, 2023. Incident reports completed by staff indicated injury resulted from the falls on the following dates and times: - January 21, 23, 24, 2023 - fall resulted in knee abrasions and scabbing; - February 3, 2023 - suspected head trauma, abrasions to right side of face; - February 12, 2023 - sore left shoulder; and - February 17, 2023 - right side facial tenderness, fall from bed. On January 23, 2023, at 7:30 p.m., an LPN wrote in R7's progress notes staff had called and R7 was complaining of knee pain, had swelling and bright redness on right knee scabs. R7's progress note dated January 24, 2023, written at 1:34 p.m., by a LPN, indicated hospice had provided new orders for wound care. On February 3, 2023, at 9:30 p.m., an LPN wrote in R7's progress notes, R7 had a fall with "complaints of pain to right knee". Incident Report dated February 3, 2023, written by an LPN indicated abrasions to right side of face and hospice nursing to be notified. On February 12, 2023, at 4:28 a.m., staff wrote R7 had fell and sustained a "sore left shoulder". On February 17, 2023, at 7:54 p.m., an LPN wrote R7 slipped out of bed and sustained three (3) bruises and abrasions to the right side of R7's face. The incident reports indicated a LPN documented and reviewed the incidents, however, R7's progress notes lacked documentation the CNS/RN-B conducted a follow up assessment	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23241	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COTTAGES	307 11TH 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
02320	Continued From page 36 with falls resulting in injury and/or a change in condition. On March 7, 2023, at 4:30 p.m., the evaluator reviewed assessments for R7 completed on March 9, 2022, and March 6, 2023 (day of survey entry), R7's assessments remain unchanged and did not address new interventions to prevent falls. On March 7, 2023, CNS/RN-B stated if a resident falls, nursing would follow up within 24 hours after the fall. CNS/RN-B verified R5 and R7's medical record lacked documentation CNS/RN-B completed a follow up assessment after R5 and R7's falls. CNS/RN-B stated, "being the only RN during COVID-19 for 31 residents, I got behind on assessments". The licensee's Fall Prevention and Reduction policy, revised August 2021, indicated the RN would identify any concerns suggesting the resident may be at risk for falls. The RN would identify any needed interventions, educate the resident, and make appropriate recommendations to reduce the risk of falls. Additionally, the policy indicated the RN would assess the residents' risk for falls every 90 days or as needed with a change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 8, 2023, at 12:20 p.m., the immediacy of this order was removed. The scope and level remain the same.	02320		

DEPARTMENT OF HEALTH

Type: Full
Date: *03/06/23*
Time: 11:30:30
Report: 1037231060

Food and Beverage Establishment Inspection Report

Location:
Good Shepherd Cottages
307 11th Street North
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0038636
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.

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.

TEST STRIPS FOR THE SANITIZING SOLUTION WERE NOT AVAILABLE AT THE TIME OF INSPECTION. PROVIDE TEST STRIPS THAT ARE READILY AVAILABLE FOR THE FOOD EMPLOYEES TO MEASURE THE CONCENTRATION OF THE SANITIZING SOLUTION.

Comply By: 03/13/23

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

AT TIME OF INSPECTION, THERE WERE NO PAPER TOWELS IN THE DISPENSER AT THE HANDWASHING SINK IN THE NORTH KITCHEN. PROVIDE AND MAINTAIN A SUPPLY OF INDIVIDUAL DISPOSABLE TOWELS AT THE HANDWASHING SINK.

Comply By: 03/06/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

POSTED CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE EXPIRED MAY 2022. EMPLOY A CURRENT CFPM.

Comply By: 05/06/23

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE - NORTH KICTHEN
Violation Issued: No

Hot Water: = at 176 Degrees Fahrenheit
Location: DISHWASHER - NORTH KITCHEN
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Upright Cooler - NORTH
Temperature: 38 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Process/Item: Upright Cooler - NORTH
Temperature: 41 Degrees Fahrenheit - Location: WHIPPED CREAM
Violation Issued: No

Process/Item: Hot Holding - NORTH
Temperature: 158 Degrees Fahrenheit - Location: CHICKEN WILD RICE CASSEROLE
Violation Issued: No

Process/Item: Hot Holding - NORTH
Temperature: 171 Degrees Fahrenheit - Location: PEAS
Violation Issued: No

Process/Item: Upright Cooler - SOUTH
Temperature: 39 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Process/Item: Upright Cooler - SOUTH
Temperature: 40 Degrees Fahrenheit - Location: SHREDDED CHEESE
Violation Issued: No

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

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1037231060 of 03/06/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

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

Report #: 1037231060

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	2	Date	03/06/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:30:30
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Good Shepherd Cottages	307 11th Street North	Sauk Rapids, MN	56379	3202526525

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038636		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1 IN OUT	PIC knowledgeable; duties & oversight		
2 IN OUT N/A	Certified food protection manager, duties		
Employee Health			
3 IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 IN OUT	Proper use of reporting, restriction & exclusion		
5 IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN OUT N/O	Hands clean & properly washed		
9 IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 IN OUT	Food obtained from approved source		
12 IN OUT N/A N/O	Food received at proper temperature		
13 IN OUT	Food in good condition, safe, & unadulterated		
14 IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 IN OUT N/A N/O	Food separated and protected		
16 IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT N/A N/O	Proper reheating procedures for hot holding		
20 IN OUT N/A N/O	Proper cooling time & temperature		
21 IN OUT N/A N/O	Proper hot holding temperatures		
22 IN OUT N/A	Proper cold holding temperatures		
23 IN OUT N/A N/O	Proper date marking & disposition		
24 IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT N/A	Food additives: approved & properly used		
28 IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O Plant food properly cooked for hot holding		
35		IN OUT N/A N/O Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/06/23

Inspector (Signature) Michelle L Thomas