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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: G599
Facility ID: 00023

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245269**
2. STATE VENDOR OR MEDICAID NO. (L2) **686240300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **1115 4TH AVENUE NORTH**
(L5) **SAUK RAPIDS, MN** (L6) **56379**

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/30/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **162** (L18)
13. Total Certified Beds **162** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	162			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE: Kathy Lucas, Unit Supervisor Date: 08/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Douglas Larson, Enforcement Specialist Date: 08/08/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1984** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/06/2018** (L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245269
August 8, 2018

Mr. Bruce Glanzer, Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

Dear Mr. Glanzer:

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

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

Effective July 20, 2018 the above facility is certified for:

162 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 162 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

August 8, 2018

Mr. Bruce Glanzer, Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: Project Number S5269025

Dear Mr. Glanzer:

On June 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 14, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 30, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 14, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 14, 2018, effective July 20, 2018 and therefore remedies outlined in our letter to you dated June 28, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

August 8, 2018

Mr. Bruce Glanzer, Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

Re: Reinspection Results - Project Number S5269025

Dear Mr. Glanzer:

On July 30, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 14, 2018, with orders received by you on June 28, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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

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___ 3. 24 Hour RN
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___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

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17. SURVEYOR SIGNATURE: Carlene Lange, HFE NE II — Date: 07/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Douglas Larson, Enforcement Specialist — Date: 08/06/2018 (L20)

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

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32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 28, 2018

Mr. Bruce Glanzer, Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: Project Number S5269025

Dear Mr. Glanzer:

On June 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 24, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 14, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as

the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 14, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 11 through June 14, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 11 through June 14, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course	F 661		7/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/06/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 661	Continued From page 1 of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a discharge summary in preparation of a resident discharge for 1 of 1 residents (R149) discharged from the facility to another care facility. Findings include: R149's Care Area Assessment (CAA) dated 3/21/18, indicated a risk for falls related to impaired mobility and narcotic analgesics with a fall prior to admission that resulted in a left humeral head (shoulder) fracture and multiple rib fractures. The CAA further indicated risk for pain related to impaired mobility and previous fracture	F 661	Good Shepherd does have a process in place to complete discharge summery on anticipation of discharge. Regarding resident number 149 the facility recognizes the discharge summary form was not completed when the resident transferred to another facility. Documentation of the discharge process and summary of information exchanged with the receiving facility was documented in the electronic chart. Regarding any other residents who have active discharge plans, an audit of their records was completed to assure that the facilities process is being carried out as	

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	245269	A. BUILDING ______ B. WING ______	06/14/2018

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F 661	Continued From page 2 to left humerus and risk for decreased mood related to current health condition and that R149 was independent and living in assisted living facility prior to fall. R149's admission Minimum Data Set (MDS) dated 3/16/18, indicated R149 was moderately cognitively impaired, required total assistance for transfers/toilet use/and personal hygiene. The MDS further indicated that R149 had frequent pain that he verbalized as severe, he was on oxygen and dialysis. R149 participated in assessment and resident's overall goal was to discharge back to the community according to family or significant other. R149's care plan dated 3/9/18, indicated a diagnosis of renal failure with dialysis, diabetic, pneumonia with shortness of breath, and pain from fractures. R149's care plan also addressed behavior of yelling out, refusing cares and potential for other behavioral indicators. Care plan indicated R149 required a mechanical Hoyer lift for transfers with two staff assist, along with bed mobility, toileting and bathing. R149's doctor discharge orders, dated 4/13/18, indicated 1) decrease oxycodone 5 mg to 2.5 mg by mouth three times a day and 2.5 mg by mouth as needed every two hours use sparingly try to use Tylenol instead per nephrology 2) to send copy of discharge summary with patient when it arrives and 3) make arrangement for follow up visit with his local provider in 1-2 weeks. The discharge order was stamped that it was faxed to the pharmacy on 4/13/18 with no indication this was shared with receiving facility. An additional discharge order was given on 4/13/18 that indicated R149 was discharging to a new facility	F 661	appropriate. Changes were made as necessary. The facility believes it has a process in place to manage effective discharge planning. To assure all components of the process are completed thoroughly, the facility has chosen to enhance its process to be more streamlined and consistent for all discharges regardless of where the resident is discharging to. The facility also has chosen to enhance the current discharge form to assure increased ease in finding the information gathered and provided to the accepting facility of discharge to. Training regarding the enhancement of this process and form will be completed for all individuals responsible for compliance to this regulation. To assure sustainability of this process change, routine audits of those residents who discharge to home or another facility will be completed daily for 1 week; weekly for two weeks, and then monthly for two months and periodically after that to assure ongoing compliance. The results of these audits will be reviewed at the facilities quarterly QI committee meetings.	

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F 661	Continued From page 3	F 661		

on 4/17/18 and indicated the new facility requested signed and dated copy of current medication list and treatments which were attached. R149's record indicated the receiving facility was faxed current medication, treatment, signed admission form, signed history and physical however, the record lacked a recapitulation of the R149's stay, including diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results or a post discharge plan of care.

R149's progress note, dated 4/11/18, indicated the social worker provided referral information to the new facility's intake coordinator for review. R149's progress note dated 4/17/18, indicated R149 left via care cab, paperwork sent with, note did not indicate what was sent and a blank recapitulation summary form was located in R149's record.

During an interview on 6/14/18, at 1:52 p.m. the director of social service (SS)-A reviewed the blank recapitulation summary form for R149 that was found in the discharge record and when asked how they summarized and recapped R149's stay, SS-A stated "That's what we usually fill out" in reference to the blank recapitulation form.

During an interview on 6/14/18, at 2:24 p.m. case manager (CM)-A indicated the discharge summary is a combined effort between social services and the case manager to collect information to be given to the receiving facility. CM-A further indicated the information they would send would be nursing needs, oxygen, diabetic needs, medication, or therapy information. CM-A

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F 661	Continued From page 4 further indicate it would be standard regardless if the resident goes home or to another facility and this is always given on discharge. During interview on 6/14/18, at 2:30 p.m. health information manager indicated the discharge summaries are located in the hard chart and the case manager takes care of forwarding the information to the receiving facility. A facility policy on discharge and recapitulation summaries was requested but not supplied.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with the removal of facial hair and assist with hearing aide placement for 1 of 1 resident (R105) who was dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R105's quarterly Minimum Data Set (MDS), dated 5/8/18, identified R105 had dementia, moderate cognitive impairment, required limited assistance with dressing and extensive assistance with personal hygiene. The MDS included, that R105 had adequate ability to hear with no difficulty in normal conversation, social interaction, however, identified that R105 used hearing aids.	F 677	Good Shepherd does assure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Regarding resident number 105 the facility recognizes that during time of the survey that one resident was noted to have facial hair and their hearing aids were not placed timely before cares were provided. The hearing aids were placed in resident□s ears at the end of cares on the day they were noted to be without them. The facial hair had also been removed at the time when they were identified. Resident 105□s care plan and task list	7/20/18

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F 677	Continued From page 5 R105's admission Minimum Data Set (MDS), dated 11/28/17, identified it was "very important" to R105 to choose what clothes to wear. R105's Care Area Assessment (CAA), printed 6/14/18, included hearing or vision impairment may have an impact on ability to process information, and physical limitations resulted in need for assistance with ADLs. R105's care plan, dated 5/7/18, indicated R105 required assistance with some activities of daily living related to weakness and impaired cognition, such as bathing, dressing, hygiene, and toilet use. R105's Task List/Assignments, printed on 6/14/18, indicated R105 required assistance of one staff for hygiene and dressing, and wore bilateral hearing aids. During an observation and interview on 6/11/18, at 7:15 p.m. R105 had several 1/4-1/2 inch long white hairs on each side of her mouth. R105 stated, "I don't like the hairs, but I don't have a scissors." R105 stated the staff had cut them once but hadn't offered to remove them in a long time. During an observation on 6/13/18, at 7:25 a.m. nursing assistant (NA)-D entered R105's room and announced she would be assisting R105 with morning cares. R105 was sitting on the toilet. Several 1/4-1/2 inch long white hairs remained on each side of R105's mouth. NA-D asked R105 what she wanted to wear. R105 did not respond. NA-D again offered choices of clothing. R105 shrugged her shoulders. NA-D took a pair of	F 677	were reviewed and revised as necessary to assure clear guidance is in place for NARs providing cares. Regarding any other residents who have a possibility of being affected by this, their care plans have also been reviewed and revised as necessary to assure clear guidance is in place for NARs providing cares. The facility believes it has a process of training staff to monitor for unwanted facial hair, hearing aid placement and other ADL and grooming needs. To assure ADL□s are provided as per expectation of the facility a checkoff form will be implemented with a listing of basic AM and PM cares highlighting checking and removal of facial hair as well as devices. This form will be signed off by the person completing the cares on the AM and PM shifts indicating that the listed tasks were completed. They will be reviewed by the Team Leader for that shift prior to the staff member leaving. In addition to the form; staff will be educated on the importance of the order in which cares are provided to assure needed appliances/devices are in place timely to be most beneficial to the resident. To assure sustainability of this process change, routine audits of the cares check off forms will be completed daily for 1 week; weekly for two weeks, and then monthly for two months and periodically after that to assure ongoing compliance. The results of these audits will be reviewed at the facilities quarterly QI committee meetings.	

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F 677	Continued From page 6	F 677		

slacks and a blouse out of the closet and brought them into the bathroom. NA-D donned gloves and handed R105 a wet washcloth and directed her to wash her face. R105 used the washcloth to wipe her face and neck. NA-D knelt on the floor in front of R105 and explained what she was doing as she removed R105's wet brief. R105 pointed to her ears and stated, "What? I can't hear you." NA-D stated, "I know, I don't want to put them in [pointing to the hearing aids on the bathroom counter] until we're done." NA-D handed R105 another wet washcloth, and motioned to R105 to wash her upper body, and then gave her a towel to dry the areas. NA-D continued to talk and ask questions and R105 stated, "I don't know what you're saying." NA-D laughed and stated, "We have to get those hearing aids in, huh?" R105 shrugged her shoulders and shook her head. NA-D brushed R105's top denture and handed it to R105, instructing her to put it in her mouth. R105 stated, "What? I can't hear you." NA-D motioned to R105 to put her denture in, and stated, "That's cause we gotta get those hearing aids in, don't we?" R105 put in her top denture and sat quietly. NA-D brushed R105's hair, still talking to R105, while R105 sat quietly, not responding. NA-D then placed R105's hearing aids in her ears. NA-D cleaned R105's glasses and handed them to R105, assisted her to stand, and performed peri care. NA-D assisted R105 to dress and then assisted her to ambulate out of the bathroom to her wheelchair, and then to the dining room for breakfast. NA-D did not offer to remove R105's facial hair.

When interviewed on 6/13/18, at 8:07 a.m. NA-D stated she didn't place R105's hearing aids prior to interacting with her and providing personal cares, and stated, "I didn't want to put them in

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F 677	Continued From page 7 until I was done with her face and hair. I didn't want to bump them." When asked about R105's facial hair, NA-D stated, "That's typically done on bath day. [R105] gets two baths a week. We don't have time to stop and do that." During an interview on 6/14/18, at 1:22 p.m. the director of nursing (DON) indicated facial hair should be removed when it is noticed. When asked about hearing aids, DON stated, "We do this all the time. I expect it to be taken care of." A policy was requested on 6/14/18, at 2:22 p.m. registered nurse (RN)-G stated, "Those things are standards of practice and we don't have policies for those."	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure placement of a call light, used as a planned fall intervention per the care plan, was appropriately placed for 1 of 1 resident (R448), reviewed for accidents. Findings include: R448's Record of Admission indicated an	F 689	Good Shepherd does ensure that the residents environment remains as free from accidents and hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Regarding resident number 448 the facility recognizes that the call light was not appropriately placed during one	7/20/18

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F 689	Continued From page 8 admission date of 5/30/18. R448's face sheet printed on 6/14/18 identified current diagnoses of dementia, Alzheimer's disease, and history of falling. R448's Care Area Assessment (CAA) dated 6/11/18, identified R448 had risk for falls including impaired balance, mobility, incontinence, cognitive impairment, depression and polypharmacy. R448's admission Minimal Data Set (MDS), printed on 6/14/18, identified the following indicators of fall risk; impaired balance during transitions, fatigue, weakness, decline in functional status, incontinence, wandering, cognitive impairment, Alzheimer's disease, cardiovascular medications, antidepressants, antipsychotics and neuroleptics. R448's care plan, dated 5/30/18, indicated R448 was at risk for falls related to impaired cognition, difficulty with mobility, and dementia. Interventions included encouraging the resident to ask for help and directed staff to have the call light close by. Other interventions included R448 needed a soft touch type of call light, and directed staff to keep frequently used items close by, to assess for pain or discomfort every shift, to monitor for side effects from medication, and that R448 required assist of one and gait belt with transfers. R448's Task List/Assignments dated 5/30/18, identified R448 as a falls risk, but did not include any interventions to ensure R448's safety. On 6/12/18, at 2:51 p.m. R448 was observed	F 689	observation. At the time that was identified the call light was put in place for the resident. The care plan and task list were reviewed and revised as needed to assure guidance was in place for NARs providing care. Regarding all other residents who may be affected by this practice an audit was completed to assure all call lights were in place. Their care plans and tasks lists were reviewed and revised as needed to assure guidance is in place for the NARs providing care. To assure sustainability further call light audits will continue daily for one week; weekly for two weeks, monthly for two months and then periodically after that to assure ongoing compliance. Immediate individual training will be completed in relation to the survey results. The results of these audits will be reviewed at the facilities quarterly QI committee meetings.	

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F 689	Continued From page 9 resting in recliner with feet reclined, blanket across lap, and no call light. Call light was noted to be across the room, attached to the bed rail, and was a button type call light, not a soft touch type as noted in the care plan. When interviewed on 6/12/18, at 2:55 p.m. nursing assistant (NA)-E verified R448 would use her call light to alert staff of her needs, and verified the call light was not within her reach. NA-E stated staff forgot to put the call light by her, and moved it from the bed rail to her lap. When interviewed on 6/12/18, at 3:10 p.m. the registered nurse (RN)-E stated, "I would expect all residents to have their call light within reach." When interviewed on 6/14/18, at 1:12 p.m. the director of nursing (DON) stated, "I would expect residents to have their call light." Review of the facility's Falls Policy, revised 5/11, directs staff with guidelines to follow after a fall occurs, however, it did not indicate any interventions or preventatives for falls in this policy.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		7/20/18

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F 880	Continued From page 10	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 11 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene including hand washing and proper use of gloves was implemented for 2 of 6 residents (R145, R105) observed for personal cares, and 1 of 1 residents (R33) observed for wound care. Findings include: R145's 14 day PPS Minimum Data Set (MDS), dated 5/17/18, indicated R145 was cognitively intact. R145 required extensive assist with bed mobility, transfers, personal hygiene, and dressing. R145 had an indwelling urinary catheter. During observations on 6/13/18, at 7:27 a.m. nursing assistant (NA)-A and nursing assistant (NA)-B entered R145's room to perform morning cares. NA-A washed her hands and donned (put	F 880	Good Shepherd does establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help to prevent the development and transmission of communicable diseases and infections. Regarding residents 145 and 105 the facility recognizes that during one observation for each resident staff did not wash their hands after removing soiled gloves. Good Shepherds expectations of staff is to follow best practice of infection control guidelines. Regarding resident number 33 the facility recognizes that during one observation a nurse did not change gloves in between removing a dressing and replacing it with a new one. Good Shepherds expectations of staff is to follow best practice of infection control guidelines. A	

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F 880	Continued From page 12 on) gloves, NA-B donned gloves. NA-B put R145's hearing aides in his ears. NA-B then applied compressions stocking to R145's legs. NA-B removed her gloves. NA-B did not wash her hands and donned new gloves. NA-B opened an alcohol wipe, cleaned the end of the drainage tube with the wipe, and emptied the urine from the catheter bag into a graduate (container). NA-B walked into the bathroom and emptied the graduate into the toilet. With the same gloved hands, NA-B turned on the sink faucet, put water in the graduate, swirled the water in the graduate, then emptied the water in the toilet. NA-B doffed (removed) her gloves, but did not wash her hands. NA-B then assisted NA-A with putting on R145's shirt and pants. NA-A and NA-B placed a lift sling under R145 and attached the sling loops to the lift. NA-A and NA-B transferred R145 into a wheelchair. During the transfer NA-B helped to guide R145 into the wheelchair. NA-B combed R145's hair, touching R145's hair with her hands while applying a hair binder. NA-B then made R145's bed and placed a pillow under R145's left arm. NA-B donned gloved and removed the trash from the trash container in the bathroom then doffed the gloves. NA-B did not wash her hands. NA-B left the room with the trash, walking down the hall to the dirty utility room, opened up the door, and disposed of the trash. NA-B then applied hand sanitizer and rubbed her hands together. During an interview on 6/13/18, at 7:54 a.m. NA-B stated hands are to be washed and gloves worn when dealing with bodily fluids. NA-B stated the gloves are then removed and hands are washed. When asked about not washing hands after emptying R145's urinary catheter NA-B state she did not but "I should have." NA-B went onto say	F 880	follow-up discussion was completed with the nurse identified in this deficiency at the time of survey – discussing best practices Regarding the above residents as well as all residents who may be affected by this practice. The facility believes that it trains the staff on proper hand washing and glove use through the infection control program. Because the facility recognizes this deficient practice for these two employees during the survey; audits will be conducted to gather data to assure staff understanding is correct on what they have been taught. Verbal audits of staff's understanding of handwashing and glove use are being conducted to determine the overall focus for ongoing training and audits. Staff responsible to this regulation will be re-educated to their responsibilities. Follow-up audits to assure staff understanding of this training will be completed daily for a week; weekly for two weeks and monthly for two months and periodically after that to assure ongoing compliance. The results of these audits will be reviewed at the facilities quarterly QI committee meetings.	

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F 880	Continued From page 13 she was nervous being watched. During an interview on 6/14/18, at 2:04 p.m., the DON stated staff are to wash hands and glove prior to starting to work with any body fluid. Once finished with the task of emptying the catheter bag, staff are to remove the gloves and wash hands. R105's quarterly Minimum Data Set (MDS), dated 5/8/18, identified R105 had dementia, moderate cognitive impairment, was occasionally incontinent of urine, and required extensive assistance with toileting. R105's care plan, dated 5/7/18, indicated R105 required assistance with some activities of daily living related to weakness and impaired cognition, such as bathing, dressing, hygiene, and toilet use. During an observation on 6/13/18, at 7:25 a.m. nursing assistant (NA)-D entered R105's room and announced she would be assisting R105 with morning cares. R105 was sitting on the toilet. NA-D asked R105 what she wanted to wear, donned gloves, and handed R105 a wet washcloth to wash her face. NA-D knelt on the floor in front of R105, removed her wet brief, tossed it into a clear plastic bag on the floor, and pulled R105's slacks, over her shoes, up to her ankles. NA-D handed R105 another wet washcloth, directed R105 to wash her upper body, and then gave her a towel to dry the areas. NA-D assisted R105 to stand, using a gait belt and the walker, and used a washcloth to clean R105's peri area. NA-D dried the peri area with a towel. Without removing the gloves, NA-D picked up a tube of ointment from the sink, squeezed ointment onto her gloved right hand, and applied	F 880		

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	245269	A. BUILDING ______ B. WING ______	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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F 880	Continued From page 14 the ointment to R105's buttocks. NA-D removed the gloves and tossed them into the plastic bag on the floor. Without performing hand hygiene, NA-D secured a clean brief, pulled up R105's slacks, and touched the handle on the bathroom door to open it. NA-D assisted R105 out of the bathroom, with one hand on the gait belt and the other on the walker, locked the brakes on the wheelchair, and assisted R105 to sit in the wheelchair. Still without performing hand hygiene, NA-D made R105's bed, touching the bed linens and straightening items on the bedside table. NA-D directed R105 to stand, and without performing hand hygiene, assisted R105 to ambulate with her walking and gait belt, through the hallway, to the dining room. NA-D assisted R105 to sit in a chair in the dining room, and walked back to R105's bathroom. NA-D donned gloves, picked up the two plastic bags on the floor containing dirty linens and garbage, tied the bags, flushed the toilet, and without removing the gloves, walked through the hallway to the soiled utility room. NA-D opened the door, touching the handle and the door, opened the bin to place a plastic bag in the soiled linen bin and opened another bin to place the plastic bag with garbage. NA-D removed her gloves, tossed them into the garbage bin, and washed her hands in the sink inside the soiled utility room. During an interview on 6/13/18, at 7:54 a.m. NA-D stated she always wears gloves when she performs cares and stated, "You should switch [gloves], but we can't let go of them [resident], even if you have a glove nearby." When asked about performing hand hygiene after removing gloves, NA-D stated, "It's definitely something I prefer to do, but I didn't do it this time. Having you guys here throws my routine."	F 880		

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

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F 880	Continued From page 15 During an interview on 6/14/18, at 1:22 p.m. director of nursing (DON) indicated staff were trained and expected to perform hand hygiene after removing gloves. R33's diagnosis list includes aphasia following cerebral infarct, hemiplegia following cerebral infarct and history of pressure ulcers. R33's progress note, dated 6/8/18, indicated R33 had an abrasion on left buttocks and is total dependence on staff for cares. During an observation on 6/14/18, at 10:45 a.m. licensed practical nurse (LPN)-A entered R33's room to change a buttocks wound dressing. LPN-A washed her hands and put on a pair of gloves and obtained a new dressing. LPN-A removed the feces soiled dressing off R33's buttocks, discarded the soiled dressing in the trash, without removing her gloves and performing hand hygiene, applied the new dressing to the wound. During an interview on 6/14/18, at 10:53 a.m. LPN-A stated should have removed the old dressing that was soiled with feces on the bottom of the dressing and she should have changed gloves before putting clean dressing on the wound. LPN-A stated she changes dressings on a daily bases, so general practice would be to remove old dressing, removed gloves, wash hands and puts on new gloves before applying a new dressings. During an interview on 6/14/18, at 11:31 a.m. RN-F stated standard practice for a dressing change would be to wash hands, apply gloves, remove dressings, assess for signs and	F 880		

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F 880	Continued From page 16 symptoms of infection, take gloves off, wash hands and apply new gloves before putting on a clean dressing. RN-A stated she expects nurses to follow the policy and stated nurses have completed competency's, have on line training, staff development, and training in nursing school related to hand hygiene with dressing change. Review of the facility's policy, Hand Hygiene Protocol, dated 4/18, included, "When it is necessary to wear gloves for personal cares, staff shall utilize gloves during those cares and wash their hands after removing the gloves." Also included, "Gloves shall be removed, when gloves become contaminated, hands washed and clean gloves donned before returning to tasks."	F 880		

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

F5269026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**06/15/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Shepherd Lutheran Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as one building: Good Shepherd Home is a 2-story building with a partial basement. The building was constructed at 6 different times: The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1969, an addition was added to the east that was determined to be of Type II (111) construction. In 1980, an addition was added to the northwest that was determined to be Type V (111). In 1997, an addition was added to the west that was determined to be of Type V (111) construction. In 2002, an addition was added to the Main Dining Room that was determined to be of Type V (111) construction. In 2010 a two story addition was added that was determined to be of Type II (111) construction located on the southwest corner of the facility. In 2010 a two story addition was added that was determined to be of Type II (111) construction located on the northeast corner of the facility. In 2010 a one story addition was added that was	K 000		

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

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

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K 000	Continued From page 1 determined to be of Type V (111) construction located north of the chapel. The building is fully sprinkler protected and the sprinkler system is installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (1999 edition) The facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The facility has a capacity of 162 beds and had a census of 158 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically delivered
June 28, 2018

Mr. Bruce Glanzer, Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

Re: State Nursing Home Licensing Orders - Project Number S5269025

Dear Mr. Glanzer:

The above facility was surveyed on June 11, 2018 through June 14, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathleen Lucas, Unit Supervisor at (320) 223-7343 or kathleen.lucas@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00023	A. BUILDING: ____ B. WING ____	06/14/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/11/18 -4/14/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a discharge summary in preparation of a resident discharge for 1 of 1 residents (R149) discharged from the facility to another care facility. Findings include: R149's Care Area Assessment (CAA) dated 3/21/18, indicated a risk for falls related to impaired mobility and narcotic analgesics with a fall prior to admission that resulted in a left humeral head (shoulder) fracture and multiple rib fractures. The CAA further indicated risk for pain related to impaired mobility and previous fracture	2 690	Good Shepherd does have a process in place to complete discharge summery on anticipation of discharge. Regarding resident number 149 the facility recognizes the discharge summary form was not completed when the resident transferred to another facility. Documentation of the discharge process and summary of information exchanged with the receiving facility was documented in the electronic chart. Regarding any other residents who have active discharge plans, an audit of their records was completed to assure that the facilities process is being carried out as	7/20/18

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2 690	Continued From page 3 to left humerus and risk for decreased mood related to current health condition and that R149 was independent and living in assisted living facility prior to fall. R149's admission Minimum Data Set (MDS) dated 3/16/18, indicated R149 was moderately cognitively impaired, required total assistance for transfers/toilet use/and personal hygiene. The MDS further indicated that R149 had frequent pain that he verbalized as severe, he was on oxygen and dialysis. R149 participated in assessment and resident's overall goal was to discharge back to the community according to family or significant other. R149's care plan dated 3/9/18, indicated a diagnosis of renal failure with dialysis, diabetic, pneumonia with shortness of breath, and pain from fractures. R149's care plan also addressed behavior of yelling out, refusing cares and potential for other behavioral indicators. Care plan indicated R149 required a mechanical Hoyer lift for transfers with two staff assist, along with bed mobility, toileting and bathing. R149's doctor discharge orders, dated 4/13/18, indicated 1) decrease oxycodone 5 mg to 2.5 mg by mouth three times a day and 2.5 mg by mouth as needed every two hours use sparingly try to use Tylenol instead per nephrology 2) to send copy of discharge summary with patient when it arrives and 3) make arrangement for follow up visit with his local provider in 1-2 weeks. The discharge order was stamped that it was faxed to the pharmacy on 4/13/18 with no indication this was shared with receiving facility. An additional discharge order was given on 4/13/18 that indicated R149 was discharging to a new facility on 4/17/18 and indicated the new facility	2 690	appropriate. Changes were made as necessary. The facility believes it has a process in place to manage effective discharge planning. To assure all components of the process are completed thoroughly, the facility has chosen to enhance its process to be more streamlined and consistent for all discharges regardless of where the resident is discharging to. The facility also has chosen to enhance the current discharge form to assure increased ease in finding the information gathered and provided to the accepting facility of discharge to. Training regarding the enhancement of this process and form will be completed for all individuals responsible for compliance to this regulation. To assure sustainability of this process change, routine audits of those residents who discharge to home or another facility will be completed daily for 1 week; weekly for two weeks, and then monthly for two months and periodically after that to assure ongoing compliance.	

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2 690	Continued From page 4	2 690		

Continued From page 4

requested signed and dated copy of current medication list and treatments which were attached. R149's record indicated the receiving facility was faxed current medication, treatment, signed admission form, signed history and physical however, the record lacked a recapitulation of the R149's stay, including diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results or a post discharge plan of care.

R149's progress note, dated 4/11/18, indicated the social worker provided referral information to the new facility's intake coordinator for review. R149's progress note dated 4/17/18, indicated R149 left via care cab, paperwork sent with, note did not indicate what was sent and a blank recapitulation summary form was located in R149's record.

During an interview on 6/14/18, at 1:52 p.m. the director of social service (SS)-A reviewed the blank recapitulation summary form for R149 that was found in the discharge record and when asked how they summarized and recapped R149's stay, SS-A stated "That's what we usually fill out" in reference to the blank recapitulation form.

During an interview on 6/14/18, at 2:24 p.m. case manager (CM)-A indicated the discharge summary is a combined effort between social services and the case manager to collect information to be given to the receiving facility. CM-A further indicated the information they would send would be nursing needs, oxygen, diabetic needs, medication, or therapy information. CM-A further indicate it would be standard regardless if the resident goes home or to another facility and

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2 690	Continued From page 5 this is always given on discharge. During interview on 6/14/18, at 2:30 p.m. health information manager indicated the discharge summaries are located in the hard chart and the case manager takes care of forwarding the information to the receiving facility. A facility policy on discharge and recapitulation summaries was requested but not supplied. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise any applicable policies and procedures related to completion of the discharge summary. The DON or designee could educate the staff responsible for completion of the discharge summary and could audit to ensure ongoing compliance and report the audit results to the quality improvement group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 690		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830		7/20/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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2 830	Continued From page 6 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with the removal of facial hair and assist with hearing aide placement for 1 of 1 resident (R105) who was dependent upon staff for assistance with activities of daily living (ADLs). In addition, the facility failed to ensure placement of a call light, used as a planned fall intervention per the care plan, was appropriately placed for 1 of 1 resident (R448), reviewed for accidents. Findings include: R105's quarterly Minimum Data Set (MDS), dated 5/8/18, identified R105 had dementia, moderate cognitive impairment, required limited assistance with dressing and extensive assistance with personal hygiene. The MDS included, that R105 had adequate ability to hear with no difficulty in normal conversation, social interaction, however, identified that R105 used hearing aids. R105's admission Minimum Data Set (MDS), dated 11/28/17, identified it was "very important" to R105 to choose what clothes to wear. R105's Care Area Assessment (CAA), printed 6/14/18, included hearing or vision impairment may have an impact on ability to process information, and physical limitations resulted in need for assistance with ADLs.	2 830	Good Shepherd does assure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Regarding resident number 105 the facility recognizes that during time of the survey that one resident was noted to have facial hair and their hearing aids were not placed timely before cares were provided. The hearing aids were placed in resident's ears at the end of cares on the day they were noted to be without them. The facial hair had also been removed at the time when they were identified. Resident 105's care plan and task list were reviewed and revised as necessary to assure clear guidance is in place for NARs providing cares. Regarding any other residents who have a possibility of being affected by this, their care plans have also been reviewed and revised as necessary to assure clear guidance is in place for NARs providing cares. The facility believes it has a process of training staff to monitor for unwanted facial hair, hearing aid placement and other ADL and grooming needs. To assure ADL's are provided as per expectation of the facility a checkoff form will be implemented with a listing of basic AM and	

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2 830	Continued From page 7 R105's care plan, dated 5/7/18, indicated R105 required assistance with some activities of daily living related to weakness and impaired cognition, such as bathing, dressing, hygiene, and toilet use. R105's Task List/Assignments, printed on 6/14/18, indicated R105 required assistance of one staff for hygiene and dressing, and wore bilateral hearing aids. During an observation and interview on 6/11/18, at 7:15 p.m. R105 had several 1/4-1/2 inch long white hairs on each side of her mouth. R105 stated, "I don't like the hairs, but I don't have a scissors." R105 stated the staff had cut them once but hadn't offered to remove them in a long time. During an observation on 6/13/18, at 7:25 a.m. nursing assistant (NA)-D entered R105's room and announced she would be assisting R105 with morning cares. R105 was sitting on the toilet. Several 1/4-1/2 inch long white hairs remained on each side of R105's mouth. NA-D asked R105 what she wanted to wear. R105 did not respond. NA-D again offered choices of clothing. R105 shrugged her shoulders. NA-D took a pair of slacks and a blouse out of the closet and brought them into the bathroom. NA-D donned gloves and handed R105 a wet washcloth and directed her to wash her face. R105 used the washcloth to wipe her face and neck. NA-D knelt on the floor in front of R105 and explained what she was doing as she removed R105's wet brief. R105 pointed to her ears and stated, "What? I can't hear you." NA-D stated, "I know, I don't want to put them in [pointing to the hearing aids on the bathroom counter] until we're done." NA-D handed R105 another wet washcloth, and motioned to R105 to	2 830	PM cares highlighting “checking and removal of facial hair” as well as “devices.” This form will be signed off by the person completing the cares on the AM and PM shifts indicating that the listed tasks were completed. They will be reviewed by the Team Leader for that shift prior to the staff member leaving. In addition to the form; staff will be educated on the importance of the order in which cares are provided to assure needed appliances/devices are in place timely to be most beneficial to the resident. To assure sustainability of this process change, routine audits of the cares check off forms will be completed daily for 1 week; weekly for two weeks, and then monthly for two months and periodically after that to assure ongoing compliance. The results of these audits will be reviewed at the facilities quarterly QI committee meetings.	

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2 830	Continued From page 8	2 830		

wash her upper body, and then gave her a towel to dry the areas. NA-D continued to talk and ask questions and R105 stated, "I don't know what you're saying." NA-D laughed and stated, "We have to get those hearing aids in, huh?" R105 shrugged her shoulders and shook her head. NA-D brushed R105's top denture and handed it to R105, instructing her to put it in her mouth. R105 stated, "What? I can't hear you." NA-D motioned to R105 to put her denture in, and stated, "That's cause we gotta get those hearing aids in, don't we?" R105 put in her top denture and sat quietly. NA-D brushed R105's hair, still talking to R105, while R105 sat quietly, not responding. NA-D then placed R105's hearing aids in her ears. NA-D cleaned R105's glasses and handed them to R105, assisted her to stand, and performed peri care. NA-D assisted R105 to dress and then assisted her to ambulate out of the bathroom to her wheelchair, and then to the dining room for breakfast. NA-D did not offer to remove R105's facial hair.

When interviewed on 6/13/18, at 8:07 a.m. NA-D stated she didn't place R105's hearing aids prior to interacting with her and providing personal cares, and stated, "I didn't want to put them in until I was done with her face and hair. I didn't want to bump them." When asked about R105's facial hair, NA-D stated, "That's typically done on bath day. [R105] gets two baths a week. We don't have time to stop and do that."

During an interview on 6/14/18, at 1:22 p.m. the director of nursing (DON) indicated facial hair should be removed when it is noticed. When asked about hearing aids, DON stated, "We do this all the time. I expect it to be taken care of."

A policy was requested on 6/14/18, at 2:22 p.m.

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2 830	Continued From page 9	2 830		

registered nurse (RN)-G stated, "Those things are standards of practice and we don't have policies for those."

R448's Record of Admission indicated an admission date of 5/30/18.

R448's face sheet printed on 6/14/18 identified current diagnoses of dementia, Alzheimer's disease, and history of falling.

R448's Care Area Assessment (CAA) dated 6/11/18, identified R448 had risk for falls including impaired balance, mobility, incontinence, cognitive impairment, depression and polypharmacy.

R448's admission Minimal Data Set (MDS), printed on 6/14/18, identified the following indicators of fall risk; impaired balance during transitions, fatigue, weakness, decline in functional status, incontinence, wandering, cognitive impairment, Alzheimer's disease, cardiovascular medications, antidepressants, antipsychotics and neuroleptics.

R448's care plan, dated 5/30/18, indicated R448 was at risk for falls related to impaired cognition, difficulty with mobility, and dementia. Interventions included encouraging the resident to ask for help and directed staff to have the call light close by. Other interventions included R448 needed a soft touch type of call light, and directed staff to keep frequently used items close by, to assess for pain or discomfort every shift, to monitor for side effects from medication, and that R448 required assist of one and gait belt with transfers.

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2 830	Continued From page 10 R448's Task List/Assignments dated 5/30/18, identified R448 as a falls risk, but did not include any interventions to ensure R448's safety. On 6/12/18, at 2:51 p.m. R448 was observed resting in recliner with feet reclined, blanket across lap, and no call light. Call light was noted to be across the room, attached to the bed rail, and was a button type call light, not a soft touch type as noted in the care plan. When interviewed on 6/12/18, at 2:55 p.m. nursing assistant (NA)-E verified R448 would use her call light to alert staff of her needs, and verified the call light was not within her reach. NA-E stated staff forgot to put the call light by her, and moved it from the bed rail to her lap. When interviewed on 6/12/18, at 3:10 p.m. the registered nurse (RN)-E stated, "I would expect all residents to have their call light within reach." When interviewed on 6/14/18, at 1:12 p.m. the director of nursing (DON) stated, "I would expect residents to have their call light." Review of the facility's Falls Policy, revised 5/11, directs staff with guidelines to follow after a fall occurs, however, it did not indicate any interventions or preventatives for falls in this policy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise any applicable policies and procedures related to assistance with activities of daily living as well as safety and supervision in relation to call light placement and educate all	2 830		

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2 830	Continued From page 11 staff. The DON or designee could audit to ensure ongoing compliance and report the audit results to the quality improvement group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene including hand washing and proper use of gloves was implemented for 2 of 6 residents (R145, R105) observed for personal cares, and 1 of 1 residents (R33) observed for wound care. Findings include: R145's 14 day PPS Minimum Data Set (MDS), dated 5/17/18, indicated R145 was cognitively intact. R145 required extensive assist with bed mobility, transfers, personal hygiene, and dressing. R145 had an indwelling urinary catheter. During observations on 6/13/18, at 7:27 a.m. nursing assistant (NA)-A and nursing assistant	21385	Good Shepherd does establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help to prevent the development and transmission of communicable diseases and infections. Regarding residents 145 and 105 the facility recognizes that during one observation for each resident staff did not wash their hands after removing soiled gloves. Good Shepherds expectations of staff is to follow best practice of infection control guidelines. Regarding resident number 33 the facility recognizes that during one observation a nurse did not change gloves in between removing a dressing and replacing it with a new one. Good Shepherds expectations	7/20/18

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21385	Continued From page 12 (NA)-B entered R145's room to perform morning cares. NA-A washed her hands and donned (put on) gloves, NA-B donned gloves. NA-B put R145's hearing aides in his ears. NA-B then applied compressions stocking to R145's legs. NA-B removed her gloves. NA-B did not wash her hands and donned new gloves. NA-B opened an alcohol wipe, cleaned the end of the drainage tube with the wipe, and emptied the urine from the catheter bag into a graduate (container). NA-B walked into the bathroom and emptied the graduate into the toilet. With the same gloved hands, NA-B turned on the sink faucet, put water in the graduate, swirled the water in the graduate, then emptied the water in the toilet. NA-B doffed (removed) her gloves, but did not wash her hands. NA-B then assisted NA-A with putting on R145's shirt and pants. NA-A and NA-B placed a lift sling under R145 and attached the sling loops to the lift. NA-A and NA-B transferred R145 into a wheelchair. During the transfer NA-B helped to guide R145 into the wheelchair. NA-B combed R145's hair, touching R145's hair with her hands while applying a hair binder. NA-B then made R145's bed and placed a pillow under R145's left arm. NA-B donned gloved and removed the trash from the trash container in the bathroom then doffed the gloves. NA-B did not wash her hands. NA-B left the room with the trash, walking down the hall to the dirty utility room, opened up the door, and disposed of the trash. NA-B then applied hand sanitizer and rubbed her hands together. During an interview on 6/13/18, at 7:54 a.m. NA-B stated hands are to be washed and gloves worn when dealing with bodily fluids. NA-B stated the gloves are then removed and hands are washed. When asked about not washing hands after emptying R145's urinary catheter NA-B state she	21385	of staff is to follow best practice of infection control guidelines. A follow-up discussion was completed with the nurse identified in this deficiency at the time of survey – discussing best practices Regarding the above residents as well as all residents who may be affected by this practice. The facility believes that it trains the staff on proper hand washing and glove use through the infection control program. Because the facility recognizes this deficient practice for these two employees during the survey; audits will be conducted to gather data to assure staff understanding is correct on what they have been taught. Verbal audits of staff's understanding of handwashing and glove use are being conducted to determine the overall focus for ongoing training and audits. Staff responsible to this regulation will be re-educated to their responsibilities. Follow-up audits to assure staff understanding of this training will be completed daily for a week; weekly for two weeks and monthly for two months and periodically after that to assure ongoing compliance. The results of these audits will be reviewed at the facilities quarterly QI committee meetings.	

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21385	Continued From page 13	21385		

did not but "I should have." NA-B went onto say she was nervous being watched.

During an interview on 6/14/18, at 2:04 p.m., the DON stated staff are to wash hands and glove prior to starting to work with any body fluid. Once finished with the task of emptying the catheter bag, staff are to remove the gloves and wash hands.

R105's quarterly Minimum Data Set (MDS), dated 5/8/18, identified R105 had dementia, moderate cognitive impairment, was occasionally incontinent of urine, and required extensive assistance with toileting.

R105's care plan, dated 5/7/18, indicated R105 required assistance with some activities of daily living related to weakness and impaired cognition, such as bathing, dressing, hygiene, and toilet use.

During an observation on 6/13/18, at 7:25 a.m. nursing assistant (NA)-D entered R105's room and announced she would be assisting R105 with morning cares. R105 was sitting on the toilet. NA-D asked R105 what she wanted to wear, donned gloves, and handed R105 a wet washcloth to wash her face. NA-D knelt on the floor in front of R105, removed her wet brief, tossed it into a clear plastic bag on the floor, and pulled R105's slacks, over her shoes, up to her ankles. NA-D handed R105 another wet washcloth, directed R105 to wash her upper body, and then gave her a towel to dry the areas. NA-D assisted R105 to stand, using a gait belt and the walker, and used a washcloth to clean R105's peri area. NA-D dried the peri area with a towel. Without removing the gloves, NA-D picked up a tube of ointment from the sink, squeezed

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21385	Continued From page 14 ointment onto her gloved right hand, and applied the ointment to R105's buttocks. NA-D removed the gloves and tossed them into the plastic bag on the floor. Without performing hand hygiene, NA-D secured a clean brief, pulled up R105's slacks, and touched the handle on the bathroom door to open it. NA-D assisted R105 out of the bathroom, with one hand on the gait belt and the other on the walker, locked the brakes on the wheelchair, and assisted R105 to sit in the wheelchair. Still without performing hand hygiene, NA-D made R105's bed, touching the bed linens and straightening items on the bedside table. NA-D directed R105 to stand, and without performing hand hygiene, assisted R105 to ambulate with her walking and gait belt, through the hallway, to the dining room. NA-D assisted R105 to sit in a chair in the dining room, and walked back to R105's bathroom. NA-D donned gloves, picked up the two plastic bags on the floor containing dirty linens and garbage, tied the bags, flushed the toilet, and without removing the gloves, walked through the hallway to the soiled utility room. NA-D opened the door, touching the handle and the door, opened the bin to place a plastic bag in the soiled linen bin and opened another bin to place the plastic bag with garbage. NA-D removed her gloves, tossed them into the garbage bin, and washed her hands in the sink inside the soiled utility room. During an interview on 6/13/18, at 7:54 a.m. NA-D stated she always wears gloves when she performs cares and stated, "You should switch [gloves], but we can't let go of them [resident], even if you have a glove nearby." When asked about performing hand hygiene after removing gloves, NA-D stated, "It's definitely something I prefer to do, but I didn't do it this time. Having you guys here throws my routine."	21385		

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21385	Continued From page 15 During an interview on 6/14/18, at 1:22 p.m. director of nursing (DON) indicated staff were trained and expected to perform hand hygiene after removing gloves. R33's diagnosis list includes aphasia following cerebral infarct, hemiplegia following cerebral infarct and history of pressure ulcers. R33's progress note, dated 6/8/18, indicated R33 had an abrasion on left buttocks and is total dependence on staff for cares. During an observation on 6/14/18, at 10:45 a.m. licensed practical nurse (LPN)-A entered R33's room to change a buttocks wound dressing. LPN-A washed her hands and put on a pair of gloves and obtained a new dressing. LPN-A removed the feces soiled dressing off R33's buttocks, discarded the soiled dressing in the trash, without removing her gloves and performing hand hygiene, applied the new dressing to the wound. During an interview on 6/14/18, at 10:53 a.m. LPN-A stated should have removed the old dressing that was soiled with feces on the bottom of the dressing and she should have changed gloves before putting clean dressing on the wound. LPN-A stated she changes dressings on a daily bases, so general practice would be to remove old dressing, removed gloves, wash hands and puts on new gloves before applying a new dressings. During an interview on 6/14/18, at 11:31 a.m. RN-F stated standard practice for a dressing change would be to wash hands, apply gloves, remove dressings, assess for signs and	21385		

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21385	Continued From page 16	21385		

symptoms of infection, take gloves off, wash hands and apply new gloves before putting on a clean dressing. RN-A stated she expects nurses to follow the policy and stated nurses have completed competency's, have on line training, staff development, and training in nursing school related to hand hygiene with dressing change.

Review of the facility's policy, Hand Hygiene Protocol, dated 4/18, included, "When it is necessary to wear gloves for personal cares, staff shall utilize gloves during those cares and wash their hands after removing the gloves." Also included, "Gloves shall be removed, when gloves become contaminated, hands washed and clean gloves donned before returning to tasks."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review training provided and educate staff on hand hygiene and glove use related to personal care and glove use. The director of nursing (DON) or designee could develop auditing systems to ensure ongoing compliance with infection control policies and procedures and report those results to the quality improvement group.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.