#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	CARE/MEDICAID CERTIFICATION A		ID: G599 Facility ID: 00023
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245269     2.STATE VENDOR OR MEDICAID NO.     (L2) 686240300     5. EFFECTIVE DATE CHANGE OF OWNERSHIP	<ul> <li>3. NAME AND ADDRESS OF FACILITY</li> <li>(L3) GOOD SHEPHERD LUTHERAN HO</li> <li>(L4) 1115 4TH AVENUE NORTH</li> <li>(L5) SAUK RAPIDS, MN</li> <li>7. PROVIDER/SUPPLIER CATEGORY</li> </ul>	ME (L6) 56379 <u>02</u> (L7)	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
(L9)	7. PROVIDER/SUPPLIER CATEGORY       01 Hospital       05 HHA       09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY     07/30/2018     (L34)       8. ACCREDITATION STATUS:     (L10)       0 Unaccredited     1 TJC       2 AOA     3 Other	02 SNF/NF/Dual     06 PRTF     10 NF       03 SNF/NF/Distinct     07 X-Ray     11 ICF/IID       04 SNF     08 OPT/SP     12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds         162	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF)	<ul> <li>6. Scope of Services Limit</li> <li>7. Medical Director</li> <li>8. Patient Room Size</li> </ul>
13.Total Certified Beds 162 (L17)	<ul> <li>B. Not in Compliance with Program Requirements and/or Applied Waivers:</li> </ul>	5. Life Safety Code * Code: A	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 162 (L37) (L38) (L39)	ICF IID (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICAE	LE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY A	PPROVAL Date:
Kathy Lucas, Unit Supervisor	08/08/2018 (L19)	Douglas Larson, Enfo	orcement Specialist 08/08/2018 (L20)
PART II - TO E	E COMPLETED BY HCFA REGIONAL	L OFFICE OR SINGLE STA	ATE AGENCY
<ul> <li>19. DETERMINATION OF ELIGIBILITY</li> <li><u>X</u> 1. Facility is Eligible to Participate</li> <li><u>2</u>. Facility is not Eligible</li> <li>(L21)</li> </ul>	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ol> <li>Statement of Finan</li> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNIN 07/01/1984 (L24) (L41)	G DATE ENDING DATE (L25)	VOLUNTARY         00           01-Merger, Closure         02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
A. Suspens	IVE SANCTIONS on of Admissions: (L44) uspension Date:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>03001</b> (L31)		
31. RO RECEIPT OF CMS-1539	2. DETERMINATION OF APPROVAL DATE 08/06/2018		
(L32)	(L33)	DETERMINATION APPRO	OVAL



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,

Duras Sfapson-

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Duries Stapeon

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Downes Stapson

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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#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

HUMAN SERVICES	CENTERSTOR
MEDICARE/MEDICAID CERTIFICATION AND	TRANSMITTAL
PADT I TO BE COMPLETED BV THE STATE S	HDVEV ACENCV

ID: G599

	PART I	- TO BE COMP	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00023
1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245269</b>		3. NAME AND AI (L3) GOOD SHE			ме	4. TYPE OF ACTION: <u>2</u> (L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 1115 4TH A	VENUE NORTH	I		1. Initial     2. Recertification       3. Termination     4. CHOW
(L2) <b>686240300</b>		(L5) SAUK RAPI	IDS, MN		(L6) <b>56379</b>	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERS	SHIP	7. PROVIDER/SU	JPPLIER CATEGOR	RY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 06/14/2018	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	:		
From (a):		A. In Complia				he Following Requirements:
To (b):			Requirements ace Based On:		2. Technical Personnel	6. Scope of Services Limit
					3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	62 (L18)	1	Acceptable POC		4. 7-Day RN (Rural SN)	
13.Total Certified Beds 1	6 <b>2</b> (L17)	X B. Not in Co	mpliance with Progr	am	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied Wai	vers:	* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF 162	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS (I	F APPLICABL	E SHOW LTC CANC	ELLATION DATE)	:		
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY	APPROVAL Date:
Carlene Lange, HFE NE			07/12/2018	(L19)	Douglas Larson, Enfo	prcement Specialist 08/06/2018 (L20)
PART	ÎII - TO BI	E COMPLETED	BY HCFA RE	GIONAI	OFFICE OR SINGLE ST	CATE AGENCY
19. DETERMINATION OF ELIGIBILITY			MPLIANCE WITH ( GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to Participa	ate				3. Both of the Above	
2. Facility is not Eligible	(L21)					
	(121)					
22. ORIGINAL DATE 23.	LTC AGREEN	IENT 2	24. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 0	0 INVOLUNTARY
07/01/1984					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursem	nent 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind Sus	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
(1	L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL DA	ATE		
a	.32)			(L33)	DETERMINATION APPE	ROVAL



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:

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

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

<u>Remedies</u> - 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;

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

## <u>Informal Dispute Resolution</u> - 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

Good Shepherd Lutheran Home June 28, 2018 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Good Shepherd Lutheran Home June 28, 2018 Page 6

#### Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Daveres Stapson

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

DEPAR1	MENT OF HEALTH	AND HUMAN SERVICES			F		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				E SURVEY IPLETED
		245269	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	)00			
F 000	Emergency Prepare conducted on June during a recertificat		FC	000			
	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483	h June 14, 2018, a standard ted at your facility by the nent of Health to determine if compliance with requirements 5, Subpart B, and ong Term Care Facilities.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 661 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Discharge Summar		F 6	\$61			7/20/18
	must have a discha but is not limited to, (i) A recapitulation of includes, but is not	nticipates discharge, a resident irge summary that includes, the following: of the resident's stay that limited to, diagnoses, course					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE
Electron	ically Signed						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.

PRINTED: 07/12/2018

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	COMPLETED	
		245269	B. WING			14/2018	
NAME OF F				STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 661	radiology, and cons (ii) A final summary include items in part the time of the disc release to authorize the consent of the part representative. (iii) Reconciliation of medications with the medications (both pover-the-counter). (iv) A post-discharg developed with the and, with the reside representative(s), v adjust to his or her	or therapy, and pertinent lab, sultation results. of the resident's status to ragraph (b)(1) of §483.20, at harge that is available for ed persons and agencies, with resident or resident's of all pre-discharge he resident's post-discharge	F 66	51			
post-disch the individ that have care and non-medi This REQ by: Based or facility fail	that have been mad care and any post- non-medical servic This REQUIREMEN by: Based on interview facility failed to com	NT is not met as evidenced v and document review, the nplete a discharge summary in		Good Shepherd does have a p place to complete discharge su			
		sident discharge for 1 of 1 scharged from the facility to /.		anticipation of discharge. Regarding resident number 14 recognizes the discharge summer was not completed when the re- transferred to another facility. Documentation of the discharg	nary form sident		
	3/21/18, indicated a impaired mobility a fall prior to admissi humeral head (sho fractures. The CAA	Assessment (CAA) dated a risk for falls related to nd narcotic analgesics with a on that resulted in a left ulder) fracture and multiple rib further indicated risk for pain mobility and previous fracture		and summary of information ex- with the receiving facility was d in the electronic chart. Regarding any other residents active discharge plans, an aud records was completed to assu facilities process is being carrie	changed ocumented who have t of their ire that the		

Facility ID: 00023

If continuation sheet Page 2 of 17

							0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245269	B. WING			06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			15 4TH AVENUE NORTH AUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 661		age 2 d risk for decreased mood	F 66		appropriate. Changes were made	26	
	related to current h was independent a facility prior to fall. R149's admission dated 3/16/18, indi- cognitively impaired transfers/toilet use. MDS further indica pain that he verbal oxygen and dialysis assessment and re- discharge back to a family or significan R149's care plan d diagnosis of renal a pneumonia with sh from fractures. R14 behavior of yelling potential for other h plan indicated R14 lift for transfers with bed mobility, toileti R149's doctor disc indicated 1) decrea by mouth three tim as needed every tw use Tylenol instead copy of discharge s arrives and 3) mak visit with his local p	Minimum Data Set (MDS) cated R149 was moderately d, required total assistance for /and personal hygiene. The ted that R149 had frequent ized as severe, he was on s. R149 participated in esident's overall goal was to the community according to t other. lated 3/9/18, indicated a failure with dialysis, diabetic, ortness of breath, and pain 49's care plan also addressed out, refusing cares and behavioral indicators. Care 9 required a mechanical Hoyer h two staff assist, along with			necessary. The facility believes it has a proce place to manage effective dischar planning. To assure all componer process are completed thoroughly facility has chosen to enhance its to be more streamlined and consis all discharges regardless of where resident is discharging to. The fac has chosen to enhance the current discharge form to assure increase in finding the information gathered provided to the accepting facility of discharge to. Training regarding the enhancement this process and form will be compliance to this regulation. To assure sustainability of this pro- change, routine audits of those resident will be completed daily for 1 week for two weeks, and then monthly fi months and periodically after that assure ongoing compliance. The results of these audits will be reviewed at the facilities quarterly committee meetings.	ss in ge the of the process stent for the cility also the case l and f ent of oleted cess sidents r facility ; weekly or two to	

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		AND HUMAN SERVICES				FORM	07/12/2018 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245269	B. WING	;		06/ <sup>.</sup>	14/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 661	on 4/17/18 and indi requested signed a medication list and attached. R149's re facility was faxed co signed admission fo physical however, t recapitulation of the diagnoses, course therapy, and pertine consultation results results or a post dis R149's progress not the social worker puthe new facility's int R149's progress not the social worker puthe new facility's int R149's progress not R149 left via care of did not indicate what recapitulation summer R149's record. During an interview director of social set blank recapitulation was found in the dis asked how they sur R149's stay, SS-As fill out" in reference form. During an interview manager (CM)-A in summary is a comb services and the ca information to be gi CM-A further indicates send would be nurse	cated the new facility nd dated copy of current treatments which were ecord indicated the receiving urrent medication, treatment, orm, signed history and	F	661			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY PLETED
			A. BUILDI	NG		
		245269	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH		
GOOD S	HEPHERD LUTHERA	N HOME		SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 661	further indicate it we the resident goes h this is always given During interview on information manage summaries are loca case manager take information to the re	ould be standard regardless if ome or to another facility and on discharge. 6/14/18, at 2:30 p.m. health er indicated the discharge ated in the hard chart and the s care of forwarding the ecciving facility.	F 6	61		
	summaries was rec ADL Care Provided CFR(s): 483.24(a)(2 §483.24(a)(2) A res	lischarge and recapitulation quested but not supplied. for Dependent Residents 2) sident who is unable to carry y living receives the necessary	F 6	77		7/20/18
	services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility fa with the removal of hearing aide placer	n good nutrition, grooming, and ygiene; NT is not met as evidenced tion, interview and document ailed to provide assistance facial hair and assist with nent for 1 of 1 resident (R105) t upon staff for assistance with		Good Shepherd does assure that resident who is unable to carry ou activities of daily living receives the necessary services to maintain go nutrition, grooming and personal a hygiene. Regarding resident number 105 the recognizes that during time of the that one resident was noted to ha	t e ood and oral ne facility survey	
	5/8/18, identified R cognitive impairmen with dressing and e personal hygiene. T had adequate ability	nimum Data Set (MDS), dated 105 had dementia, moderate nt, required limited assistance extensive assistance with The MDS included, that R105 y to hear with no difficulty in n, social interaction, however, used hearing aids.		hair and their hearing aids were n placed timely before cares were p The hearing aids were placed in resident⊡s ears at the end of care day they were noted to be without The facial hair had also been rem the time when they were identified Resident 105⊡s care plan and tas	ot rovided. es on the them. oved at l.	

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		I AND HUMAN SERVICES & MEDICAID SERVICES				APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245269	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 677	Continued From pa	age 5	F 67	7		
	dated 11/28/17, ide to R105 to choose R105's Care Area A 6/14/18, included h may have an impact information, and ph need for assistance R105's care plan, or required assistance living related to we such as bathing, dr use. R105's Task List/As 6/14/18, indicated F one staff for hygien bilateral hearing aid During an observat at 7:15 p.m. R105 f white hairs on each stated, "I don't like scissors." R105 sta once but hadn't offe time. During an observat nursing assistant (I and announced sho morning cares. R10 Several 1/4-1/2 inc each side of R105's what she wanted to NA-D again offered	dated 5/7/18, indicated R105 e with some activities of daily akness and impaired cognition, ressing, hygiene, and toilet ssignments, printed on R105 required assistance of he and dressing, and wore		were reviewed and revised as n to assure clear guidance is in p NARs providing cares. Regarding any other residents of possibility of being affected by t care plans have also been revie revised as necessary to assure guidance is in place for NARs p cares. The facility believes it has a pro- training staff to monitor for unwa facial hair, hearing aid placeme other ADL and grooming needs assure ADL and grooming needs assure ADL and grooming needs assure ADL and grooming needs assure ADL s are provided as expectation of the facility a chee will be implemented with a listin AM and PM cares highlighting of and removal of facial hair as we devices. This form will be signed the person completing the cares AM and PM shifts indicating that tasks were completed. They wi reviewed by the Team Leader for prior to the staff member leavin addition to the form; staff will be on the importance of the order if cares are provided to assure ne appliances/devices are in place be most beneficial to the reside To assure sustainability of this p change, routine audits of the ca- off forms will be completed daily week; weekly for two weeks, an monthly for two months and per after that to assure ongoing cor The results of these audits will I reviewed at the facilities quarter committee meetings.	ace for who have a his, their wed and clear roviding cess of anted ht and To per skoff form g of basic hecking II as d off by s on the t the listed II be or that shift g. In educated n which eded timely to nt. vrocess res check r for 1 d then iodically npliance. pe	

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TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´	PLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		245269				14 4 100 4 9
NAME OF		140200		STREET ADDRESS, CITY, STATE, ZIP CODE		6/14/2018
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHU CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 677	slacks and a blous them into the bathr handed R105 a we wash her face. R10 her face and neck. of R105 and explais she removed R105 her ears and stated NA-D stated, "I kno [pointing to the hea counter] until we're another wet washc wash her upper bo to dry the areas. N. questions and R10 you're saying." NA- have to get those h shrugged her shou NA-D brushed R10 to R105, instructing R105 stated, "Wha motioned to R105 f stated, "That's cau aids in, don't we?" and sat quietly. NA talking to R105, wh responding. NA-D aids in her ears. Na and handed them t and performed per dress and then ass the bathroom to he dining room for bre remove R105's fac	e out of the closet and brought coom. NA-D donned gloves and it washcloth and directed her to 05 used the washcloth to wipe NA-D knelt on the floor in front ned what she was doing as 5's wet brief. R105 pointed to d, "What? I can't hear you." ow, I don't want to put them in aring aids on the bathroom done." NA-D handed R105 loth, and motioned to R105 to dy, and then gave her a towel A-D continued to talk and ask 5 stated, "I don't know what D laughed and stated, "We hearing aids in, huh?" R105 lders and shook her head. 05's top denture and handed it g her to put it in her mouth. tt? I can't hear you." NA-D to put her denture in, and se we gotta get those hearing R105 put in her top denture -D brushed R105's hair, still nile R105 sat quietly, not then placed R105's hearing A-D cleaned R105's glasses to R105, assisted her to stand, i care. NA-D assisted R105 to sisted her to ambulate out of er wheelchair, and then to the eakfast. NA-D did not offer to	F 67	7		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		0.45000				
		245269		STREET ADDRESS, CITY, STATE, ZIP CODE	06/1	4/2018
	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
	until I was done wit want to bump them facial hair, NA-D st bath day. [R105] ge have time to stop a During an interview director of nursing of should be removed asked about hearin this all the time. I et A policy was reques registered nurse (R are standards of pr policies for those." Free of Accident Ha CFR(s): 483.25(d)( §483.25(d) Accider The facility must en §483.25(d)(1) The as free of accident \$483.25(d)(2)Each supervision and as accidents. This REQUIREMEN by: Based on observat review the facility fac call light, used as a the care plan, was	h her face and hair. I didn't ." When asked about R105's ated, "That's typically done on ets two baths a week. We don't nd do that." o on 6/14/18, at 1:22 p.m. the (DON) indicated facial hair when it is noticed. When ig aids, DON stated, "We do xpect it to be taken care of." sted on 6/14/18, at 2:22 p.m. (N)-G stated, "Those things actice and we don't have azards/Supervision/Devices 1)(2) hts.	F 67		he ree ossible equate to e facility	7/20/18

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TATEMENT	OF DEFICIENCIES F CORRECTION	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245200				
		245269		WING STREET ADDRESS, CITY, STATE, ZIP CODE		14/2018
	IEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 689	current diagnoses of disease, and histor R448's Care Area / 6/11/18, identified F impaired balance, in cognitive impairme polypharmacy. R448's admission I printed on 6/14/18, indicators of fall ris transitions, fatigue, functional status, in cognitive impairme cardiovascular med antipsychotics and R448's care plan, of was at risk for falls difficulty with mobil Interventions includ to ask for help and light close by. Othe needed a soft touch staff to keep freque assess for pain or of monitor for side eff	5/30/18. printed on 6/14/18 identified of dementia, Alzheimer's y of falling. Assessment (CAA) dated R448 had risk for falls including mobility, incontinence, nt, depression and Winimal Data Set (MDS), identified the following k; impaired balance during weakness, decline in ncontinence, wandering, nt, Alzheimer's disease, dications, antidepressants, neuroleptics. dated 5/30/18, indicated R448 related to impaired cognition,	F 689	<ul> <li>observation. At the time that was identified the call light was put in the resident. The care plan and the were reviewed and revised as ne assure guidance was in place for providing care.</li> <li>Regarding all other residents who affected by this practice an audit completed to assure all call lights place. Their care plans and task were reviewed and revised as ne assure guidance is in place for the providing care.</li> <li>To assure sustainability further care audits will continue daily for one weekly for two weeks, monthly for months and then periodically after assure ongoing compliance. Immindividual training will be completer relation to the survey results.</li> <li>The results of these audits will be reviewed at the facilities quarterly committee meetings.</li> </ul>	place for ask list eded to NARs o may be was were in s lists eded to e NARs all light veek; r two r that to rediate ed in	
	identified R448 as	ssignments dated 5/30/18, a falls risk, but did not include o ensure R448's safety.				

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		AND HUMAN SERVICES				FORM	07/12/2018 APPROVED 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		E SURVEY PLETED
		245269	B. WING			06/	14/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689 F 880 SS=D	resting in recliner w across lap, and no to be across the rod and was a button ty type as noted in the When interviewed of nursing assistant (N her call light to alert verified the call ligh NA-E stated staff for and moved it from to When interviewed of registered nurse (R all residents to have When interviewed of director of nursing ( residents to have the Review of the facility directs staff with gu occurs, however, it interventions or pre- policy. Infection Prevention CFR(s): 483.80(a)( §483.80 Infection C The facility must es- infection prevention designed to provide comfortable environ development and tr diseases and infection	with feet reclined, blanket call light. Call light was noted om, attached to the bed rail, ype call light, not a soft touch a care plan. on 6/12/18, at 2:55 p.m. NA)-E verified R448 would use t staff of her needs, and t was not within her reach. orgot to put the call light by her, the bed rail to her lap. on 6/12/18, at 3:10 p.m. the N)-E stated, "I would expect their call light within reach." on 6/14/18, at 1:12 p.m. the (DON) stated, "I would expect their call light." ty's Falls Policy, revised 5/11, idelines to follow after a fall did not indicate any eventatives for falls in this in & Control 1)(2)(4)(e)(f) control and control program a a safe, sanitary and ment and to help prevent the ransmission of communicable		389			7/20/18

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245269	B. WING			06/ <sup>,</sup>	4/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH GAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services of arrangement based conducted accordin accepted national st §483.80(a)(2) Writth procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facilit (ii) When and to wh communicable dise reported; (iii) Standard and the to be followed to pre- (iv)When and how in resident; including the (A) The type and du depending upon the involved, and (B) A requirement the least restrictive posi- circumstances. (v) The circumstance must prohibit emplo-	tablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment og to §483.70(e) and following standards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a	F 8	80			

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PRINTED: 07/12/2018

		& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		<u>. 0938-039</u> e survey
	OF CORRECTION	IDENTIFICATION NUMBER:	· /	NG		IPLETED
		245269	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 880	contact will transmi (vi)The hand hygiei by staff involved in §483.80(a)(4) A sys- identified under the corrective actions t §483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual in The facility will con- IPCP and update the This REQUIREMED by: Based on observa- review, the facility fi hand hygiene inclu- use of gloves was in residents (R145, R cares, and 1 of 1 re- wound care. Findings include: R145's 14 day PPS dated 5/17/18, indice intact. R145 requires mobility, transfers, dressing. R145 had catheter. During observation	t the disease; and ne procedures to be followed direct resident contact. stem for recording incidents facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of review. duct an annual review of its neir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to ensure appropriate ding hand washing and proper mplemented for 2 of 6 105) observed for personal esidents (R33) observed for S Minimum Data Set (MDS), cated R145 was cognitively ed extensive assist with bed personal hygiene, and d an indwelling urinary s on 6/13/18, at 7:27 a.m.	F 8	Good Shepherd does estab maintain an infection preven control program designed to safe, sanitary and comfortab environment and help to pre development and transmissi communicable diseases and Regarding residents 145 and facility recognizes that during observation for each resider wash their hands after remo gloves. Good Shepherds ex staff is to follow best practice control guidelines. Regarding resident number recognizes that during one of nurse did not change gloves removing a dressing and rep	tion and provide a le vent the on of l infections. d 105 the g one t staff did not ving soiled pectations of e of infection 33 the facility bservation a in between placing it with	
	nursing assistant (I (NA)-B entered R1	VA)-A and nursing assistant 45's room to perform morning d her hands and donned (put		a new one. Good Shepherd expectations of staff is to fol practice of infection control g	s low best	

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY	
		BENTI IOATION NOMBER.	A. BUILDIN	G			
		245269	B. WING		06/	14/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA	N HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379				
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 880	on) gloves, NA-B d R145's hearing aid applied compression NA-B removed her hands and donned alcohol wipe, clean tube with the wipe, the catheter bag im NA-B walked into the graduate into the to hands, NA-B turner in the graduate, sw then emptied the w (removed) her glow hands. NA-B turner in the graduate, sw then emptied the w (removed) her glow hands. NA-B then a R145's shirt and pa lift sling under R14 to the lift. NA-A and wheelchair. During guide R145 into the R145's hair, touchi while applying a ha R145's bed and pla arm. NA-B donned from the trash cont doffed the gloves. I NA-B left the room the hall to the dirty door, and disposed applied hand saniti together. During an interview stated hands are to when dealing with I gloves are then rer When asked about	age 12 onned gloves. NA-B put es in his ears. NA-B then ons stocking to R145's legs. gloves. NA-B did not wash her new gloves. NA-B opened an ed the end of the drainage and emptied the urine from to a graduate (container). he bathroom and emptied the bilet. With the same gloved d on the sink faucet, put water iriled the water in the graduate, rater in the toilet. NA-B doffed es, but did not wash her assisted NA-A with putting on ants. NA-A and NA-B placed a 5 and attached the sling loops d NA-B transferred R145 into a the transfer NA-B helped to e wheelchair. NA-B combed ng R145's hair with her hands ir binder. NA-B then made aced a pillow under R145's left gloved and removed the trash ainer in the bathroom then NA-B did not wash her hands. with the trash, walking down utility room, opened up the l of the trash. NA-B then zer and rubbed her hands	F 88		ency at best s well as d by this t it trains y and ontrol cognizes vo dits will ssure what they of staff's nd glove rmine the and their s to s training k; weekly vo months ure		

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		AND HUMAN SERVICES				FORM	07/12/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245269	B. WING	;		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			1115 4TH AVENUE NORTH		
					SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	Continued From no	222.12		~~~			
F 00U		•	F 5	880			
	she was nervous be	ang watched.					
		on 6/14/18, at 2:04 p.m., the re to wash hands and glove					
		vork with any body fluid. Once					
		sk of emptying the catheter					
	bag, staπ are to ren hands.	nove the gloves and wash					
		inimum Data Set (MDS), dated					
		105 had dementia, moderate					
		nt, was occasionally , and required extensive					
	assistance with toile						
	required assistance living related to wea	lated 5/7/18, indicated R105 e with some activities of daily akness and impaired cognition, essing, hygiene, and toilet					
	nursing assistant (N	ion on 6/13/18, at 7:25 a.m. NA)-D entered R105's room					
		e would be assisting R105 with 05 was sitting on the toilet.					
		what she wanted to wear,					
		d handed R105 a wet					
		her face. NA-D knelt on the 05, removed her wet brief,					
		ar plastic bag on the floor, and					
	•	ks, over her shoes, up to her					
		ed R105 another wet I R105 to wash her upper					
		e her a towel to dry the areas.					
	NA-D assisted R10	5 to stand, using a gait belt					
		d used a washcloth to clean IA-D dried the peri area with a					
		oving the gloves, NA-D picked					
	up a tube of ointme	ent from the sink, squeezed					
	ointment onto her o	loved right hand, and applied					

Facility ID: 00023

If continuation sheet Page 14 of 17

		AND HUMAN SERVICES						FORM	: 07/12/2018 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE			CONSTRUCTION		(X3) DATI	E SURVEY IPLETED
		245269	B. WING	<u> </u>				06/	14/2018
NAME OF	PROVIDER OR SUPPLIER				STRE	EET ADDRESS, CITY, STATE,	ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME				4TH AVENUE NORTH JK RAPIDS, MN 56379			
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XI		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPF	BE	(X5) COMPLETION DATE
F 880	the ointment to R10 the gloves and toss on the floor. Withou NA-D secured a cle slacks, and touched door to open it. NA- bathroom, with one other on the walker wheelchair, and as wheelchair. Still wit NA-D made R105's and straightening it NA-D directed R10 performing hand hy ambulate with her w the hallway, to the of R105 to sit in a cha walked back to R10 gloves, picked up th containing dirty line flushed the toilet, an gloves, walked thro utility room. NA-D of handle and the doo plastic bag in the so another bin to place NA-D removed her garbage bin, and w inside the soiled uti During an interview NA-D stated she all performs cares and [gloves, NA-D stated	25's buttocks. NA-D removed and them into the plastic bag at performing hand hygiene, an brief, pulled up R105's d the handle on the bathroom -D assisted R105 out of the hand on the gait belt and the sisted R105 to sit in the hout performing hand hygiene, bed, touching the bed linens ems on the bedside table. 5 to stand, and without rgiene, assisted R105 to valking and gait belt, through dining room. NA-D assisted ir in the dining room, and 05's bathroom. NA-D donned he two plastic bags on the floor ns and garbage, tied the bags, nd without removing the ugh the hallway to the soiled opened the door, touching the r, opened the bin to place a biled linen bin and opened e the plastic bag with garbage. gloves, tossed them into the ashed her hands in the sink lity room.	F	880	0				

Facility ID: 00023

If continuation sheet Page 15 of 17

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES					MAPPROVED
	RS FOR MEDICARE	& MEDICAID SERVICES					<u>O. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ´				ATE SURVEY OMPLETED
		245269	B. WING			C	6/14/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SI	HEPHERD LUTHERA	N HOME					
					SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	Continued From pa	ige 15	F٤	380			
	director of nursing ( trained and expected after removing glov R33's diagnosis list cerebral infarct, her infarct and history of R33's progress noted	t includes aphasia following miplegia following cerebral of pressure ulcers. e, dated 6/8/18, indicated R33					
	dependence on sta						
	licensed practical n room to change a b LPN-A washed her gloves and obtained removed the feces buttocks, discarded trash, without remo	ion on 6/14/18, at 10:45 a.m. nurse (LPN)-A entered R33's buttocks wound dressing. hands and put on a pair of d a new dressing. LPN-A soiled dressing off R33's d the soiled dressing in the bying her gloves and giene, applied the new und.					
	LPN-A stated shoul dressing that was s of the dressing and gloves before puttir wound. LPN-A state a daily bases, so ge remove old dressin	on 6/14/18, at 10:53 a.m. Id have removed the old soiled with feces on the bottom I she should have changed ng clean dressing on the ed she changes dressings on eneral practice would be to g, removed gloves, wash new gloves before applying a					
	RN-F stated standa change would be to	on 6/14/18, at 11:31 a.m. ard practice for a dressing wash hands, apply gloves, assess for signs and					

If continuation sheet Page 16 of 17

PRINTED: 07/12/2018

		AND HUMAN SERVICES				FORM	07/12/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245269	B. WING	;		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	hands and apply ne clean dressing. RN to follow the policy a completed compete staff development, related to hand hyg Review of the facilit Protocol, dated 4/12 necessary to wear shall utilize gloves of their hands after re included, "Gloves s become contamina	ige 16 ion, take gloves off, wash w gloves before putting on a -A stated she expects nurses and stated nurses have ency's, have on line training, and training in nursing school iene with dressing change. cy's policy, Hand Hygiene 8, included, "When it is gloves for personal cares, staff during those cares and wash moving the gloves." Also hall be removed, when gloves ted, hands washed and clean ore returning to tasks."	F	880			

	MENT OF HEALTH			FG	269026	FORM	06/18/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SU COMPLET	
		245269		B. WING		06/15	5/2018
	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
GOOD S	HEPHERD LUTHER			'H AVENUE RAPIDS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	Minnesota Departm time of this survey, Home was found in requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the Fire Protection Asso 01, Life Safety Code	At the heran 2 2012 ciation				
	Good Shepherd Ho partial basement. T 6 different times: The original building was determined to construction. In 19 the east that was do (111) construction. added to the northw	69, an addition was etermined to be of T In 1980, an additior vest that was determ	ling with a structed at 1963 and added to ype II was nined to be				
LABORATO	the west that was d (111) construction. In 2002, an addition Dining Room that w (111) construction. was added that was (111) construction I corner of the facility In 2010 a two story determined to be o located on the north	addition was added f Type II (111) constr heast corner of the f ddition was added th	Type V Main e of Type V addition of Type II west that was that was acility. In nat was	SNATURE	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.

	TMENT OF HEALTH					FORM	06/18/2018 APPROVED 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLET	
	245269			B. WING		06/15	/2018
					STATE, ZIP CODE		
GOOD	SHEPHERD LUTHEF			H AVENUI RAPIDS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	Continued From particular determined to be of located north of the The building is fully sprinkler system is NFPA 13 the Stand Sprinkler Systems of a manual fire alarm detection and smok the corridors. The automatic fire depa installed in accorda National Fire Alarm The facility has a ca census of 158 at th	age 1 Type V (111) constr	and the nce with of acility has r smoke es open to for nd The i).	K 000			

If continuation sheet Page 2 of 2



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: 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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Good Shepherd Lutheran Home June 28, 2018 Page 2 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,

Dourses Stappon

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00023	B. WING		06/1	4/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	NHOME	AVENUE NO PIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf clicensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 07/06/18

Electronically Signed

If continuation sheet 1 of 17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00023	B. WING		06/*	14/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GOOD S	HEPHERD LUTHERA	NHOME	I AVENUE NOF APIDS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 000	Department of Hea you electronically.	ige 1 Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please	2 000				
	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.						
	the following correct Please indicate in y correction that you	B, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed					
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled " II statute/rule out of co "Summary Stateme and replaces the "T correction order. Th findings which are after the statement evidence by." Follo	umber appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.					

G59911

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED 06/14/2018	
		00023	B. WING	06		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	NHOME	AVENUE NO PIDS, MN 5			
(X4) <b>I</b> D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE D DEFICIENCY)		
2 000	Continued From page 2		2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 690	MN Rule 4658.0468 and Death	5 Subp. 3 Transfer, Discharge,	2 690		7/20/18	
	When a resident is another health care nursing home must compiled according information about th and sufficient inform care prior to or at th discharge to the oth program. Additional for the resident's im the new health care	or discharge to another facility. transferred or discharged to a facility or program, the send the discharge summary to subpart 2, and pertinent he resident's immediate care nation to ensure continuity of he time of the transfer or her health care facility or al information not necessary mediate care may be sent to a facility or program at the transfer or discharge.				
	by: Based on interview facility failed to com preparation of a res residents (R149) di another care facility Findings include: R149's Care Area A 3/21/18, indicated a impaired mobility ar fall prior to admission humeral head (show fractures. The CAA	ent is not met as evidenced and document review, the pplete a discharge summary in sident discharge for 1 of 1 scharged from the facility to 7. Assessment (CAA) dated a risk for falls related to nd narcotic analgesics with a on that resulted in a left ulder) fracture and multiple rib further indicated risk for pain mobility and previous fracture		Good Shepherd does have a process in place to complete discharge summery on anticipation of discharge. Regarding resident number 149 the facilit 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		

G59911

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00023	B. WING		06/14/2018
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
SOOD S	HEPHERD LUTHERA		AVENUE NO APIDS, MN &		
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET IE APPROPRIATE DATE
2 690	Continued From pa	ge 3	2 690		
	related to current he was independent at facility prior to fall. R149's admission M dated 3/16/18, indic cognitively impaired transfers/toilet use/ MDS further indicat pain that he verbali oxygen and dialysis assessment and re discharge back to t family or significant R149's care plan da diagnosis of renal fa pneumonia with she from fractures. R14 behavior of yelling of potential for other b plan indicated R148 lift for transfers with bed mobility, toiletin R149's doctor disch indicated 1) decrea by mouth three time as needed every tw use Tylenol instead copy of discharge s arrives and 3) make visit with his local p discharge order wa the pharmacy on 4/ was shared with red discharge order wa indicated R149 was	ated 3/9/18, indicated a ailure with dialysis, diabetic, ortness of breath, and pain 9's care plan also addressed out, refusing cares and behavioral indicators. Care 9 required a mechanical Hoyer o two staff assist, along with		appropriate. Changes were necessary. The facility believes it has place to manage effective planning. To assure all co process are completed the facility has chosen to enhat to be more streamlined an all discharges regardless of resident is discharging to. has chosen to enhance the discharge form to assure it in finding the information g provided to the accepting f discharge to. Training regarding the enh this process and form will for all individuals responsit compliance to this regulati To assure sustainability of change, routine audits of tt who discharge to home or will be completed daily for for two weeks, and then m months and periodically af assure ongoing compliance	a process in discharge mponents of the proughly, the ance its process d consistent for of where the The facility also e current increased ease jathered and facility of ancement of be completed ole for on. this process hose residents another facility 1 week; weekly onthly for two ter that to

G59911

If continuation sheet 4 of 17

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00023	B. WING		06/14/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		AVENUE NOF PIDS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 690	Continued From pa	age 4	2 690			
2 690	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.					
	director of social se blank recapitulation was found in the di asked how they su R149's stay, SS-A fill out" in reference form.	v on 6/14/18, at 1:52 p.m. the ervice (SS)-A reviewed the n summary form for R149 that ischarge record and when mmarized and recapped stated "That's what we usually e to the blank recapitulation				
	manager (CM)-A in summary is a com- services and the ca information to be g CM-A further indica send would be nur- needs, medication, further indicate it w	v on 6/14/18, at 2:24 p.m. case adicated the discharge bined effort between social ase manager to collect iven to the receiving facility. ated the information they would sing needs, oxygen, diabetic , or therapy information. CM-A yould be standard regardless if nome or to another facility and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY IPLETED
		00023	B. WING		06/	/14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	NHOME	I AVENUE NOF APIDS, MN 56			
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPR <b>I</b> ATE	(X5) COMPLETE DATE
2 690	Continued From pa	age 5	2 690			
	this is always given	on discharge.				
	information manages summaries are located case manager takes information to the r A facility policy on c	16/14/18, at 2:30 p.m. health er indicated the discharge ated in the hard chart and the es care of forwarding the eceiving facility. discharge and recapitulation quested but not supplied.				
	The director of nurs review and revise a procedures related summary. The DOI the staff responsibl discharge summar	THOD OF CORRECTION: sing (DON) or designee could any applicable policies and to completion of the discharge N or designee could educate e for completion of the y and could audit to ensure e and report the audit results vement group.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			7/20/18
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident	1			

Minnesc	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMPI	
		00023	B. WING		06/1	4/2018
NAME OF I		STREET ADI	DRESS. CITY. S	STATE, ZIP CODE		
		1115 4TH	AVENUE NO			
GOODS	HEPHERD LUTHERA	N HOME SAUK RA	PIDS, MN 5	6379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	prefers to remain in	bed.				
	This MN Requireme by: Based on observati review, the facility fa with the removal of hearing aide placer who was dependen activities of daily liv facility failed to ensuised used as a planned plan, was appropria (R448), reviewed for Findings include: R105's quarterly Mi 5/8/18, identified R cognitive impairment with dressing and e personal hygiene. T had adequate ability normal conversation identified that R105 R105's admission M dated 11/28/17, ide to R105 to choose of R105's Care Area A 6/14/18, included ho may have an impao	ent is not met as evidenced on, interview and document ailed to provide assistance facial hair and assist with nent for 1 of 1 resident (R105) t upon staff for assistance with ing (ADLs). In addition, the sure placement of a call light, fall intervention per the care itely placed for 1 of 1 resident or accidents.		Good Shepherd does assure that resident who is unable to carry out activities of daily living receives the necessary services to maintain go nutrition, grooming and personal a hygiene. Regarding resident number 105 th recognizes that during time of the that one resident was noted to hav hair and their hearing aids were not timely before cares were provided hearing aids were placed in reside ears at the end of cares on the da were noted to be without them. Th hair had also been removed at the when they were identified. Resider care plan and task list were review revised as necessary to assure de guidance is in place for NARs prov cares. Regarding any other residents who possibility of being affected by this care plans have also been review revised as necessary to assure de guidance is in place for NARs prov cares. The facility believes it has a proce training staff to monitor for unwant hair, hearing aid placement and of and grooming needs. To assure A	t e od und oral e facility survey ve facial ot placed ot placed . The ent's y they ne facial e time nt 105's ved and ear viding o have a d, their ed and ear viding ss of ced facial her ADL vDL's	
	need for assistance	ysical limitations resulted in with ADLs.		are provided as per expectation of facility a checkoff form will be implemented with a listing of basic		
	enartment of Health					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00023	B. WING		06/14/20	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
SOOD S	HEPHERD LUTHERA		AVENUE NO APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPR <b>I</b> ATE	(X5) COMPLE DATE
2 830	Continued From pa	age 7	2 830			
nursing assistant (NA)-D entered R105's and announced she would be assisting R morning cares. R105 was sitting on the to Several 1/4-1/2 inch long white hairs rema each side of R105's mouth. NA-D asked I what she wanted to wear. R105 did not re NA-D again offered choices of clothing. R shrugged her shoulders. NA-D took a pai slacks and a blouse out of the closet and them into the bathroom. NA-D donned glo handed R105 a wet washcloth and directe wash her face. R105 used the washcloth her face and neck. NA-D knelt on the floo of R105 and explained what she was doir she removed R105's wet brief. R105 poin her ears and stated, "What? I can't hear y NA-D stated, "I know, I don't want to put t	e with some activities of daily akness and impaired cognition, ressing, hygiene, and toilet ssignments, printed on R105 required assistance of he and dressing, and wore ds. tion and interview on 6/11/18, had several 1/4-1/2 inch long n side of her mouth. R105 the hairs, but I don't have a ated the staff had cut them		PM cares highlighting "chear removal of facial hair" as w This form will be signed off completing the cares on the shifts indicating that the list completed. They will be re Team Leader for that shift p member leaving. In addition staff will be educated on the the order in which cares are assure needed appliances/ place timely to be most ber resident. To assure sustainability of t change, routine audits of th off forms will be completed week; weekly for two week monthly for two months and after that to assure ongoing	ell as "devices." by the person e AM and PM ed tasks were viewed by the prior to the staff on to the form; e importance of e provided to devices are in heficial to the this process he cares check daily for 1 s, and then d periodically		
	nursing assistant ( and announced sh morning cares. R1 Several 1/4-1/2 inc each side of R105' what she wanted to NA-D again offered shrugged her shou slacks and a blous them into the bathr handed R105 a we wash her face. R10 her face and neck. of R105 and explais she removed R105 her ears and stated NA-D stated, "I kno [pointing to the hea counter] until we're	uring an observation on 6/13/18, at 7:25 a.m. ursing assistant (NA)-D entered R105's room and announced she would be assisting R105 with orning cares. R105 was sitting on the toilet. everal 1/4-1/2 inch long white hairs remained on ach side of R105's mouth. NA-D asked R105 that she wanted to wear. R105 did not respond. A-D again offered choices of clothing. R105 arugged her shoulders. NA-D took a pair of acks and a blouse out of the closet and brought em into the bathroom. NA-D donned gloves and anded R105 a wet washcloth and directed her to ash her face. R105 used the washcloth to wipe er face and neck. NA-D knelt on the floor in front R105 and explained what she was doing as the removed R105's wet brief. R105 pointed to er ears and stated, "What? I can't hear you." A-D stated, "I know, I don't want to put them in ointing to the hearing aids on the bathroom		The results of these audits reviewed at the facilities qu committee meetings.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00023	B. WING		06/	06/14/2018	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
OOD SH	IEPHERD LUTHERA		HAVENUE NOI APIDS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 8	2 830				
	to dry the areas. N questions and R10 you're saying." NA- have to get those h shrugged her shou NA-D brushed R10 to R105, instructing R105 stated, "What motioned to R105 stated, "That's cau aids in, don't we?" and sat quietly. NA- talking to R105, wh responding. NA-D aids in her ears. Na and handed them to and performed per dress and then ass the bathroom to her	dy, and then gave her a towel A-D continued to talk and ask 5 stated, "I don't know what -D laughed and stated, "We hearing aids in, huh?" R105 Idders and shook her head. D5's top denture and handed it g her to put it in her mouth. tt? I can't hear you." NA-D to put her denture in, and se we gotta get those hearing R105 put in her top denture A-D brushed R105's hair, still hile R105 sat quietly, not then placed R105's hearing A-D cleaned R105's glasses to R105, assisted her to stand, i care. NA-D assisted R105 to sisted her to ambulate out of er wheelchair, and then to the eakfast. NA-D did not offer to sial hair.					
	stated she didn't pl to interacting with h cares, and stated, until I was done with want to bump them facial hair, NA-D st	on 6/13/18, at 8:07 a.m. NA-D lace R105's hearing aids prior her and providing personal "I didn't want to put them in th her face and hair. I didn't n." When asked about R105's tated, "That's typically done on ets two baths a week. We don' and do that."					
	director of nursing should be removed asked about hearing	v on 6/14/18, at 1:22 p.m. the (DON) indicated facial hair d when it is noticed. When ng aids, DON stated, "We do expect it to be taken care of."					
	A policy was reque	sted on 6/14/18, at 2:22 p.m.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			E SURVEY PLETED
		00023	B. WING		06/14/2018	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IOOD S	HEPHERD LUTHERA		H AVENUE NOF APIDS, MN 56			
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	age 9	2 830			
		RN)-G stated, "Those things ractice and we don't have				
	R448's Record of <i>i</i> admission date of	Admission indicated an 5/30/18.				
		printed on 6/14/18 identified of dementia, Alzheimer's ry of falling.				
	6/11/18, identified impaired balance,	Assessment (CAA) dated R448 had risk for falls includin mobility, incontinence, ent, depression and	9			
	printed on 6/14/18 indicators of fall ris transitions, fatigue functional status, in cognitive impairme	Minimal Data Set (MDS), , identified the following sk; impaired balance during , weakness, decline in ncontinence, wandering, ent, Alzheimer's disease, dications, antidepressants, neuroleptics.				
	was at risk for falls difficulty with mobi Interventions inclu- to ask for help and light close by. Othe needed a soft touc staff to keep freque assess for pain or monitor for side eff	dated 5/30/18, indicated R448 related to impaired cognition, lity, and dementia. ded encouraging the resident directed staff to have the call er interventions included R448 th type of call light, and directed ently used items close by, to discomfort every shift, to fects from medication, and that ist of one and gait belt with				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00023	B. WING		06/14/201	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
SOOD S	HEPHERD LUTHERA		HAVENUE NOP APIDS, MN 56			
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	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.					
	resting in recliner w across lap, and no to be across the ro	1 p.m. R448 was observed vith feet reclined, blanket call light. Call light was noted om, attached to the bed rail, ype call light, not a soft touch e care plan.				
	nursing assistant (I her call light to aler verified the call ligh NA-E stated staff for	on 6/12/18, at 2:55 p.m. NA)-E verified R448 would use t staff of her needs, and ht was not within her reach. orgot to put the call light by her the bed rail to her lap.				
	registered nurse (F	on 6/12/18, at 3:10 p.m. the RN)-E stated, "I would expect re their call light within reach."				
		on 6/14/18, at 1:12 p.m. the (DON) stated, "I would expect heir call light."				
	directs staff with guo	ity's Falls Policy, revised 5/11, uidelines to follow after a fall did not indicate any eventatives for falls in this				
	The director of nurse review and revise a procedures related daily living as well a	THOD OF CORRECTION: sing (DON) or designee could any applicable policies and I to assistance with activities of as safety and supervision in placement and educate all				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY IPLETED
		00023	B. WING	06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	HEPHERD LUTHERA		AVENUE NO PIDS, MN 5		
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830		
		designee could audit to ensure e and report the audit results evement group.			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one			
21385	MN Rule 4658.080 Staff assistance	0 Subp. 3 Infection Control;	21385		7/20/18
	Personnel must be infection control pro the residents and r	sistance with infection control. assigned to assist with the ogram, based on the needs of nursing home, to implement ocedures of the infection			
	by: Based on observat review, the facility f hand hygiene inclu use of gloves was residents (R145, R cares, and 1 of 1 re wound care. Findings include: R145's 14 day PPS dated 5/17/18, india intact. R145 require mobility, transfers, dressing. R145 had catheter.	ent is not met as evidenced tion, interview, and document failed to ensure appropriate ding hand washing and proper implemented for 2 of 6 105) observed for personal esidents (R33) observed for 6 Minimum Data Set (MDS), cated R145 was cognitively ed extensive assist with bed personal hygiene, and d an indwelling urinary as on 6/13/18, at 7:27 a.m. NA)-A and nursing assistant		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	

G59911

If continuation sheet 12 of 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMPI	
		00023	B. WING		06/1	4/2018
AME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, C <b>I</b> TY,	STATE, ZIP CODE		
OOD SI	HEPHERD LUTHERA		AVENUE NO PIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21385	Continued From pa	ige 12	21385			
	cares. NA-A washe on) gloves, NA-B d R145's hearing aid applied compression NA-B removed her hands and donned alcohol wipe, clean tube with the wipe, the catheter bag int NA-B walked into the graduate into the to hands, NA-B turned in the graduate, sw then emptied the w (removed) her glov hands. NA-B turned in the graduate, sw then emptied the w (removed) her glov hands. NA-B then a R145's shirt and pa lift sling under R145 to the lift. NA-A and wheelchair. During guide R145 into the R145's hair, touching while applying a ha R145's bed and pla arm. NA-B donned from the trash cont doffed the gloves. I NA-B left the room the hall to the dirty door, and disposed applied hand saniti together. During an interview	45's room to perform morning d her hands and donned (put onned gloves. NA-B put es in his ears. NA-B then ons stocking to R145's legs. gloves. NA-B did not wash her new gloves. NA-B opened an ed the end of the drainage and emptied the urine from to a graduate (container). ne bathroom and emptied the bilet. With the same gloved d on the sink faucet, put water irled the water in the graduate, ater in the toilet. NA-B doffed es, but did not wash her assisted NA-A with putting on onts. NA-A and NA-B placed a 5 and attached the sling loops I NA-B transferred R145 into a the transfer NA-B helped to e wheelchair. NA-B combed ng R145's hair with her hands ir binder. NA-B then made aced a pillow under R145's left gloved and removed the trash ainer in the bathroom then NA-B did not wash her hands. with the trash, walking down utility room, opened up the of the trash. NA-B then zer and rubbed her hands		of staff is to follow best pract infection control guidelines. A discussion was completed w identified in this deficiency at survey – discussing best pra Regarding the above resider all residents who may be affe practice. The facility believes the staff on proper hand was glove use through the infection program. Because the facilit this deficient practice for these employees during the survey be conducted to gather data staff understanding is correc have been taught. Verbal au understanding of handwashin use are being conducted to co overall focus for ongoing trai audits. Staff responsible to regulation will be re-educated responsibilities. Follow-up a assure staff understanding o will be completed daily for a so for two weeks and monthly for and periodically after that to a ongoing compliance. The results of these audits w reviewed at the facilities qual committee meetings.	A follow-up ith the nurse the time of ctices its as well as ected by this that it trains hing and on control y recognizes se two ; audits will to assure t on what they dits of staff's ng and glove letermine the ning and this d to their udits to f this training week; weekly or two months assure ill be	
	when dealing with I gloves are then ren When asked about	be washed and gloves worn bodily fluids. NA-B stated the noved and hands are washed. not washing hands after rinary catheter NA-B state she				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00023	B. WING		06/14/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, C <b>I</b> TY, S <sup>-</sup>	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	NHOME	I AVENUE NOF APIDS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21385	Continued From pa	age 13	21385			
	did not but "I should have." NA-B went onto say she was nervous being watched.					
	DON stated staff a prior to starting to v finished with the ta	v on 6/14/18, at 2:04 p.m., the re to wash hands and glove work with any body fluid. Once sk of emptying the catheter move the gloves and wash				
	5/8/18, identified R cognitive impairme	inimum Data Set (MDS), dated 105 had dementia, moderate nt, was occasionally e, and required extensive eting.	1			
	required assistance living related to we	dated 5/7/18, indicated R105 e with some activities of daily akness and impaired cognition ressing, hygiene, and toilet	,			
	nursing assistant (I and announced sho morning cares. R10 NA-D asked R105 donned gloves, and washcloth to wash floor in front of R10 tossed it into a clear pulled R105's slack ankles. NA-D hand washcloth, directed body, and then gav NA-D assisted R10 and the walker, and R105's peri area. N	tion on 6/13/18, at 7:25 a.m. NA)-D entered R105's room e would be assisting R105 with 05 was sitting on the toilet. what she wanted to wear, d handed R105 a wet her face. NA-D knelt on the 05, removed her wet brief, ar plastic bag on the floor, and ks, over her shoes, up to her led R105 another wet d R105 to wash her upper re her a towel to dry the areas. 05 to stand, using a gait belt d used a washcloth to clean IA-D dried the peri area with a oving the gloves, NA-D picked				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00023	B. WING		06/14/2018	
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
SOOD S	HEPHERD LUTHERA		I AVENUE NOF APIDS, MN 56			
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE	
21385	Continued From pa	age 14	21385			
	the ointment to R10 the gloves and toss on the floor. Without NA-D secured a cle slacks, and touche door to open it. NA bathroom, with one other on the walker wheelchair, and as wheelchair. Still wit NA-D made R105's and straightening it NA-D directed R10 performing hand hy ambulate with her the hallway, to the R105 to sit in a cha walked back to R10 gloves, picked up t containing dirty line flushed the toilet, a gloves, walked throut utility room. NA-D ch handle and the doo plastic bag in the s another bin to place NA-D removed her garbage bin, and w inside the soiled ut During an interview NA-D stated she all performs cares and [gloves], but we ca even if you have a	gloved right hand, and applied 05's buttocks. NA-D removed sed them into the plastic bag ut performing hand hygiene, ean brief, pulled up R105's ed the handle on the bathroom -D assisted R105 out of the e hand on the gait belt and the r, locked the brakes on the ssisted R105 to sit in the thout performing hand hygiene s bed, touching the bed linens tems on the bedside table. 05 to stand, and without ygiene, assisted R105 to walking and gait belt, through dining room. NA-D assisted air in the dining room, and 05's bathroom. NA-D donned the two plastic bags on the floo ens and garbage, tied the bags and without removing the bugh the hallway to the soiled opened the door, touching the pr, opened the bin to place a coiled linen bin and opened e the plastic bag with garbage. r gloves, tossed them into the vashed her hands in the sink ility room.	r ,			

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00023	B. WING		06/14/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		HAVENUE NOI APIDS, MN 56			
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPR <b>I</b> ATE	(X5) COMPLET DATE
21385	Continued From pa	age 15	21385			
	director of nursing	v on 6/14/18, at 1:22 p.m. (DON) indicated staff were ed to perform hand hygiene ves.				
	0	t includes aphasia following miplegia following cerebral of pressure ulcers.				
		te, dated 6/8/18, indicated R33 n left buttocks and is total aff for cares.				
	licensed practical r room to change a b LPN-A washed her gloves and obtaine removed the feces buttocks, discarded trash, without remo	tion on 6/14/18, at 10:45 a.m. hurse (LPN)-A entered R33's puttocks wound dressing. hands and put on a pair of d a new dressing. LPN-A soiled dressing off R33's d the soiled dressing in the oving her gloves and ygiene, applied the new und.				
	LPN-A stated shou dressing that was s of the dressing and gloves before puttin wound. LPN-A stat a daily bases, so g remove old dressin	v on 6/14/18, at 10:53 a.m. Id have removed the old soiled with feces on the bottom d she should have changed ng clean dressing on the ed she changes dressings on eneral practice would be to ng, removed gloves, wash new gloves before applying a				
	RN-F stated standa change would be to	v on 6/14/18, at 11:31 a.m. ard practice for a dressing o wash hands, apply gloves, assess for signs and				

ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00023	B. WING		06/14/20	
PROVIDER OR SUPPLIER					
HEPHERD LUTHERA					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE COMPLETE HE APPROPRIATE DATE	
Continued From page 16		21385			
<ul> <li>Symptoms of infection, take gloves on, 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.</li> <li>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."</li> </ul>					
The director of nur- review training pro- hand hygiene and g care and glove use (DON) or designee systems to ensure infection control po- report those results group.	sing (DON) or designee could vided and educate staff on glove use related to personal e. The director of nursing e could develop auditing ongoing compliance with olicies and procedures and s to the quality improvement				
	T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER HEPHERD LUTHERA SUMMARY ST. (EACH DEFICIENC REGULATORY OR Continued From pa symptoms of infec hands and apply n clean dressing. RN to follow the policy completed compet staff development, related to hand hys Review of the facil Protocol, dated 4/1 necessary to wear shall utilize gloves their hands after re- included, "Gloves a become contamina gloves donned bef SUGGESTED ME The director of nur review training pro- hand hygiene and care and glove use (DON) or designee systems to ensure infection control por report those result group. TIME PERIOD FO	TOF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         O0023       00023         PROVIDER OR SUPPLIER       STREET A 1115 4TH SAUK R.         TEPHERD LUTHERAN HOME       1115 4TH SAUK R.         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       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."         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	TOF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING:         00023       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST 1115 4TH AVENUE NOI SAUK RAPIDS, MN 56         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX PREFIX TAG         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." 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WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         IEPHERD LUTHERAN HOME       1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CROSS-REFERENCED TO THE DEFICIENCY         Continued From page 16       21385       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.       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CITY, STATE, ZIP CODE         'HEPHERD LUTHERAN HOME       1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379       PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION)       ID PREFK TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         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." 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