#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

|                                                                                                                                                                          | CARE/MEDICAID CERTIFICATION A                                                                                                                                                                        |                                                                                                      | ID: G599<br>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<br>(L6) 56379<br><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<br>15 ASC<br>16 HOSPICE                                                                      | FISCAL YEAR ENDING DATE: (L35)<br>12/31                                                                                                                                         |
| 11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds         162                                                               | 10.THE FACILITY IS CERTIFIED AS:<br>X A. In Compliance With<br>Program Requirements<br>Compliance Based On:<br>1. Acceptable POC                                                                     | And/Or Approved Waivers Of The<br>2. Technical Personnel<br>3. 24 Hour RN<br>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<br/>Requirements and/or Applied Waivers:</li> </ul>                                                                                                       | 5. Life Safety Code<br>* Code: A                                                                     | 9. Beds/Room<br>(L12)                                                                                                                                                           |
| 14. LTC CERTIFIED BED BREAKDOWN<br>18 SNF 18/19 SNF 19 SNF<br>162<br>(L37) (L38) (L39)                                                                                   | ICF IID<br>(L42) (L43)                                                                                                                                                                               | 15. FACILITY MEETS<br>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<br>(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<br>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<br>07/01/1984<br>(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<br>on of Admissions:<br>(L44)<br>uspension Date:                                                                                                                                       | 03-Risk of Involuntary Termination<br>04-Other Reason for Withdrawal                                 | OTHER<br>07-Provider Status Change<br>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.<br>(L1) <b>245269</b> |                  | 3. NAME AND AI<br>(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<br>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<br>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<br>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 (<br>GHTS ACT:  | CIVIL      |                                    | ncial Solvency (HCFA-2572)<br>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<br>OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                        | · /                |      |                                                                                                                 |               | E SURVEY<br>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<br>SAUK RAPIDS, MN 56379                                                                   |               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                          | ID<br>PREFI<br>TAG |      | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE          | (X5)<br>COMPLETION<br>DATE |
| E 000                    | Initial Comments                                                                                                |                                                                                                                                                                                                              | EC                 | )00  |                                                                                                                 |               |                            |
| F 000                    | Emergency Prepare<br>conducted on June<br>during a recertificat                                                 |                                                                                                                                                                                                              | FC                 | 000  |                                                                                                                 |               |                            |
|                          | survey was comple<br>Minnesota Departm<br>your facility was in o<br>of 42 CFR Part 483                          | h June 14, 2018, a standard<br>ted at your facility by the<br>nent of Health to determine if<br>compliance with requirements<br>5, Subpart B, and<br>ong Term Care Facilities.                               |                    |      |                                                                                                                 |               |                            |
|                          | as your allegation of<br>Department's accept<br>enrolled in ePOC, y<br>at the bottom of the                     | f correction (POC) will serve<br>of compliance upon the<br>otance. Because you are<br>your signature is not required<br>a first page of the CMS-2567<br>ic submission of the POC will<br>tion of compliance. |                    |      |                                                                                                                 |               |                            |
| F 661<br>SS=D            | on-site revisit of you<br>validate that substa<br>regulations has bee<br>your verification.<br>Discharge Summar |                                                                                                                                                                                                              | F 6                | \$61 |                                                                                                                 |               | 7/20/18                    |
|                          | must have a discha<br>but is not limited to,<br>(i) A recapitulation of<br>includes, but is not                 | nticipates discharge, a resident<br>irge summary that includes,<br>the following:<br>of the resident's stay that<br>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<br>SAUK RAPIDS, MN 56379                                                                                                                                                                                            |                                                                |                           |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                       | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                     | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)                                                                                                                                    | OULD BE                                                        | (X5)<br>COMPLETIO<br>DATE |  |
| F 661                                                                                                          | radiology, and cons<br>(ii) A final summary<br>include items in part<br>the time of the disc<br>release to authorize<br>the consent of the part<br>representative.<br>(iii) Reconciliation of<br>medications with the<br>medications (both pover-the-counter).<br>(iv) A post-discharg<br>developed with the<br>and, with the reside<br>representative(s), v<br>adjust to his or her | or therapy, and pertinent lab,<br>sultation results.<br>of the resident's status to<br>ragraph (b)(1) of §483.20, at<br>harge that is available for<br>ed persons and agencies, with<br>resident or resident's<br>of all pre-discharge<br>he resident's post-discharge | F 66                | 51                                                                                                                                                                                                                                        |                                                                |                           |  |
| post-disch<br>the individ<br>that have<br>care and<br>non-medi<br>This REQ<br>by:<br>Based or<br>facility fail | that have been mad<br>care and any post-<br>non-medical servic<br>This REQUIREMEN<br>by:<br>Based on interview<br>facility failed to com                                                                                                                                                                                                                                             | NT is not met as evidenced<br>v and document review, the<br>nplete a discharge summary in                                                                                                                                                                              |                     | Good Shepherd does have a p<br>place to complete discharge su                                                                                                                                                                             |                                                                |                           |  |
|                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      | sident discharge for 1 of 1<br>scharged from the facility to<br>/.                                                                                                                                                                                                     |                     | anticipation of discharge.<br>Regarding resident number 14<br>recognizes the discharge summer<br>was not completed when the re-<br>transferred to another facility.<br>Documentation of the discharg                                      | nary form<br>sident                                            |                           |  |
|                                                                                                                | 3/21/18, indicated a<br>impaired mobility a<br>fall prior to admissi<br>humeral head (sho<br>fractures. The CAA                                                                                                                                                                                                                                                                      | Assessment (CAA) dated<br>a risk for falls related to<br>nd narcotic analgesics with a<br>on that resulted in a left<br>ulder) fracture and multiple rib<br>further indicated risk for pain<br>mobility and previous fracture                                          |                     | and summary of information ex-<br>with the receiving facility was d<br>in the electronic chart.<br>Regarding any other residents<br>active discharge plans, an aud<br>records was completed to assu<br>facilities process is being carrie | changed<br>ocumented<br>who have<br>t of their<br>ire that the |                           |  |

Facility ID: 00023

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

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

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

Facility ID: 00023

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

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

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

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| TATEMENT                 | OF DEFICIENCIES<br>F CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                |                     | PLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DAT                                                                                                                                                               | 0938-039<br>E SURVEY<br>PLETED |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 245200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                        |                                |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 245269                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | WING<br>STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                        | 14/2018                        |
|                          | IEPHERD LUTHERA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | N HOME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 1115 4TH AVENUE NORTH<br>SAUK RAPIDS, MN 56379                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                        |                                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | LD BE                                                                                                                                                                  | (X5)<br>COMPLETIC<br>DATE      |
| F 689                    | current diagnoses of<br>disease, and histor<br>R448's Care Area /<br>6/11/18, identified F<br>impaired balance, in<br>cognitive impairme<br>polypharmacy.<br>R448's admission I<br>printed on 6/14/18,<br>indicators of fall ris<br>transitions, fatigue,<br>functional status, in<br>cognitive impairme<br>cardiovascular med<br>antipsychotics and<br>R448's care plan, of<br>was at risk for falls<br>difficulty with mobil<br>Interventions includ<br>to ask for help and<br>light close by. Othe<br>needed a soft touch<br>staff to keep freque<br>assess for pain or of<br>monitor for side eff | 5/30/18.<br>printed on 6/14/18 identified<br>of dementia, Alzheimer's<br>y of falling.<br>Assessment (CAA) dated<br>R448 had risk for falls including<br>mobility, incontinence,<br>nt, depression and<br>Winimal Data Set (MDS),<br>identified the following<br>k; impaired balance during<br>weakness, decline in<br>ncontinence, wandering,<br>nt, Alzheimer's disease,<br>dications, antidepressants,<br>neuroleptics.<br>dated 5/30/18, indicated R448<br>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<br>ask list<br>eded to<br>NARs<br>o may be<br>was<br>were in<br>s lists<br>eded to<br>e NARs<br>all light<br>veek;<br>r two<br>r that to<br>rediate<br>ed in |                                |
|                          | identified R448 as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ssignments dated 5/30/18,<br>a falls risk, but did not include<br>o ensure R448's safety.                                                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                        |                                |

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

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

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

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

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|                          |                                              | AND HUMAN SERVICES                                                                                                               |                    |     |                                                                                                                 | FORM      | 07/12/2018<br>APPROVED<br>0938-0391 |
|--------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------|-----|-----------------------------------------------------------------------------------------------------------------|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                            |                    |     | LE CONSTRUCTION                                                                                                 | (X3) DATI | E SURVEY<br>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<br>PREFIX<br>TAG | (EACH DEFICIENCY                             | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                             | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>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<br>hands.               | nove the gloves and wash                                                                                                         |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | inimum Data Set (MDS), dated                                                                                                     |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | 105 had dementia, moderate                                                                                                       |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | nt, was occasionally<br>, and required extensive                                                                                 |                    |     |                                                                                                                 |           |                                     |
|                          | assistance with toile                        |                                                                                                                                  |                    |     |                                                                                                                 |           |                                     |
|                          | required assistance<br>living related to wea | lated 5/7/18, indicated R105<br>e with some activities of daily<br>akness and impaired cognition,<br>essing, hygiene, and toilet |                    |     |                                                                                                                 |           |                                     |
|                          | nursing assistant (N                         | ion on 6/13/18, at 7:25 a.m.<br>NA)-D entered R105's room                                                                        |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | e would be assisting R105 with<br>05 was sitting on the toilet.                                                                  |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | what she wanted to wear,                                                                                                         |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | d handed R105 a wet                                                                                                              |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | her face. NA-D knelt on the<br>05, removed her wet brief,                                                                        |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | ar plastic bag on the floor, and                                                                                                 |                    |     |                                                                                                                 |           |                                     |
|                          | •                                            | ks, over her shoes, up to her                                                                                                    |                    |     |                                                                                                                 |           |                                     |
|                          |                                              | ed R105 another wet<br>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<br>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                                                                                                    |                    |     |                                                                                                                 |           |                                     |

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

Facility ID: 00023

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

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

|                          | MENT OF HEALTH                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                   | FG                      | 269026                                                                                                | FORM                    | 06/18/2018<br>APPROVED<br>0938-0391 |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------|
|                          | OF DEFICIENCIES                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NUM                                                   |                                                                                                                   |                         | LE CONSTRUCTION<br>01 - MAIN BUILDING 01                                                              | (X3) DATE SU<br>COMPLET |                                     |
|                          |                                                                                                                                                                                                                                                              | 245269                                                                                        |                                                                                                                   | B. WING                 |                                                                                                       | 06/15                   | 5/2018                              |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                   |                         | TATE, ZIP CODE                                                                                        |                         |                                     |
| GOOD S                   | HEPHERD LUTHER                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                   | 'H AVENUE<br>RAPIDS, MI |                                                                                                       |                         |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY MUST                                                                                                                                                                                                                                        | ATEMENT OF DEFICIENCI<br>BE PRECEDED BY FULL<br>NTIFYING INFORMATION)                         |                                                                                                                   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                 | (X5)<br>COMPLETION<br>DATE          |
| K 000                    | INITIAL COMMENT                                                                                                                                                                                                                                              | ſS                                                                                            |                                                                                                                   | K 000                   |                                                                                                       |                         |                                     |
|                          | FIRE SAFETY                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                   |                         |                                                                                                       |                         |                                     |
|                          | Minnesota Departm<br>time of this survey,<br>Home was found in<br>requirements for pa<br>Medicare/Medicaid<br>483.70(a), Life Safe<br>edition of National F                                                                                                  | at 42 CFR, Subpart<br>ety from Fire, and the<br>Fire Protection Asso<br>01, Life Safety Code  | At the<br>heran<br>2<br>2012<br>ciation                                                                           |                         |                                                                                                       |                         |                                     |
|                          | Good Shepherd Ho<br>partial basement. T<br>6 different times:<br>The original building<br>was determined to<br>construction. In 19<br>the east that was do<br>(111) construction.<br>added to the northw                                                     | 69, an addition was<br>etermined to be of T<br>In 1980, an additior<br>vest that was determ   | ling with a<br>structed at<br>1963 and<br>added to<br>ype II<br>was<br>nined to be                                |                         |                                                                                                       |                         |                                     |
| LABORATO                 | the west that was d<br>(111) construction.<br>In 2002, an addition<br>Dining Room that w<br>(111) construction.<br>was added that was<br>(111) construction I<br>corner of the facility<br>In 2010 a two story<br>determined to be o<br>located on the north | addition was added<br>f Type II (111) constr<br>heast corner of the f<br>ddition was added th | Type V<br>Main<br>e of Type V<br>addition<br>of Type II<br>west<br>that was<br>that was<br>acility. In<br>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<br>APPROVED<br>0938-0391 |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NUI                           |                                                                                              |                       | PLE CONSTRUCTION<br>G 01 - MAIN BUILDING 01                                                              | (X3) DATE SU<br>COMPLET |                                     |
|                          | 245269                                                                                                                                                                                                                                                                                                                                                         |                                                                       |                                                                                              | B. WING               |                                                                                                          | 06/15                   | /2018                               |
|                          |                                                                                                                                                                                                                                                                                                                                                                |                                                                       |                                                                                              |                       | STATE, ZIP CODE                                                                                          |                         |                                     |
| GOOD                     | SHEPHERD LUTHEF                                                                                                                                                                                                                                                                                                                                                |                                                                       |                                                                                              | H AVENUI<br>RAPIDS, M |                                                                                                          |                         |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY MUST                                                                                                                                                                                                                                                                                                                                          | ATEMENT OF DEFICIENCI<br>BE PRECEDED BY FULL<br>NTIFYING INFORMATION) | REGULATORY                                                                                   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE                  | (X5)<br>COMPLETION<br>DATE          |
| K 000                    | Continued From particular<br>determined to be of<br>located north of the<br>The building is fully<br>sprinkler system is<br>NFPA 13 the Stand<br>Sprinkler Systems of<br>a manual fire alarm<br>detection and smok<br>the corridors. The<br>automatic fire depa<br>installed in accorda<br>National Fire Alarm<br>The facility has a ca<br>census of 158 at th | age 1<br>Type V (111) constr                                          | and the<br>nce with<br>of<br>acility has<br>r smoke<br>es open to<br>for<br>nd<br>The<br>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<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                     | . ,                     | E CONSTRUCTION                                                                                                 | (X3) DATE<br>COMP | SURVEY<br>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<br>PIDS, MN 5 |                                                                                                                |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                     | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                       | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Initial Comments                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                           | 2 000                   |                                                                                                                |                   |                          |
|                          | *****ATTEI                                                                                                                                                                                                                                                                                                                                                           | NTION*****                                                                                                                                                                |                         |                                                                                                                |                   |                          |
|                          | NH LICENSING                                                                                                                                                                                                                                                                                                                                                         | CORRECTION ORDER                                                                                                                                                          |                         |                                                                                                                |                   |                          |
|                          | 144A.10, this correct<br>pursuant to a surver<br>found that the defic<br>herein are not corrected shall<br>with a schedule of f<br>the Minnesota Depa<br>Determination of wh<br>corrected requires of<br>requirements of the<br>number and MN Ru<br>When a rule contain<br>comply with any of<br>lack of compliance.<br>re-inspection with a<br>result in the assess | nether a violation has been                                                                                                                                               |                         |                                                                                                                |                   |                          |
|                          | that may result from<br>orders provided tha<br>the Department wit                                                                                                                                                                                                                                                                                                    | hearing on any assessments<br>n non-compliance with these<br>t a written request is made to<br>hin 15 days of receipt of a<br>ant for non-compliance.                     |                         |                                                                                                                |                   |                          |
|                          | receipt of State lice<br>the Minnesota Depa<br>Informational Bullet<br>http://www.health.st<br>obul.htm The State<br>delineated on the a                                                                                                                                                                                                                             | participate in the electronic<br>nsure orders consistent with<br>artment of Health<br>in 14-01, available at<br>tate.mn.us/divs/fpc/profinfo/inf<br>clicensing orders are |                         |                                                                                                                |                   |                          |
| ABORATOR                 | epartment of Health<br>Y DIRECTOR'S OR PROVID<br>ically Signed                                                                                                                                                                                                                                                                                                       | ER/SUPPLIER REPRESENTATIVE'S SIGI                                                                                                                                         | NATURE                  | TITLE                                                                                                          |                   | (X6) DATE<br>07/06/18    |

Electronically Signed

If continuation sheet 1 of 17

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

G59911

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

G59911

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

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If continuation sheet 4 of 17

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                            |                           | CONSTRUCTION                                                                                |             | E SURVEY<br>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<br>PIDS, MN 56 |                                                                                             |             |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 690                    | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | age 4                                                                                                                                                                                                                                                                                                                            | 2 690                     |                                                                                             |             |                         |
| 2 690                    | requested signed and dated copy of current<br>medication list and treatments which were<br>attached. R149's record indicated the receiving<br>facility was faxed current medication, treatment,<br>signed admission form, signed history and<br>physical however, the record lacked a<br>recapitulation of the R149's stay, including<br>diagnoses, course of illness, treatment, and/or<br>therapy, and pertinent lab, radiology, and<br>consultation results, including any pending lab<br>results or a post discharge plan of care.<br>R149's progress note, dated 4/11/18, indicated<br>the social worker provided referral information to<br>the new facility's intake coordinator for review.<br>R149's progress note dated 4/17/18, indicated<br>R149 left via care cab, paperwork sent with, note<br>did not indicate what was sent and a blank<br>recapitulation summary form was located in<br>R149's record. |                                                                                                                                                                                                                                                                                                                                  |                           |                                                                                             |             |                         |
|                          | director of social se<br>blank recapitulation<br>was found in the di<br>asked how they su<br>R149's stay, SS-A<br>fill out" in reference<br>form.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | v on 6/14/18, at 1:52 p.m. the<br>ervice (SS)-A reviewed the<br>n summary form for R149 that<br>ischarge record and when<br>mmarized and recapped<br>stated "That's what we usually<br>e to the blank recapitulation                                                                                                             |                           |                                                                                             |             |                         |
|                          | manager (CM)-A in<br>summary is a com-<br>services and the ca<br>information to be g<br>CM-A further indica<br>send would be nur-<br>needs, medication,<br>further indicate it w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | v on 6/14/18, at 2:24 p.m. case<br>adicated the discharge<br>bined effort between social<br>ase manager to collect<br>iven to the receiving facility.<br>ated the information they would<br>sing needs, oxygen, diabetic<br>, or therapy information. CM-A<br>yould be standard regardless if<br>nome or to another facility and |                           |                                                                                             |             |                         |

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

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

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

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

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

|                                           | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                    |                             |                                                                                |                                   | E SURVEY<br>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<br>APIDS, MN 56 |                                                                                |                                   |                         |
| (X4) <b>I</b> D<br>PREF <b>I</b> X<br>TAG | (EACH DEFICIENC                                                                                                                                   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                     | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                                     | Continued From pa                                                                                                                                 | age 10                                                                                                                                                                                   | 2 830                       |                                                                                |                                   |                         |
|                                           | R448's Task List/Assignments dated 5/30/18,<br>identified R448 as a falls risk, but did not include<br>any interventions to ensure R448's safety. |                                                                                                                                                                                          |                             |                                                                                |                                   |                         |
|                                           | resting in recliner w<br>across lap, and no<br>to be across the ro                                                                                | 1 p.m. R448 was observed<br>vith feet reclined, blanket<br>call light. Call light was noted<br>om, attached to the bed rail,<br>ype call light, not a soft touch<br>e care plan.         |                             |                                                                                |                                   |                         |
|                                           | nursing assistant (I<br>her call light to aler<br>verified the call ligh<br>NA-E stated staff for                                                 | on 6/12/18, at 2:55 p.m.<br>NA)-E verified R448 would use<br>t staff of her needs, and<br>ht was not within her reach.<br>orgot to put the call light by her<br>the bed rail to her lap. |                             |                                                                                |                                   |                         |
|                                           | registered nurse (F                                                                                                                               | on 6/12/18, at 3:10 p.m. the<br>RN)-E stated, "I would expect<br>re their call light within reach."                                                                                      |                             |                                                                                |                                   |                         |
|                                           |                                                                                                                                                   | on 6/14/18, at 1:12 p.m. the<br>(DON) stated, "I would expect<br>heir call light."                                                                                                       |                             |                                                                                |                                   |                         |
|                                           | directs staff with guo                                                                                                                            | ity's Falls Policy, revised 5/11,<br>uidelines to follow after a fall<br>did not indicate any<br>eventatives for falls in this                                                           |                             |                                                                                |                                   |                         |
|                                           | The director of nurse<br>review and revise a<br>procedures related<br>daily living as well a                                                      | THOD OF CORRECTION:<br>sing (DON) or designee could<br>any applicable policies and<br>I to assistance with activities of<br>as safety and supervision in<br>placement and educate all    |                             |                                                                                |                                   |                         |

| STATEMEN                                  | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                            | . ,                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E SURVEY<br>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<br>PIDS, MN 5 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |
| (X4) <b>I</b> D<br>PREF <b>I</b> X<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                 | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X5)<br>COMPLET<br>DATE |
| 2 830                                     | Continued From pa                                                                                                                                                                                                                                                                                               | age 11                                                                                                                                                                                                                                                                                                                                                                                                                           | 2 830                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |
|                                           |                                                                                                                                                                                                                                                                                                                 | designee could audit to ensure<br>e and report the audit results<br>evement group.                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |
|                                           | TIME PERIOD FO<br>(21) days.                                                                                                                                                                                                                                                                                    | R CORRECTION: Twenty-one                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |
| 21385                                     | MN Rule 4658.080<br>Staff assistance                                                                                                                                                                                                                                                                            | 0 Subp. 3 Infection Control;                                                                                                                                                                                                                                                                                                                                                                                                     | 21385                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7/20/18                 |
|                                           | Personnel must be<br>infection control pro<br>the residents and r                                                                                                                                                                                                                                               | sistance with infection control.<br>assigned to assist with the<br>ogram, based on the needs of<br>nursing home, to implement<br>ocedures of the infection                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |
|                                           | by:<br>Based on observat<br>review, the facility f<br>hand hygiene inclu<br>use of gloves was<br>residents (R145, R<br>cares, and 1 of 1 re<br>wound care.<br>Findings include:<br>R145's 14 day PPS<br>dated 5/17/18, india<br>intact. R145 require<br>mobility, transfers,<br>dressing. R145 had<br>catheter. | ent is not met as evidenced<br>tion, interview, and document<br>failed to ensure appropriate<br>ding hand washing and proper<br>implemented for 2 of 6<br>105) observed for personal<br>esidents (R33) observed for<br>6 Minimum Data Set (MDS),<br>cated R145 was cognitively<br>ed extensive assist with bed<br>personal hygiene, and<br>d an indwelling urinary<br>as on 6/13/18, at 7:27 a.m.<br>NA)-A and nursing assistant |                         | Good Shepherd does establish and<br>maintain an infection prevention and<br>control program designed to provide a<br>safe, sanitary and comfortable<br>environment and help to prevent the<br>development and transmission of<br>communicable diseases and infections.<br>Regarding residents 145 and 105 the<br>facility recognizes that during one<br>observation for each resident staff did not<br>wash their hands after removing soiled<br>gloves. Good Shepherds expectations of<br>staff is to follow best practice of infection<br>control guidelines.<br>Regarding resident number 33 the facility<br>recognizes that during one observation a<br>nurse did not change gloves in between<br>removing a dressing and replacing it with<br>a new one. Good Shepherds expectations |                         |

G59911

If continuation sheet 12 of 17

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

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

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

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

| ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION A. BUILDING:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| HEPHERD LUTHERA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                   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| SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                   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| The director of nur-<br>review training pro-<br>hand hygiene and g<br>care and glove use<br>(DON) or designee<br>systems to ensure<br>infection control po-<br>report those results<br>group.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | sing (DON) or designee could<br>vided and educate staff on<br>glove use related to personal<br>e. The director of nursing<br>e could develop auditing<br>ongoing compliance with<br>olicies and procedures and<br>s to the quality improvement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                        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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | T OF DEFICIENCIES<br>OF CORRECTION<br>PROVIDER OR SUPPLIER<br>HEPHERD LUTHERA<br>SUMMARY ST.<br>(EACH DEFICIENC<br>REGULATORY OR<br>Continued From pa<br>symptoms of infec<br>hands and apply n<br>clean dressing. RN<br>to follow the policy<br>completed compet<br>staff development,<br>related to hand hys<br>Review of the facil<br>Protocol, dated 4/1<br>necessary to wear<br>shall utilize gloves<br>their hands after re-<br>included, "Gloves a<br>become contamina<br>gloves donned bef<br>SUGGESTED ME<br>The director of nur<br>review training pro-<br>hand hygiene and<br>care and glove use<br>(DON) or designee<br>systems to ensure<br>infection control por<br>report those result<br>group.<br>TIME PERIOD FO | TOF DEFICIENCIES<br>OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         O0023       00023         PROVIDER OR SUPPLIER       STREET A<br>1115 4TH<br>SAUK R.         TEPHERD LUTHERAN HOME       1115 4TH<br>SAUK R.         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 16         Symptoms of infection, take gloves off, wash<br>hands and apply new gloves before putting on a<br>clean dressing. RN-A stated she expects nurses<br>to follow the policy and stated nurses have<br>completed competency's, have on line training,<br>staff development, and training in nursing school<br>related to hand hygiene with dressing change.         Review of the facility's policy, Hand Hygiene<br>Protocol, dated 4/18, included, "When it is<br>necessary to wear gloves for personal cares, staff<br>shall utilize gloves during those cares and wash<br>their hands after removing the gloves." Also<br>included, "Gloves shall be removed, when gloves<br>become contaminated, hands washed and clean<br>gloves donned before returning to tasks."         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WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST<br>1115 4TH AVENUE NOI<br>SAUK RAPIDS, MN 56         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX<br>PREFIX<br>TAG         Continued From page 16       21385         symptoms of infection, take gloves off, wash<br>hands and apply new gloves before putting on a<br>clean dressing. RN-A stated she expects nurses<br>to follow the policy and stated nurses have<br>completed competency's, have on line training,<br>staff development, and training in nursing school<br>related to hand hygiene with dressing change.         Review of the facility's policy, Hand Hygiene<br>Protocol, dated 4/18, included, "When it is<br>necessary to wear gloves for personal cares, staff<br>shall utilize gloves during those cares and wash<br>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<br>SAUK RAPIDS, MN 56379         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MIST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTIO<br>(EACH DEFICIENCY MIST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX<br>TAG       CROSS-REFERENCED TO THE<br>DEFICIENCY         Continued From page 16       21385       21385         symptoms of infection, take gloves off, wash<br>hands and apply new gloves before putting on a<br>clean dressing, RN-A stated she expects nurses<br>to follow the policy and stated nurses have<br>completed competency's, have on line training,<br>staff development, and training in nursing school<br>related to hand hygiene with dressing change.       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CITY, STATE, ZIP CODE         'HEPHERD LUTHERAN HOME       1115 4TH AVENUE NORTH<br>SAUK RAPIDS, MN 56379       PROVIDER'S PLAN OF CORRECTION<br>(EACH DEPICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTFYING INFORMATION)       ID<br>PREFK<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         Continued From page 16       21385         symptoms of infection, take gloves off, wash<br>hands and apply new gloves before putting on a<br>clean dressing, RN-A stated she expects nurses<br>to follow the policy and stated nurses have<br>completed competency's, have on line training,<br>staff development, and training in nursing school<br>related to hand hygiene with dressing change.         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