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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M9U0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**
2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 08/26/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective August 20, 2013, the facility is certified for 75 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 09/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specicialist 12/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/09/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5393 December 26, 2013

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, Minnesota 55971

Dear Mr. Lindh:

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 August 20, 2013, the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 20, 2013

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, Minnesota 55971

RE: Project Number S5393022

Dear Mr. Lindh:

On July 24, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 11, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 26, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 21, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 11, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 11, 2013, effective August 20, 2013 and therefore remedies outlined in our letter to you dated July 24, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245393	A. Building B. Wing	8/26/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/06/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/06/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/06/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/06/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/06/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GN/AK	**Date:** 09/20/2013	**Signature of Surveyor:** 10160	**Date:** 08/26/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/11/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245393	A. Building B. Wing **01 - MAIN BUILDING 01**	8/21/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/20/2013**	ID Prefix	Correction Completed **08/09/2013**	ID Prefix	Correction Completed **08/02/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0045		LSC K0062	
ID Prefix	Correction Completed **08/02/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 09/20/2013	**Signature of Surveyor:** 25822	**Date:** 08/21/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/11/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M9U0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**

2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/11/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the July 11, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Michelle McFarland, HFE NEII 08/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
09/07/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2833

July 24, 2013

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, Minnesota 55971

RE: Project Number S5393022

Dear Mr. Lindh:

On July 11, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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>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;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731

Fax: (507) 206-2711

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 August 20, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 20, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 October 11, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 11, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____ AUG 8 - 2013 MN Dept of Health Rochester	07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) 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. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	See attachment #1 8/13/2013 sPN	8/6/13 sPN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas C Reindl — TITLE: Administrator — (X6) DATE: 8/6/2013

A 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.

Tag	Good Shepherd Lutheran Home Plan of Correction Attachment number 1	Complete Date
F 279	**Corrective Action:** R29's skin was reassessed for bruising on 7/11/13. His skin assessment was then updated to include a bruise on his left hand ring finger and his risk related to the use of the blood thinning agent Coumadin. His care plan was revised to include the above findings, interventions to prevent further bruising and the potential for increased/further bruising related to the use of Coumadin and his level of independence. **Identification:** An audit identifying all residents in the facility on blood thinning agents was conducted. Each resident identified had their skin reassessed for bruising, care plan reviewed and updated to include the risk for increased bleeding/bruising along with interventions to prevent further bruising. **Measures:** Each identified resident's comprehensive care plan was reviewed for proper documentation to identify risk for increased bleeding/bruising, preventative measures to decrease risk and nursing direction to report bruising. Good Shepherd skin assessment, which is utilized during development of each resident's comprehensive care plan, was reviewed and revised to incorporate quick identification of resident's risks while on blood thinning agents. All nurse Case Managers were in-serviced to include in their comprehensive care plan risk identification and preventive measures for those on blood thinning agents and nursing direction regarding reporting bruising. Good Shepherd's policy on Bruising was reviewed and found to be accurate. All nursing department staff were re-educated during the mandatory Plan of Corrections in-service held on 8/6/13 on Good Shepherd's *Bruise and Injury, Policy, Procedure and Investigation Form.* **Monitoring:** Initial audit was conducted by the Director of Nursing on all residents that were identified as being on blood thinning agents. All current resident care plans include the above required documentation. Quality Improvement Coordinator will perform audits on all new admits and current residents starting a blood thinning agent x 3 months, then random audits x 3 months. Audit findings will be shared with the QA Committee which meets quarterly.	7/11/13 8/6/13 8/6/13

	Responsible Person: Clinical Case Managers monitored by the Quality Improvement Coordinator and the Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____ AUG 8 - 2013 MN Dept of Health Received	07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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F 279	Continued From page 1 by: Based on observation, interview and document review, the facility failed to develop a care plan for increased risk of bruising while on Coumadin (anticoagulant-blood thinner) for 1 of 3 residents (R29) observed for non-pressure related skin conditions. Findings include: R29 had a history of having ongoing bruising while on Coumadin however, the care plan did not identify interventions to prevent or reduce bruising. Also there was no direction as to report the bruise to nursing to determine likely cause and/or rule out possible abuse. R29 was admitted on 1/29/07 with diagnoses including but not limited to atrial fibrillation and chronic kidney disease. R29's quarterly Minimum Data Set dated 4/19/13 identified R29 was independent with set up help with bed mobility, transfers and personal hygiene and required limited assistance with one staff with dressing. R29's brief interview for mental status completed on the Minimum Data Set indicated R29 was alert and oriented. During review of R29's physician orders noted R29 received Coumadin (medication used to thin the blood and potential to cause increased risk for bleeding/bruising) on a daily basis. During stage I observation on 7/9/13, a bruise was noted on left hand ring finger. During review of the care plan date (initiated) 2/18/07, it was noted there was no interventions developed to identify R29's risk for bruising	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ AUG 8 - 2013 B. WING _____ MN Dept of Health Rochester	07/11/2013

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F 279	Continued From page 2 related to Coumadin therapy. During interview on 7/10/13 at 11:25 a.m., registered nurse (RN)-B verified there was no care plan to identify risk for bruising and indicated they would have expected the fragile skin risk for bruising to be care planned. During interview on 7/11/13 at 8:49 a.m., the director of nursing (DON) confirmed they would have expected the risk for bruising to be care planned. During interview on 7/11/13 at 1:35 p.m. the DON confirmed no care plan policy available.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess the continued need for the use of a prophylactic urinary tract infection (UTI) antibiotic (Macrodantin) for 1 of 2 residents (R47) reviewed for urinary incontinence.	F 315	see attachment #2	8/6/13 SDN

Tag	Good Shepherd Lutheran Home Plan of Correction Attachment number 2	Complete Date
F 315	**Corrective Action:** The use of R47's macrodantin to prevent urinary tract infections was specifically addressed by her primary physician on 8/5/13. MD records from Gunderson regarding initiation of the medication and urinary history were reviewed at that time along with current bladder assessment, orders and diagnoses per Policy and Procedure. MD ordered to stop macrodantin for UTI prophylaxis and re-assess in 6 months for the number of urinary tract infection episodes. If < 2, continue off UTI antimicrobial prophylaxis, if ≥ 2, consider reinitiation of UTI antimicrobial prophylaxis with trimethoprim 100 mg po qday. **Identification:** All current residents' medications were reviewed for prophylactic antibiotics used to prevent urinary tract infections to ensure a complete comprehensive assessment was performed. **Measures:** Newly created policy and procedure for use of prophylactic antibiotics was established to ensure each resident receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Per Policy and Procedure the required documentation includes urinary function history, reason for initiation of the prophylactic antibiotic, duration to-date, current bladder assessment noting recurrent UTIs, physician complete review noting justification for continued use along with risk factors associated with prolonged use and physician ordered review date. Each resident identified on a prophylactic antibiotic for urinary tract infections was re-assessed per Policy and Procedure. Good Shepherd Temporary Care Plan for Infections will be filled out for all antibiotic use including those residents noted to have them ordered upon admission. This form was updated to include a line to indicate if the antibiotic is used prophalactically and the need for the above noted documentation. All nursing department staff were educated on the required documentation per Policy and Procedure during the mandatory Plan of Corrections in-service held on 8/6/13. **Monitoring:** Bi-monthly audit x 3 months, then once a month x 3 months to ensure proper clinical justification is present for the use of	8/6/13 8/6/13 8/6/13

	prophylactic antibiotics used to prevent urinary tract infections per Policy and Procedure. Findings will be shared with the QA Committee which meets quarterly. **Responsible Person:** Clinical Case Manager monitored by the Quality Improvement Coordinator and Director of Nursing.	

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F 315	Continued From page 3 Findings include: R47 had received prophylactic antibiotic therapy for chronic UTI since admission to the facility on 2/28/13 and there was no comprehensive assessment and physician justification as to why it should be used prophylactically for this resident. R47 had been admitted to the facility on 2/28/13, with diagnoses included acute kidney failure and altered mental status. During review of the medical record it was noted that R47 had a physician order for Macrodantin (an antibiotic) 50 milligram (mg) by mouth daily with a start date of 2/28/13. Review of R47's bladder assessment dated 3/4/13, identified R47 as having continent of urine and had no current history of UTI. The comprehensive assessment lacked identification of the use of the antibiotic. Further review of the medical record revealed no documentation of a physician ' s clinical justification for the continued use of the antibiotic and no documentation to evaluate the risk factors for continued use of an antibiotic. During interview on 7/11/13, at 9:03 a.m. registered nurse (RN)-A stated no specific discussion had been held with the physician to identify the continued use of the antibiotic and confirmed no documentation had been identified to indicate clinical justification for continued use of an antibiotic prophylactically.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329	see attachment #3	8/6/13 dpn

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F 329	Continued From page 4 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an antibiotic was not used for an excessive duration or a physician ' s clinical justification as to why the antibiotic was used for ongoing prophylactic use for 1 of 11 residents (R47) who received Macrodantin antibiotic daily and in addition the facility failed to obtain an annual digoxin level to determine if the medication was in a safe blood level range for 1 of 11 resident (R3) who received digoxin daily which was noted during the review for unnecessary medications.	F 329		

Tag	Good Shepherd Lutheran Home Plan of Correction Attachment number 3	Complete Date
F 329	**Corrective Action:** The use of R47's macrodantin to prevent urinary tract infections was specifically addressed by her primary physician on 8/5/13. MD records from Gunderson regarding initiation of the medication were reviewed at that time along with current bladder assessment, orders and diagnoses per Prophylactic Antibiotic Policy and Procedure. MD reviewed the pharmacy consultant's recommendation and ordered stop macrodantin for UTI prophylaxis and re-assess in 6 months for the number of urinary tract infection episodes. If < 2, continue off UTI antimicrobial prophylaxis, if ≥ 2, consider reinitiation of UTI antimicrobial prophylaxis with trimethoprim 100 mg po qday. R3's digoxin level was obtained on 7/22/13 and reviewed by her primary physician who made no changes at this time. MD ordered recheck digoxin level in the following situations: suspected toxicity (e.g. bradycardia or slowed heart rhythm or less than 50bpm), presence of new diseases (e.g. CHF exacerbation) or physiologic changes (e.g. renal impairment, thyroid disease). **Identification:** All current residents' medications were reviewed for use of prophylactic antibiotics used to prevent urinary tract infections. All current resident medications were reviewed for the use of digoxin preparations. **Measures:** Pharmacy Consultant reviewed all current residents for unnecessary prophylactic medications. Recommendations were provided and reviewed by their primary physician. Each resident orders along with their bladder assessment was reviewed for the required justification and documentation listed in the newly created Prophylactic Antibiotic Policy and Procedure. All were reviewed to ensure these medications are not given for excessive duration without adequate indications for there use. All nursing department staff were educated on the required documentation per Policy and Procedure during the mandatory Plan of Corrections in-service held on 8/6/13. Pharmacy Consultant recommendation to review digoxin levels on an individualized basis was reviewed by the Medical	8/6/13 7/22/13 8/6/13 8/6/13 8/6/13 8/6/13

Director. MD ordered to remove annual lab test to monitor digoxin levels from standing orders. Pharmacy Consultant reviewed all residents currently taking digoxin and made recommendations for monitoring based on their current status, renal function and most recent lab value. These recommendations were reviewed by their primary physician who ordered individualized monitoring. Case Managers were educated and will have all new admissions admitted on digoxin reviewed and individual orders for monitoring will be established by their primary physician. All nursing department staff were educated on the change in lab standing orders and requirement for follow-up on an individualized basis during the mandatory Plan of Corrections in-service held on 8/6/13.

Monitoring:
All new admissions and current residents that have antibiotics initiated during their stay will be screened for use of prophylactic antibiotics during the daily management meeting for required documentation per Policy and Procedure. Findings will be reviewed with QA Committee.

Audit to ensure individualized monitoring orders for residents receiving digoxin has been done on all current residents and are up-to-date. A monthly audit of all new admits will be conducted x 4 months, then every other month x 4 months. Results will be shared with the QA Committee which meets quarterly.

Responsible Person:
Clinical Case Manager monitored by Quality Improvement Coordinator and Director of Nursing.

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MN Dept of Health

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F 329	Continued From page 5 Findings include: R47 received Macrodantin (an antibiotic) prophylactically to prevent a urinary tract infection (UTI) from developing. However, the facility had failed to have a physician's justification as to why the antibiotic was used for long term use. R47 had been admitted to the facility on 2/28/13, with diagnoses that included acute kidney failure and altered mental status. Review of R47's physicians' orders included Macrodantin 50 milligram (mg) by mouth daily with a start date of 2/28/13, for UTI prophylaxis. Review of R47 ' s care plan dated 3/14/13; indicated R47 had a history of repeated UTI's. Further review of the record revealed R47 had no UTIs since admission to the facility and was treated with antibiotic daily since admission. During interview on 7/11/13, at 9:03 a.m. registered nurse (RN)-A verified after they had reviewed R47 ' s medical records that they had been unable to locate any information from a physician providing justification for the continued use of the prophylactic antibiotic. During interview on 7/11/13, at 9:51 a.m. the director of nursing (DON) stated R47 was admitted to the facility on the prophylactic antibiotic for recurrent UTI's. The DON stated justification for continued use should have been located in R47's medical record. R3 had received daily digoxin (medication used for heart rhythm) however; a yearly recommended digoxin blood level had not been completed within the last 12 months.	F 329		

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F 329	Continued From page 6 R3 was admitted on 9/9/2009, with diagnoses that included but not limited to atrial fibrillation. R3 had a physician order for digoxin 0.125 milligram (mg) by mouth (PO) twice a day (bid). Good Shepherd Lutheran Home Lab Services Protocol signed by the physician on 10/16/12 reads " Diagnosis/Medications: Lanoxin [digoxin] use; Lab Test: Dig [digoxin level] Level; Frequency: Q [every] year once stable. " During document review on 7/11/13, no laboratory test had been obtained over the past year for digoxin level. During interview on 7/11/13 at 8:23 a.m., registered nurse (RN)-C indicated should have had a digoxin level completed annually and verified no digoxin level was located in the chart for the past year. During interview on 7/11/13 at 8:52 a.m., the director of nursing (DON) verified the facility requirement was to obtain a digoxin level every year once stable. The DON indicated the lab orders for a digoxin level were on the doctor standing orders.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	See attachment #5	8/6/13 HPN

Attachment F F371

8-6-13

Labeling and Dating.

Dietary staff were reminded on 7-8-13 to date all food items that they open and to reseal all opened bags of food.

The Dietary Manager held an inservice with all dietary staff on 8-1-13 to review the labeling and dating policy, staff completed a quiz on labeling and dating. Dietary staff who were unable to attend the inservice will make up the inservice by 8-15-13 or will be taken off of the schedule until the inservice is completed. The Dietary Manager will use the "Audit for Checking for Food Outdates and Food Labeling" to ensure the policy is followed. The Dietary Manager will monitor two times a week for one month, one time a week for a month and then monthly.

LABELING AND DATING FOOD ITEMS

POLICY: Dietary staff will label and date all food items that they open , seal open bags with a twist tie or scotch tape.

Why do we date food products?

1. Ensure the food is consumed while at peak quality.
2. To ensure food is consumed before it may spoil or cause a food borne illness.
3. To help track when a product was produced in the event of a recall.
4. To help rotate food so that the oldest product is used first.
5. To maintain freshness.

PROCEDURE

1. **On each container, package, bag etc, write the date that the product was opened, seal all opened bags with a twist tie or scotch tape.**

9-2-05 sa
Reviewed and Revised 3-23-06 sa
Reviewed & Revised 2-3-09 SA, 1-5-2010 SA, 10-16-12 SA, 6-3-13 SA, Reviewed and Revised 7-25-13 SA

Name:
Date:
Job Title:

Dietary Inservice (8-1-13)
Topic : Labeling and Dating Food Items

1. Why do we date food products?

2. What is the procedure for labeling food items and sealing?

3. Where do you find the guide for discarding food items?

Audit for Checking for Food Outdates and Food Labeling

	Yes	No	Comments
All food in walk in cooler is labeled and dated if opened?			
All outdated food in walk in cooler is disposed of?			
All food in cupboards is labeled and dated if opened?			
All outdated food in cupboard is disposed of?			
All food in dry store room is labeled and dated if opened?			
All outdated food in dry store room is disposed of?			
Opened packages are sealed properly			

Additional Comments:_____

_____

_____

_____

_____

_____

_____

_____

Auditor:_____

Date:_____

8/2013 kjd

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food containers were sealed when not in use and dated as to when they were opened. This had the potential to affect 71 of 71 residents residing in the facility. Findings include: During the initial tour of the main kitchen on 7/8/13, at 1:10 p.m., four 10 pound bags of noodles were kept in the dry storage area. All four bags were not dated as to when they were opened and one of the bags had not been resealed. During interview on 7/8/13, at 1:10 p.m., dietary aide-A verified the four bags of noodles were not dated and one had no twister on to hold the bag closed. DOCUMENT REVIEW OF LABELING AND DATING FOOD ITEMS a facility policy dated 6/3/13, read, "Dietary staff will label and date all food items that they open." PROCEDURE "1. On each container, package, bag etc., write the date that the product was opened."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428	See attachment #4	8/6/13 SPH

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F 428	Continued From page 8 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the consulting pharmacist failed to report irregularities concerning the lack of documentation for justification for the continued use of a prophylactic antibiotic for 1 of 11 residents (R47) and failed to ensure the consultant pharmacist reviewed documentation for a digoxin level for 1 of 11 resident (R3) reviewed for unnecessary medications. Findings include: R47 received daily Macrodantin (an antibiotic) prophylactically and the medical record did not include a clinical justification for prophylactic use. The consultant pharmacist had not reported this irregularity to the attending physician and to the director of nursing. R47 had been admitted to the facility on 2/28/13, with diagnoses that included acute kidney failure and altered mental status. Review of R47's physicians' orders included Macrodantin 50 milligram (mg) by mouth daily with a start date of 2/28/13, for UTI prophylaxis. Review of R47 ' s care plan dated 3/14/13; indicated R47 had a history of repeated UTI's. Further review of the record revealed R47 had no UTIs since admission to the facility and was	F 428		

Tag	Good Shepherd Lutheran Home Plan of Correction Attachment number 4	Complete Date
F 428	**Corrective Action:** Pharmacy Consultant was instructed to review R47's chart and provide the Director of Nursing with recommendations to clinically justify the use of macrodantin in a prophylactic manner for this resident. Recommendations were reviewed with R47's primary physician. The use of R47's macrodantin to prevent urinary tract infections was specifically addressed by her primary physician on 8/5/13. MD records from Gunderson regarding initiation of the medication were reviewed at that time along with Pharmacy Consultant recommendation, current bladder assessment, orders and diagnoses per Prophylactic Antibiotic Policy and Procedure. MD reviewed the pharmacy consultant's recommendation and ordered stop macrodantin for UTI prophylaxis and re-assess in 6 months for the number of urinary tract infection episodes. If < 2, continue off UTI antimicrobial prophylaxis, if ≥ 2, consider reinitiation of UTI antimicrobial prophylaxis with trimethoprim 100 mg po qday. R3's digoxin level was obtained and reviewed by the physician on 7/22/13 with no medication changes made at that time. Pharmacy Consultant was instructed to review R3's chart and provide the Director of Nursing with recommendations based on their current status, renal function and most recent lab value. Recommendation was reviewed with resident's primary physician who ordered to recheck digoxin level in in the following situations: suspected toxicity (e.g. bradycardia or slowed heart rhythm or less than 50bpm), presence of new diseases (e.g. CHF exacerbation) or physiologic changes (e.g. renal impairment, thyroid disease). **Identification:** Pharmacy Consultants were instructed to review all resident medications for antibiotics used to treat urinary tract infections in a prophylactic manner and provide the Director of Nursing with recommendations to justify the use of each antibiotic identified. Director of Nursing also reviewed all current residents' medication lists for antibiotics used to ensure proper documentation to justify continued use per Policy and Procedure. Pharmacy Consultants were instructed to review all residents' medications for use of digoxin and provide recommendations for blood level monitoring based on current status, renal	8/6/13 7/22/13 8/6/13 8/6/13

	Responsible Party: Case Managers, Quality Improvement Coordinator, Director of Nursing	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 9 treated with antibiotic daily since admission. During interview on 7/11/13, at 9:03 a.m. registered nurse (RN)-A verified after they had reviewed R47 ' s medical records that they had been unable to locate any information from a physician providing justification for the continued use of the prophylactic antibiotic. During interview on 7/11/13, at 9:51 a.m. the director of nursing (DON) stated R47 was admitted to the facility on the prophylactic antibiotic for recurrent UTI's. The DON stated justification for continued use should have been located in R47's medical record. R3 had received daily digoxin (medication used for heart rhythm) and a digoxin blood level had not been completed within the last year and had not been identified by the consultant pharmacist. R3 was admitted on 9/9/2009, with diagnoses that included but not limited to atrial fibrillation. R3 had a physician order for digoxin 0.125 milligram (mg) by mouth (PO) twice a day (bid). During document review on 7/11/13, no laboratory test had been obtained over the past year for digoxin level. Good Shepherd Lutheran Home Lab Services Protocol signed by the physician on 10/16/12 reads " Diagnosis/Medications: Lanoxin [digoxin] use; Lab Test: Dig [digoxin level] Level; Frequency: Q [every] year once stable. " During review of monthly medication regimen review the consultant pharmacist had not identified no digoxin level was present in R3's	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____	07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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F 428	Continued From page 10 medical record. During interview on 7/11/13 at 8:23 a.m., registered nurse (RN)-C indicated should have had a digoxin level completed annually and verified no digoxin level was located in the chart. During interview on 7/11/13 at 8:52 a.m., the director of nursing (DON) verified the facility requirement was to obtain a digoxin level every year once stable. The DON indicated the lab orders for a digoxin level were on the doctor standing orders. During interview on 7/11/13 at 1:50 p.m., the facility consultant pharmacist indicated had not looked for a digoxin level. The consultant pharmacist indicated they were working on updating the laboratory protocols. The consultant pharmacist was unaware of the digoxin level on the current laboratory protocols and indicated if the protocol form was not present in the electronic file would not routinely review it. It was learned that the monthly pharmacist review was done by computer access through the facility electronic medical records and the pharmacist is not on site during the review. The Good Shepherd Lutheran Home Lab Services Protocol signed by the physician on 10/16/1 was one of many forms that were not on the electronic record.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2013**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	RECEIVED AUG - 6 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok JB 8-12-13	

DC: 08.20.2013

EXIT: 07.11.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas C Smith — TITLE: Administrator — (X6) DATE: 8/5/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2013**

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Shepherd Lutheran Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1982, an addition was constructed and was determined to be of Type II(111) construction, with a partial basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkled as 07/26/2012. The facility has full corridor smoke detection, spaces open to the corridors and resident sleep rooms that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2013**

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K 000	Continued From page 2 The facility has a capacity of 75 beds and had a census of 73 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 30 out of 75 residents. Findings include: On facility tour between 9:15 AM and 1:45 PM on 07/11/2013, observation revealed that the following was found:	K 029	Plywood in linen storage room will be replaced with sheet rock. Fire rated caulking will be applied between the sheet rock and walls Duane Franzwa Environmental services will assure this is completed 8/9/13 Entrance doors to the laundry room, wheelchair storage room, and maintenance repair shop room will have magnetic locks tied in to the building fire alarm system. Good Shepherd has contracted with Custom alarm to perform this work Duane Franzwa will assure this is completed 8/20/13	

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	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2013**

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K 029	Continued From page 3 Basement: 1. Linen storage room (over 50 sq ft), east wall has plywood with wood 2 x 4 studs 2. Entrance doors to the following areas are held open by a magnetic that is NOT tied into building fire alarm system: a. Laundry room (over 100 sq ft) b. Wheelchair storage (over 50 sq ft) c. Maintenance repair shop 1st floor: 3. Day care storage rooms (over 50 sq ft) in the east and west sun rooms do not have automatic door closer's These deficient practices were confirmed by the facility maintenance staff (DH) at the time of discovery.	K 029	Automatic door closer's have been ordered and will be installed in the east and west sun rooms. Duane Franzwa will assure this work is completed	~~8/16/13~~
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility failed to provide continuous illumination of exit access corridors in accordance with LSC Sections 19.2.8 and 7.8 . This deficient practice could affect all 73 residents, as well as an undeterminable number of staff and visitors, if an evacuation was hindered due to an	K 045	The one bulb night light fixtures on 1st floor A, B, C, south, east and west access corridors will have an additional bulb installed in each fixture so that if one bulb burned out the required level of continuous illumination would be met. Duane Franzwa will assure work is completed	8/9/13

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K 045	Continued From page 4 unilluminated exit access corridor. Findings include: On facility tour between 9:15 AM and 1:45 PM on 07/11/2013, observation revealed that the light switches on the corridor wall on 1st floor, A, B, C, north, south, east and west exit access corridors controlled all the lights on theses exit access corridors. An interview with the facility maintenance staff (DH) revealed all resident room halls have overhead lights controlled by switches on the wall. With all light switches turned off, the one bulb night light fixture turns on. If one of the night light bulbs burnt out, the exit access corridors would not have the required level of continuous illumination as required by LSC Section 19.2.8 and 7.8.1. These deficient practices were confirmed by the facility maintenance staff (DH) at the time of discovery.	K 045		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system	K 062	Quarterly flow alarm test will be performed and documented - forms are attached. Weekly fire pump runtest will be performed and documented. Form is attached. Duane Franzwa will monitor the work.	8/2/13

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K 062	Continued From page 5 in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-3.3 and 5-3.2.1. This deficient practice could affect all 73 residents. Findings include: On facility tour between 9:15 AM and 1:45 PM on 07/11/2013, the review of the quarter flow alarm report and weekly fire pump run test revealed that the following was found: 1. No documentation for quarterly flow alarm test for 2012 - 3rd, 4th quarters and 2013 - 1st quarter. 2. New fire pump went in service on 7/26/2013. No documentation for fire pump weekly run test as follows: 7/30,8/6,8/13,8/20,8/27,9/10,9/17 and 9/24/2012. These deficient practices were confirmed by the facility maintenance staff (DH) at the time of discovery.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	Generators will be inspected weekly and exercised under load for 30 minutes per month. The method to comply will be to test under load of 30 percent or more of the nameplate rating of generator. New forms will be used (attached) Duane Franzwa will monitor	8/2/13

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K 144	Continued From page 6	K 144		

This STANDARD is not met as evidenced by:
Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 73 residents.

Findings include:

On facility tour between 9:15 AM and 1:45 PM on 07/11/2013, documentation review of the monthly emergency generator testing log (July 2012 to June 2013), indicated that in August, September, October 2012 and January 2013 the facility did not run the diesel emergency generator at 30% of nameplate rating or by one of the following means.

1. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or

2. under load of 30 percent or more of the nameplate rating of generator or

3. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%)

This deficient practice was confirmed by the facility maintenance staff (DH) at the time of discovery.

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K 144	Continued From page 7 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

Custom Alarm | Custom Communications, Inc.
PURCHASE AGREEMENT (PA)

1661 Greenview Dr. SW. Rochester, MN 55902
507.288.5522 | 855.288.5522 | 507.287.0757 fax

Agreement dated 7.26.13, by and between CUSTOM COMMUNICATIONS, INC. dba Custom Alarm (hereinafter "CCi") and

PURCHASER NAME: Good Shepherd Lutheran Home (hereinafter "Purchaser").

BILLING ADDRESS: 800 Home Street

CITY/STATE/ZIP: Rushford, MN 55971

PHONE: _____ TYPE OF SYSTEM: FA System Add

LOCATION OF ALARM SYSTEM (hereinafter "Premises")

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PREMISES PHONE: _____ AGREEMENT # _____

EMAIL ADDRESS: _____

1. CCi agrees to supply and install an alarm system or equipment (hereinafter "Alarm System"), in accordance with the terms and conditions set forth below.

2. **Schedule of Protection:**

DOOR HOLDER #1 #2 and #3
100' OF 16/2 FPLP/THHN CABLING
CONDUIT FROM EXISTING TO NEW DEVICE
ONE (1) Notifier FM998 Door Holder

Door 1 total = $642.00

Door Holder #2 = $357.00

Door Holder #3 = $357.00

CCi to provide equipment listed, cabling, install of devices, programming, and testing.

Good Shepherd to provide installation assistance with cabling/conduit.

INSTALL TO BE COMPLETED BY 8/16/13

Purchaser acknowledges that additional protection may be obtained over and above that provided herein at additional cost. Purchaser agrees to supply, at Purchaser's expense, all electrical, telephone, internet connections, jacks, outlets and receptacles required for CCi to complete its installation and/or service of the Alarm System.

3. **Price.** PURCHASE PRICE: $_____, plus applicable taxes which will be included on final invoice x taxes not applicable

DEPOSIT: Purchaser agrees to pay CCi, or to others as directed by CCi $_____ when this Agreement is signed.

PAYMENT TERMS: Purchaser hereby agrees to pay CCi the balance of the invoice total upon completion of installation. **A late fee up to 1.5% per month may be applied to unpaid balances over 30 days. Purchaser is responsible for all collection costs incurred for unpaid bills, including attorneys' fees and costs.**

INVOICING: Enroll Purchaser in e-invoices and send to this email: _____.

4. Effective Date. The Agreement shall become effective when signed by the purchaser and approved by CCi or when the Alarm System becomes operative or is activated, whichever occurs first ("Effective Date").

5. Limited Equipment Warranty. CCi warrants that the equipment and parts installed for Purchaser under the Agreement will be free from defects in material and workmanship for a period of ninety (90) days from the Effective Date. If, during this warranty period, any of the equipment or parts are defective or malfunction, they will be repaired or replaced, at CCi's option, free of charge. This limited warranty will not apply if the damage or malfunction occurs through no fault of CCi while the Alarm System is in Purchaser's possession, or occurs because the Alarm System has been altered, abused, misused, or tampered with, or has otherwise been operated or used contrary to CCi's or the manufacturer's instructions. If CCi's inspection fails to discover defect covered by this limited warranty, the equipment will be repaired or replaced at Purchaser's expense and CCi's regular service charges will apply. In the event there is a conflict between this warranty and a manufacturer's warranty, the terms of this warranty shall control. If warranty service is needed, Purchaser agrees to contact CCi at the address provided in this Agreement. In addition to the legal rights provided herein, Purchaser may have additional rights provided by law.

6. Disclaimer of All Other Warranties. Except for the limited warranty described above, CCi makes no other express warranties. The duration of any implied warranties, including any implied warranty of merchantability or fitness for a particular purpose is hereby limited to the ninety day (90) duration of this warranty. CCi makes no warranty that the Alarm System or services supplied will not be compromised or that the Alarm System or service will provide the protection for which it is intended. Purchaser further acknowledges that any affirmation of fact or promise made by CCi shall not be deemed to create an express warranty unless included in the Agreement in writing; that Purchaser is not relying on CCi's skill or judgment in selecting or furnishing a system suitable for any particular purpose and that there are no warranties that extend beyond the face of this agreement, and that CCi has offered additional and more sophisticated equipment for an additional charge, which Purchaser has declined.

7. Limitations of Alarm System and Monitoring. Purchaser understands that an alarm system does not guarantee the safety of any person or property. Alarm systems may be bypassed; and may not always operate properly for numerous reasons, including equipment malfunction or failure, phone lines being cut, inoperative, or damaged and unable to transmit an alarm signal. In addition, CCi cannot control the response of fire departments, police departments, or emergency medical services. Purchaser acknowledges that CCi does not represent or warrant: that the Alarm System may not be compromised or circumvented; that the Alarm System will prevent any loss by burglary, theft, robbery, fire, or otherwise; or that the Alarm System will in all cases provide the protection for which it is installed or intended. Purchaser understands that due to the nature of the method used for communicating alarm signals, there may be times when the communication method is not able to transmit signals and the monitoring entity will not receive alarm signals. Digital communications use standard telephone lines and no one will receive signals when the telephone system becomes non-operational or the telephone line is cut, interfered with or otherwise damaged. There will be times when any radio frequency method, such as cellular, public or private radio systems, cannot transmit an alarm signal due to lack of signal strength or availability of a communication channel. Any other type of communication method installed under this Agreement may also experience an inability to communicate alarms signals. Purchaser understands that CCi offers several levels of communication methods of alarm signals and the Alarm System and its components described on the front page of this Agreement have been chosen by the Purchaser after considering and balancing the levels of protection afforded by various communication methods and the related costs. Purchaser acknowledges and agrees that Purchaser is solely responsible for the selection of the type of communication method and whether the utilization of more than one communication is required.

8. CCi's Limit of Liability. CCi SHALL NOT BE LIABLE FOR ANY DELAY OR INTERRUPTION OF SERVICE, OR NON-OPERATION OF THE ALARM SYSTEM DUE TO CIRCUMSTANCES BEYOND CCi'S REASONABLE CONTROL. PURCHASER AGREES THAT CCi IS NOT RESPONSIBLE FOR PERSONAL INJURY OR OTHER LOSSES THAT ARE ALLEGED TO BE CAUSED BY IMPROPER OPERATION OR NON-OPERATION OF THE ALARM SYSTEM, AND/OR ITS INSTALLATION, AND/OR ITS SERVICE, INCLUDING CASES WHERE THE ALARM SYSTEM AND/OR SERVICE NEVER FUNCTIONS WHETHER DUE TO DEFECTS IN THE ALARM SYSTEM, AND/OR ITS INSTALLATION, AND/OR ITS SERVICE, OR FROM CCI'S ACTS OR OMISSIONS IN RECEIVING AND RESPONDING TO ALARM SIGNALS. PURCHASER FURTHER AGREES THAT CCI IS NOT AN INSURER AND THAT INSURANCE, COVERING PERSONAL INJURY AND OTHER LOSSES, SHALL BE OBTAINED BY PURCHASER.
It is agreed that it would be impractical and extremely difficult to fix actual damages which may arise in situations where there may be a failure of services or equipment, due to the uncertain value of Purchaser's property or the property of others kept on the Premises. THEREFORE, IF ANY LIABILITY IS IMPOSED ON CCi, ITS EMPLOYEES, AGENTS OR REPRESENTATIVES, IT WILL BE LIMITED TO 10% OF THE PURCHASE PRICE PROVIDED ABOVE OR TWO HUNDRED FIFTY DOLLARS ($250.00), WHICHEVER IS GREATER. If Purchaser wants to increase the amount of CCi's maximum liability, Purchaser may do so by paying an additional payment determined by CCi consistent with CCi's increased liability. This shall not be construed to establish CCi as an insurer. IN NO EVENT WILL CCI BE LIABLE FOR INCIDENTAL, CONSEQUENTIAL OR SPECIAL DAMAGES DUE TO A FAILURE ON THE PART OF CCI OR A FAILURE OF THE ALARM SYSTEM IN ANY RESPECT. Purchaser and CCi agree that this Agreement limits CCi's liability to Purchaser unless CCi's actions are deemed to be willful and wanton. Notwithstanding any contrary definitions found in any case law, Purchaser and CCi expressly agree that willful and wanton means conscious and intentional disregard of and indifference to the rights and safety of others.

9. Indemnify and Hold Harmless. The parties agree that Purchaser retains the sole responsibility for the life and safety of all persons in the protected Premises, and for protecting against personal injury and losses to Purchaser's own property and the property of others in the Premises. Purchaser and CCi agree that there are no third party beneficiaries to this Agreement. PURCHASER AGREES TO INDEMNIFY AND HOLD HARMLESS CCi, ITS EMPLOYEES, AGENTS, OR REPRESENTATIVES, FROM AND AGAINST ALL CLAIMS, LAWSUITS AND LOSSES, BY PERSONS NOT A PARTY TO THE AGREEMENT, ALLEGED TO BE CAUSED BY THE IMPROPER OPERATION OF THE ALARM SYSTEM AND/OR

SEE REVERSE SIDE (PAGE 2) FOR TERMS AND CONDITIONS THAT ARE PART OF THIS AGREEMENT. PURCHASER ACKNOWLEDGES THAT HE/SHE/IT HAS READ AND UNDERSTANDS THE ENTIRE AGREEMENT, INCLUDING ALL THE TERMS AND CONDITIONS ON THE REVERSE SIDE (PAGE 2) AND ANY ATTACHMENTS HERETO.

9. Cont. SERVICE, WHETHER DUE TO MALFUNCTIONING OR NON-FUNCTIONING OF THE ALARM SYSTEM OR THE NEGLIGENT PERFORMANCE OR NONPERFORMANCE BY CCi OF THE INSTALLATION, REPAIR, MONITORING, SIGNAL-HANDLING, OR DISPATCHING ASPECTS OF THE SERVICE. The provisions of this section shall apply to any other company or entity that, in addition to CCi, promotes, markets or endorses the installation, monitoring or repair services provided hereunder.

10. No Subrogation. Purchaser does hereby for himself/herself/itself and other parties claiming under him/her/it, release and discharge CCi from and against all claims arising from hazards covered by Purchaser's insurance, it being expressly agreed and understood that no insurance company or insurer will have any right of subrogation against CCi. Purchaser agrees that this paragraph is not an exculpatory provision, but a risk shifting provision. It will apply to preclude any subrogation action without regard to CCi's negligence or whether CCi's conduct is considered to be willful and wanton as defined above. Paragraph 10 shall be void if Purchaser's homeowner's insurance policy specifically prohibits this type of waiver.

11. Installation Delays. CCi shall not be liable for any damage or loss sustained by Purchaser from delays in installation of equipment or for delays or interruption of service due to electric failure, strikes, walk-outs, war, acts of God, or any other causes. Any date given to Purchaser as to when work is to be substantially completed is not a definite completion date, but an estimate. The Purchaser agrees that time is not of the essence.

12. Testing the Alarm System. The parties hereto agree that the Alarm System, once installed, is in Purchaser's exclusive possession, custody and control. Purchaser agrees to test and inspect the Alarm System immediately upon completion of installation and to advise CCi in writing within three (3) days after installation of any defect, error, or omission in the Alarm System. Upon expiration of the three (3) day period, the Alarm System and the protection provided shall be deemed accepted by Purchaser. Thereafter, Purchaser must regularly test the Alarm System's operation, according to CCi's and the manufacturer's instructions, and notify CCi if any equipment is in need of repair at Purchaser's expense if not covered by the limited warranty herein.

13. Installation on Premises. CCi is authorized to install, service, move and/or remove components of the Alarm System on the Premises. In doing so, CCi is authorized to cut into walls, drill holes, drive nails, and do any other thing necessary in CCi's sole discretion to install and/or service and/or move and/or remove the Alarm System and its components. CCi shall not be responsible for any condition created as a result of such installation, service, move or removal. CCi shall not be responsible for any damage caused to the Premises as a result of installation, service, or the removal of the Alarm System. CCi is under no obligation to redecorate any portion of Purchaser's building upon installation, service, move or removal of the Alarm System. Purchaser represents that the owner of the Premises, if other than Purchaser, authorizes the installation of the Alarm System under the terms of this Agreement; and Purchaser agrees to indemnify CCi for any claims made by the owner of the Premises arising directly or indirectly, or otherwise related to, this Agreement or any provision thereof.

14. Lead Paint. If the Premises was built before 1978, or if Purchaser believes lead paint is located at the Premises, Purchaser must notify CCi in writing before CCi begins its work at the Premises. If the Premises has lead paint that will or may be disturbed by CCi's installation, service, move, or removal of the Alarm System or any of its components, Purchaser agrees to reimburse CCi for its or its agent's expenses for abatement and containment of the lead paint, per federal requirements. Purchaser also agrees to indemnify and hold CCi harmless for any damages caused by removal or disturbance of lead paint at the Premises.

15. Laws and Permit Requirements and Fees. CCi does not have the duty to disclose or inform Purchaser of any applicable laws, regulations, and/or codes regarding the use or adequacy of an alarm system. CCi also does not have a duty to obtain any alarm use permits that may be required. Purchaser is responsible for all alarm permits and permit fees. Purchaser agrees to file for and maintain any permits required by applicable law. CCi shall have no liability for permit fees, false alarms, false alarm fines, police or fire response fees. Purchaser agrees to indemnify or reimburse CCi for any fines imposed against CCi relating to permits or false alarms. If CCi is required by law to perform any service or furnish any material not specifically covered by the terms of this Agreement Purchaser agrees to reimburse CCi for such service or material.

16. Fire Alarm Code and Permit Requirements. Unless a Fire Alarm System to Code is to be installed on the schedule of protection, CCi makes no representation that the Alarm System's fire detection equipment meets local code, fire department, or any Authority Having Jurisdiction [AHJ] requirements. It is not CCi's responsibility to apply for any permits or fees in connection with such equipment. The law requires, and CCi recommends, that Purchaser install a Fire Alarm System to Code with plans and specifications prepared by an architect or professional engineer, and that the Alarm System be properly permitted, inspected and approved by the AHJ. Purchaser represents that any existing fire alarm system is approved by the AHJ and that any repairs or replacement parts installed by CCi are not additional equipment that would require the AHJ's approval. If, at the time of installation, additional equipment is needed there will be additional charges to Purchaser.

17. CCi's Service Obligations. CCi shall not be obligated to render any service to Purchaser under the terms of this Agreement, except as expressly stated in this agreement. During the warranty period, CCi shall not be required to service the Alarm System unless it has received written notice from Purchaser, and upon such notice, and provided Purchaser is not in default of this Agreement, CCi shall during the warranty period service the Alarm System as soon as reasonably possible during CCi's regular business hours.

18. Title. Title to the Alarm System and all the component parts herein shall remain in CCi until Purchaser pays for the Alarm System in full. Purchaser authorizes CCi and its designated representatives to enter the Premises and remove the Alarm System in the event of default in payment of the purchase price when due.

19. Key Service Authorization. If key service is provided as part of the Alarm System, Purchaser hereby authorizes CCi, its agents and assigns (including, but not limited to, police and fire officials) to enter Purchaser's premises in an emergency to make repairs to the Alarm System and/or to take other necessary action, in CCi's discretion. Purchaser further agrees that CCi may authorize emergency repairs to be made by others. Purchaser agrees to pay any expenses incurred as a result of the provisions of this paragraph.

20. Unfavorable Conditions. If the Alarm System or any of its components is affected by unfavorable conditions in the Premises (e.g., air turbulence), Purchaser agrees to turn off, disable, or remove all things, animate or inanimate, causing the disturbance. This includes, but is not limited to, all forced air heaters, air conditioners, animated display signs, animals, covering of chemical vats, and any other source of air turbulence, movement, or other unfavorable condition that may interfere with the effectiveness of the Alarm System.

21. Assignment. Purchaser cannot assign this Agreement without CCi's prior written consent. CCi may assign this Agreement or subcontract any of its obligation under this Agreement without notice to Purchaser.

22. Litigation. In the event CCi institutes legal action to recover any amounts owed by Purchaser to CCi hereunder, the parties agree that the amount to be recovered, and any judgment to be entered, shall include interest at the rate of 1.5% per month from the date payment is due; and the interest shall be payable in addition to any statutory interest on judgments allowed under Minnesota law, as calculated in Minn. Stat. § 549.09. Should CCi prevail in any litigation between the parties arising directly or indirectly or otherwise related to this Agreement, or any provision hereof, Purchaser shall pay CCi's attorneys' fees and costs. Any lawsuit arising directly or indirectly or otherwise related to this Agreement, or any provision hereof, shall be litigated only in the courts of the State of Minnesota, County of Olmsted. The parties waive trial by jury in any action between them. Any action by Purchaser against CCi must be commenced within one year of the accrual of the cause of action or shall be barred. All actions or proceedings against CCi must be commenced based on the provisions of this Agreement. Any other action that Purchaser may have or bring against CCi in respect to services rendered in connection with this Agreement shall be deemed to have merged in and be restricted to the terms and conditions of this Agreement.

23. Complete Agreement; Modification. This written Agreement (including the provisions on both the front and back and any attachments thereto) is the entire and complete agreement between CCi and Purchaser and replaces any prior oral or written agreements related to the subject matter of this Agreement. No verbal understandings or agreements will change the terms and conditions of this Agreement. Purchaser understands that any changes in this Agreement must be approved by CCi and its insurer, and any changes must be in writing and signed by CCi and Purchaser.

24. Conflict. Purchaser understands and agrees that if there is any conflict between this Agreement and any other contract between Purchaser and CCi, this Agreement will govern as to the terms in conflict, whether or not it was signed first.

25. Severability. If any provision of this Agreement is deemed void or unenforceable the remaining parts of the Agreement will remain in full force and effect.

26. Not Binding Until Accepted. This is not a binding agreement until CCi accepts it. If CCi does not accept it, CCi will refund any amount Purchaser has paid under this Agreement. THIS CONTRACT IS VALID EVEN IF UNSIGNED BY CUSTOM COMMUNICATIONS, INC./CUSTOM ALARM REPRESENTATIVE.

26. Notice of Lien Rights. (a) Any person or company supplying labor or materials for this improvement to your property may file a lien against your property if that person or company is not paid for the contributions; (b) Under Minnesota law, you have the right to pay persons who supplied labor or materials for this improvement directly and deduct this amount from our contract price, or withhold the amounts due them from us until 120 days after completion of the improvement unless we give you a lien waiver signed by persons who supplied any labor or material for the improvement and who gave you timely notice.

If this is a home solicitation sale, the following cancellation clause applies: "BUYER'S RIGHT TO CANCEL" Purchaser, the Buyer, may cancel this transaction at any time prior to midnight of the third business day after the date of this transaction. See attached notice of cancellation form for an explanation of this right.

PURCHASER ACKNOWLEDGES THAT HE/SHE/IT HAS READ AND UNDERSTANDS THE ENTIRE AGREEMENT INCLUDING THE TERMS AND CONDITIONS ON BOTH SIDES OF THIS DOCUMENT AND ANY ATTACHMENTS HERETO.

CCi	PURCHASER - COMMERCIAL		PURCHASER - RESIDENTIAL
CUSTOM COMMUNICATIONS, INC. / CUSTOM ALARM AGREEMENT IS VALID EVEN IF UNSIGNED BY CCi	Good Shepherd	Tom Lindh	
	PURCHASER COMPANY NAME	SIGNATURE	PURCHASER NAME
Jordan Barnes	Tom Lindh	Administrator	
CCI REPRESENTATIVE	AUTHORIZED OFFICER NAME	TITLE	PURCHASER SIGNATURE / DATE
AUTHORIZED OFFICER SIGNATURE / DATE	EMAIL ADDRESS	7/29/2013 DATE	EMAIL ADDRESS

GOOD SHEPHERD HOME QUARTERLY FLOW TEST

	2013				2014				2015			
	May	Aug.	Nov.	Feb.	May	Aug.	Nov.	Feb	May	Aug.	Nov.	Feb.
Date of inspection	5-30-13											
Inspection Performed By	Nate.H											
PSI	42											
Pump On/Off	NO											
Alarm Audible	Yes											

ELECTRIC FIRE PUMP TEST AND MAINTENANCE RECORD

SERVICE: FIRE PUMP		MANUFACTURER: AURORA	
SIZE: 3-383-9	MODEL: 3-383-9	SERIAL NO.: 12-2230585	
DUTY CONDITION: Fire Pump	GPM: 250	PSI: 70	RPM: 3500
MOTOR MANUFACTURER: Nidec Motor Co.		SERIAL NO.: FF20E1XV	
HP: 20	RPM: 3535	FL AMPS: 54	VOLTS: 200/400
CONTROLLER MFG: Firetroll		MODEL: FTA1000-AM20HH	SERIAL NO.: 867693-01RE

TEST RECORD

DATE	6-5	6-15	6-19	6-26	7-3	7-10	7-18	7-25	
DISCHARGE PSI	130	130	130	130	130	130	130	130	
SUCTION PSI	42	42	42	42	42	42	42	42	
NET HEAD PSI	88	88	88	88	88	88	88	88	
GPM									
RPM	3600								
VOLTS	210	210	208	209	210	209	206	207	
AMPS	27	27	28	28	27	27	27	27	
BEARING TEMP	84	85	85	88	88	89	90	88	
BEARING LUBE									
SEALS	✓	✓	✓	✓	✓	✓	✓	✓	
PACKING	✓	✓	✓	✓	✓	✓	✓	✓	
ANCHOR BOLTS	✓	✓	✓	✓	✓	✓	✓	✓	
VIBRATION	✓	✓	✓	✓	✓	✓	✓	✓	
ALIGNMENT	✓	✓	✓	✓	✓	✓	✓	✓	
CASING RELIEF VALVE DISCHARGE	✓	✓	✓	✓	✓	✓	✓	✓	
FIRE PUMP START PSI	120	120	120	120	120	120	120	120	
FIRE PUMP RESET PSI									
JOCKEY PUMP START PSI	125	125	125	125	125	125	125	125	
JOCKEY PUMP STOP PSI	150	150	150	150	150	150	150	150	
INITIALS	DH	DH	DH	DH	DH	DH	DH	DH	

MAINTENANCE RECORD

DATE	DESCRIPTION OF MAINTENANCE	INITIALS

W. W. GOETSCH ASSOCIATES, INC.
5250 WEST 74TH STREET
MINNEAPOLIS, MINNESOTA 55439
952-831-4340

Good Shepherd Lutheran Home

Emergency Generator – Monthly Test Log

Generator Model: DS00300DGSPAH1574 Engine Model: 6R1600G80S Date installed: 08/29/2012

Standby kW nameplate rating: 300 30% of standby rating = 90 KW Fuel type: Diesel Normal operating temp: _____
313 AMP

Month	Test Date	Time Meter Reading		Transfer Switch		Battery Specific Gravity	Oil Pressure	Operating Temp.	Load kW /AMP	Tested By	Comments
		Start	End	Inspection	Test						
January											
February											
March											
April											
May											
June											
July											
August											
September											
October											
November											
December											

Good Shepherd Lutheran Home

Emergency Generator – Weekly Inspection Checklist

	2013									Comments/Corrective Actions
Date of inspection	7/10	7/17	7/24	7/31						
Inspection performed by	JH	JH	JH	JH						
General condition of prime mover/generator	OK	OK	OK	OK						
Condition of belts & hoses	OK	OK	OK	OK						
Engine oil level	OK	OK	OK	OK						
Lube oil heater	OK	OK	OK	OK						
Coolant level	OK	OK	OK	OK						
Water pump	OK	OK	OK	OK						
Jacket water heater	OK	OK	OK	OK						
Radiator	OK	OK	OK	OK						
Electrical/Generator breaker closed	OK	OK	OK	OK						
Battery system:	OK	OK	OK	OK						
Electrolyte level	OK	OK	OK	OK						
Charger	OK	OK	OK	OK						
Exhaust system	OK	OK	OK	OK						
Fuel system:	OK	OK	OK	OK						
Fuel supply level	OK	OK	OK	OK						
Tank vent(s)	OK	OK	OK	OK						

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2833

July 24, 2013

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, Minnesota 55971

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5393022

Dear Mr. Lindh:

The above facility was surveyed on July 8, 2013 through July 11, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

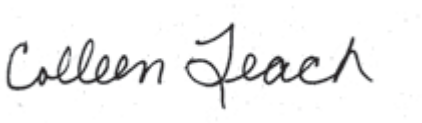
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast, Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00123	A. BUILDING: _____ B. WING _____ AUG 8 - 2013 MN Dept of Health Rochester	07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On July 8, 9, 10 and 11 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

Thomas C Smith
RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 8/6/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00123	A. BUILDING: _____ B. WING _____	07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 555	Continued From page 2 practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for increased risk of bruising while on Coumadin (anticoagulant-blood thinner) for 1 of 3 residents (R29) observed for non-pressure related skin conditions. Findings include: R29 had a history of having ongoing bruising while on Coumadin however, the care plan did not identify interventions to prevent or reduce bruising. Also there was no direction as to report the bruise to nursing to determine likely cause and/or rule out possible abuse. R29 was admitted on 1/29/07 with diagnoses including but not limited to atrial fibrillation and chronic kidney disease. R29's quarterly Minimum Data Set dated 4/19/13 identified R29 was independent with set up help with bed mobility, transfers and personal hygiene and required limited assistance with one staff with dressing. R29's brief interview for mental status completed on the Minimum Data Set indicated R29 was alert and oriented. During review of R29's physician orders noted R29 received Coumadin (medication used to thin the blood and potential to cause increased risk for bleeding/bruising) on a daily basis. During stage I observation on 7/9/13, a bruise was noted on left hand ring finger.	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00123	A. BUILDING: _____ B. WING _____	07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 555	Continued From page 3 During review of the care plan date (initiated) 2/18/07, it was noted there was no interventions developed to identify R29's risk for bruising related to Coumadin therapy. During interview on 7/10/13 at 11:25 a.m., registered nurse (RN)-B verified there was no care plan to identify risk for bruising and indicated they would have expected the fragile skin risk for bruising to be care planned. During interview on 7/11/13 at 8:49 a.m., the director of nursing (DON) confirmed they would have expected the risk for bruising to be care planned. During interview on 7/11/13 at 1:35 p.m. the DON confirmed no care plan policy available. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized plans related to behaviors. The Director of Nursing could randomly audit the care plan for the effectiveness of the behavior interventions TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 555		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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21015	Continued From page 4 by: Based on observation, interview and document review the facility failed to ensure food containers were sealed when not in use and dated as to when they were opened. This had the potential to affect 71 of 71 residents residing in the facility. Findings include: During the initial tour of the main kitchen on 7/8/13, at 1:10 p.m., four 10 pound bags of noodles were kept in the dry storage area. All four bags were not dated as to when they were opened and one of the bags had not been resealed. During interview on 7/8/13, at 1:10 p.m., dietary aide-A verified the four bags of noodles were not dated and one had no twister on to hold the bag closed. DOCUMENT REVIEW OF LABELING AND DATING FOOD ITEMS a facility policy dated 6/3/13, read, "Dietary staff will label and date all food items that they open." PROCEDURE "1. On each container, package, bag etc., write the date that the product was opened." SUGGESTED METHOD OF CORRECTION: The dietary manager or her designee could develop a system to ensure compliance of all staff wearing hairnets when appropriate, to monitor the kitchen floors and storage areas to ensure that all surfaces are clean and in good repair, and develop policies and procedures to ensure refrigerators are kept clean. The Dietary Manager could educate all staff on the importance of hairnets. The Dietary Manager could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Ten (10)	21015		

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	00123	A. BUILDING: _____ B. WING _____	07/11/2013

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21015	Continued From page 5 days.	21015		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist	21530		

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21530	Continued From page 6 must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and record review, the consulting pharmacist failed to report irregularities concerning the lack of documentation for justification for the continued use of a prophylactic antibiotic for 1 of 11 residents (R47) and failed to ensure the consultant pharmacist reviewed documentation for a digoxin level for 1 of 11 resident (R3) reviewed for unnecessary medications. Findings include: R47 received daily Macrodantin (an antibiotic) prophylactically and the medical record did not include a clinical justification for prophylactic use. The consultant pharmacist had not reported this irregularity to the attending physician and to the director of nursing. R47 had been admitted to the facility on 2/28/13, with diagnoses that included acute kidney failure and altered mental status. Review of R47's physicians' orders included Macrodantin 50 milligram (mg) by mouth daily with a start date of 2/28/13, for UTI prophylaxis. Review of R47 ' s care plan dated 3/14/13; indicated R47 had a history of repeated UTI's. Further review of the record revealed R47 had no UTIs since admission to the facility and was treated with antibiotic daily since admission. During interview on 7/11/13, at 9:03 a.m. registered nurse (RN)-A verified after they had reviewed R47 ' s medical records that they had	21530		

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21530	Continued From page 7 been unable to locate any information from a physician providing justification for the continued use of the prophylactic antibiotic. During interview on 7/11/13, at 9:51 a.m. the director of nursing (DON) stated R47 was admitted to the facility on the prophylactic antibiotic for recurrent UTI's. The DON stated justification for continued use should have been located in R47's medical record. R3 had received daily digoxin (medication used for heart rhythm) and a digoxin blood level had not been completed within the last year and had not been identified by the consultant pharmacist. R3 was admitted on 9/9/2009, with diagnoses that included but not limited to atrial fibrillation. R3 had a physician order for digoxin 0.125 milligram (mg) by mouth (PO) twice a day (bid). During document review on 7/11/13, no laboratory test had been obtained over the past year for digoxin level. Good Shepherd Lutheran Home Lab Services Protocol signed by the physician on 10/16/12 reads " Diagnosis/Medications: Lanoxin [digoxin] use; Lab Test: Dig [digoxin level] Level; Frequency: Q [every] year once stable. " During review of monthly medication regimen review the consultant pharmacist had not identified no digoxin level was present in R3's medical record. During interview on 7/11/13 at 8:23 a.m., registered nurse (RN)-C indicated should have had a digoxin level completed annually and verified no digoxin level was located in the chart.	21530		

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21530	Continued From page 8 During interview on 7/11/13 at 8:52 a.m., the director of nursing (DON) verified the facility requirement was to obtain a digoxin level every year once stable. The DON indicated the lab orders for a digoxin level were on the doctor standing orders. During interview on 7/11/13 at 1:50 p.m., the facility consultant pharmacist indicated had not looked for a digoxin level. The consultant pharmacist indicated they were working on updating the laboratory protocols. The consultant pharmacist was unaware of the digoxin level on the current laboratory protocols and indicated if the protocol form was not present in the electronic file would not routinely review it. It was learned that the monthly pharmacist review was done by computer access through the facility electronic medical records and the pharmacist is not on site during the review. The Good Shepherd Lutheran Home Lab Services Protocol signed by the physician on 10/16/1 was one of many forms that were not on the electronic record. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		

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21535	Continued From page 9	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an antibiotic was not used for an excessive duration or a physician ' s clinical justification as to why the antibiotic was used for ongoing prophylactic use for 1 of 11 residents (R47) who received Macrodantin antibiotic daily and in addition the facility failed to obtain an annual digoxin level to determine if the medication was in a safe blood level range for 1 of 11 resident (R3) who received digoxin daily	21535		

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21535	Continued From page 10 which was noted during the review for unnecessary medications. Findings include: R47 received Macrodantin (an antibiotic) prophylactically to prevent a urinary tract infection (UTI) from developing. However, the facility had failed to have a physician's justification as to why the antibiotic was used for long term use. R47 had been admitted to the facility on 2/28/13, with diagnoses that included acute kidney failure and altered mental status. Review of R47's physicians' orders included Macrodantin 50 milligram (mg) by mouth daily with a start date of 2/28/13, for UTI prophylaxis. Review of R47 ' s care plan dated 3/14/13; indicated R47 had a history of repeated UTI's. Further review of the record revealed R47 had no UTIs since admission to the facility and was treated with antibiotic daily since admission. During interview on 7/11/13, at 9:03 a.m. registered nurse (RN)-A verified after they had reviewed R47 ' s medical records that they had been unable to locate any information from a physician providing justification for the continued use of the prophylactic antibiotic. During interview on 7/11/13, at 9:51 a.m. the director of nursing (DON) stated R47 was admitted to the facility on the prophylactic antibiotic for recurrent UTI's. The DON stated justification for continued use should have been located in R47's medical record. R3 had received daily digoxin (medication used for heart rhythm) however; a yearly	21535		

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21535	Continued From page 11 recommended digoxin blood level had not been completed within the last 12 months. R3 was admitted on 9/9/2009, with diagnoses that included but not limited to atrial fibrillation. R3 had a physician order for digoxin 0.125 milligram (mg) by mouth (PO) twice a day (bid). Good Shepherd Lutheran Home Lab Services Protocol signed by the physician on 10/16/12 reads " Diagnosis/Medications: Lanoxin [digoxin] use; Lab Test: Dig [digoxin level] Level; Frequency: Q [every] year once stable. " During document review on 7/11/13, no laboratory test had been obtained over the past year for digoxin level. During interview on 7/11/13 at 8:23 a.m., registered nurse (RN)-C indicated should have had a digoxin level completed annually and verified no digoxin level was located in the chart for the past year. During interview on 7/11/13 at 8:52 a.m., the director of nursing (DON) verified the facility requirement was to obtain a digoxin level every year once stable. The DON indicated the lab orders for a digoxin level were on the doctor standing orders. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects.	21535		

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21535	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		