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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P2S1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00023

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245269**

2.STATE VENDOR OR MEDICAID NO.
(L2) **686240300**

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

4. TYPE OF ACTION: **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 **09/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **162** (L18)

13.Total Certified Beds **162** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Holly Kranz, HFE NE II — 09/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/21/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/25/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245269

September 16, 2014

Mr. Bruce Glanzer, Administrator
Good Shepherd Lutheran Home
1115 Fourth Avenue North
Sauk Rapids, Minnesota 56379

Dear Mr. Glanzer:

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

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

Effective August 22, 2014 the above facility is certified for or recommended for:

162 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 10, 2014

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

RE: Project Number S5269021

Dear Mr. Glanzer:

On August 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 17, 2014. 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 September 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 18, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 17, 2014, effective August 22, 2014 and therefore remedies outlined in our letter to you dated August 1, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
245269	A. Building B. Wing	9/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/22/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **08/22/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **08/22/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/22/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/22/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	09/10/2014	33561	09/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/17/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245269	A. Building / B. Wing: 01 - MAIN BUILDING 01	8/18/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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 Reg. # NFPA 101 LSC K0029	Correction Completed 08/08/2014	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	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 PS/KJ	Date: 09/10/2014	Signature of Surveyor: 28120	Date: 08/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/16/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00023	A. Building B. Wing	9/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **08/22/2014**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 ABC** LSC	Correction Completed **08/22/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	Correction Completed **08/22/2014**
ID Prefix **21810** Reg. # **MN St. Statute 144.651 Subd. 6** LSC	Correction Completed **08/22/2014**	ID Prefix **21830** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **08/22/2014**	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	Date:	Signature of Surveyor:	Date:
	JS/KJ	09/10/2014	33561	09/02/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/17/2014

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 10, 2014

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

Re: Reinspection Results - Project Number S5269021

Dear Mr. Glanzer:

On September 2, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 2, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P2S1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00023

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245269**

2.STATE VENDOR OR MEDICAID NO.
(L2) **686240300**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **162** (L18)

13.Total Certified Beds **162** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Marilyn Kaelke, HFE NE II — 08/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 08/21/2014 (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
07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/25/2014 Co.

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

Electronically delivered
August 1, 2014

Mr. Bruce Glanzer, Administrator
Good Shepherd Lutheran Home
1115 Fourth Avenue North
Sauk Rapids, Minnesota 56379

RE: Project Number S5269021

Dear Mr. Glanzer:

On July 17, 2014, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

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 26, 2014, 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 26, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 17, 2014 (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 17, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R88) reviewed for dignity, received care and services in a dignified manner. Findings include: R88's room was observed and there was a sign posted on the wall by the right side of the resident's entry 7/14/14, at 5:55 p.m. which indicated, "STOP. Please ask at Desk before Visiting. Thank you. Staff read the back and Follow Directions." The back of the sign	F 241	Good Shepherd Lutheran Home does promote care of the residents in a manner and an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. Regarding resident # 88, the resident had been on isolation precautions for an active MRSA infection on re-admission from the hospital on 05-28-2014; please note attached supporting documentation numbered "1 & 2". The facility recognizes	8/22/14

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

Electronically Signed | 08/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 instructed staff, "Precaution Directions- Room... Date- 5/14/14. Wear gloves for touching infected materials, gowns indicated--Yes if soiling likely. Masks indicated--Yes within 3 feet of resident/ dressing change. Private Room not indicated." During interview on 7/14/14, at 5:55 p.m. R88 stated he did not feel he was treated with dignity in the facility. He stated he was upset about a sign posted by the entrance of his door. R88 stated the previous evening he had discussed the sign with his son because he was so upset about it being posted outside his room. R88 stated he had recently returned to the facility from the hospital and assumed he had picked up something infectious up at the hospital, although he was not sure what that could have been. R88 could not remember if he had talked to the facility staff about the sign and why it was posted. R88 was discharged to the hospital from the facility on 6/24/14, via ambulance due to bloody emesis and was readmitted back to the facility on 7/2/14. On 7/2/14, R88 was readmitted to the facility with diagnoses including congestive heart failure and atrial fibrillation. R88's quarterly Minimum Data Set (MDS) dated 5/21/14, identified the resident was cognitively intact and had no problems communicating. During interview on 7/14/14, at 6:15 p.m. registered nurse (RN)-F stated she was unsure as to why the sign was posted by R88's bedroom door, and was not aware the resident had a infectious disease which would require special precautions in the past, or currently.	F 241	that at the time of the survey the staff had forgotten to remove the infection control STOP sign after the infection was cleared. The STOP sign identifies nothing more than to direct visitors to the nurse before entering. Any information regarding the type of isolation (i.e. gown □ mask □ gloves) was not visible to the general public as it is on the back of the posted sign and no one would be aware that there is any information behind the front STOP sign. Also □ this Infection Control Process does not include the type of infection anywhere on the form. The facility believes that it complied with the regulation in respect to posting signs to protect the resident□s privacy and dignity □ the regulation clearly identifies that this posting of a sign that is utilized within the Infection Control Process to prevent the spread of infection is acceptable as is noted in the Surveyor Guidance verbiage □ note: This restriction does not include the CDC isolation precaution transmission-based signage for reason of public health protection, as long as the sign does not reveal the TYPE of infection. It was discussed at the time of surveyor□s interview with the DON that the STOP sign in no way gave away any information in regard to the resident□s infection and was the facility□s process for the management of the spread of infection throughout the facility as is allowed under the regulation □ the removal of the STOP sign was an oversight after the infection had cleared.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 During a second interview on 7/16/14, at 8:48 a.m. RN-F stated the sign should not have been posted outside R88's door. She stated in the, "Remote past" R88 had an open wound to his leg and had a wound vac. A precaution cart and the sign were placed by his room during that time, although the resident was not diagnosed with any specific infectious disease which would required special precautions in addition to the standard precautions which would be used for all resident body fluids. RN-F stated R88's wound vac had been discontinued and the open wound was no longer an issue so the precaution cart had been removed prior to R88 going to the hospital on 6/24/14. RN-F stated the sign should have been removed at that time, and was unable to determine why the sign had been initially posted outside of R88's room. A policy regarding resident dignity and sign posting was requested. On 717/14, at 1:33 p.m. social worker (SW)-A reported the facility did not have a specific policy for this.	F 241	It was also discussed at the time of the surveyor□s interview with the DON; that this resident always makes his needs and wishes known and his son is very proactive in regard to the needs of his father and neither of them had ever mentioned the sign □had the resident or resident□s son done so; the staff would have noticed that the sign had inadvertently been left up and it would have been removed at that time. Regarding resident # 88 - At this time the STOP sign has been removed since the week of the survey. In regard to all other residents in the facility who may have been affected by an oversight in removing the STOP sign post infection; the residents were checked in regard to the entry area of their rooms for an unnecessary STOP signs on 07-21-2014. None were found outside of any of the 158 rooms without an active infection control process in place. But in the spirit of cooperation, □ since our request was not granted for this tag to be reconsidered and deleted given the above information, which the facility sent to the MDH, the facility has chosen to enhance its Infection Control Process to include that the Infection Control Nurse; when closing out her surveillance of a resident□'s infection; shall remove the STOP sign. Please note that the sign will continue to be used as the facility'□s means of controlling the spread of infection as is allowed under	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3	F 241	this tag. Audits of the surveillance closure process will be completed weekly for the first month and periodically thereafter for efficacy of this process enhancement. The results of those audits will be reviewed at the facility□s quarterly QA meetings.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate an identified preference for bathing for 1 of 4 residents (R189) reviewed for choices. Findings Include: R189's quarterly Minimum Data Set (MDS) dated 4/29/14, indicated the resident had diagnoses of Alzheimer's disease and anxiety, but suffered no cognitive impairment. R189's Resident Activity Assessment, dated 11/12/13, indicated R189 preferred showers for bathing, and having a choice between a tub bath, shower, bed bath, or sponge bath, was very important.	F 242	Good Shepherd Lutheran Home does assure that the residents who reside at the facility are able to make choices about the aspects of his/her life in the facility that are significant to the resident. Regarding resident # 189; this resident has short term memory loss but is able to make decisions regarding his/her activities. He/she was encouraged to fill his/her time as he/she wishes. These decisions regarding leisure time and personal cares changes from day to day and hour by hour due to the short time	8/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 4 An activity progress note dated 2/3/14, indicated R189 "...Has a daily routine and can get confused with changes in schedule." R189's care plan dated 4/29/14, indicated R189 could become sarcastic, angry, and would make negative remarks to the staff. The care plan instructed staff to be consistent with her routine to reduce these behaviors. The care plan also identified R189 preferred to have a bath (shower) twice a week, and for staff to offer R189 choices and allow time for her to make a decision and answer questions. During observation on 7/16/14, at 7:23 a.m., R189 was seated in her recliner watching television in her room. During interview at that time, R189 stated she was supposed to have had a shower earlier that morning, but was still waiting for staff to assist her. R189 stated she was supposed to have her shower first thing in the morning, but when she walked down to the shower room, the staff stated they were not ready for her. R189 was frustrated with not having her shower completed when she desired in the morning, and stated "..If you're scheduled for a shower, you should get it!" During interview on 7/16/14, at 7:35 a.m., R189's family member (FM)-A stated R189 had been having trouble getting her showers in the morning and staff will tell R189 a certain date for her shower, but then it doesn't get done. During interview on 7/16/14, at 8:37 a.m., R189 stated she still had not had her scheduled shower and was, "...Probably not going to get one today." R189 stated she was told by staff they were too busy to give the resident a shower. R189 stated she did not receive a shower at all last week because staff didn't have time until late in the day. During interview on 7/16/14, at 8:43 a.m. nursing assistant (NA)-E stated R189's shower was	F 242	memory loss. The resident was allowed this freedom within the capabilities of the facility to provide for those needs as they were requested. The resident never requested a certain bath time (i.e. 6 AM) but would show up ready for a bath and the staff would respond to this as soon as they are able to do so. Resident has short term memory loss and would often show up for a bath on an altogether different day than where she was scheduled staff would adjust their day and bathe her on the day she showed up for a bath. This resident no longer resides at our facility as of 08-04-2014. Regarding all other residents in the facility that could possibly be affected by this concern for meeting choice; their plans of care were reviewed and revised as necessary to assure guidance to staff in regard to meeting the resident s needs as he/she requests from day to day and within the staffs ability to do so pending no greater resident need presents itself in regard to another resident. The facility does offer choice and will continue to offer bathing choice according to the regulation in relationship to the type of bath the resident would like and time of day (AM-PM). The facility staff does honor the residents wish as to time of bath and makes every effort to provide the bath as close to the time of day the resident would like pending no other greater/emergent need presents itself at the time. Staff received informational re-training in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 5 scheduled for 6:30 a.m., however, staff was not always available to do the residents shower in the morning. NA-E stated R189 becomes upset if she does not receive a shower in the morning and will make negative remarks to the staff as she stands outside the shower room waiting to be bathed. NA-E stated if R189 does not receive her shower at her desired time in the morning, she will talk about it all day and continue to be upset. During interview on 7/16/14, at 11:43 a.m., licensed practical nurse (LPN)-C stated she was aware of R189 's preference to have a shower in the morning, but on some days it was not able to be completed in the morning due to lack of staff. LPN-C stated the registered nurse (RN) managers were aware of R189's preference for an early morning shower. When interviewed on 7/16/14, at 11:54 a.m., RN-D stated she was aware of R189's preference for a morning shower, but had not heard about the preference for it to be an early morning shower. RN-D further stated R189 was cognitively able to make choices regarding her bathing preferences. During interview on 7/16/14, at 1:37 p.m., licensed social worker (LSW)-A stated choices and preferences are discussed when a resident is admitted to the facility, and reviewed at least quarterly. LSW-A stated R189 required a structured routine for her day, and liked to make choices about her day. LSW-A stated it is a facility expectation to try as hard as possible to meet resident preferences, and R189 would cognitively benefit from having her bath at the same time each day. During another interview on 7/17/14, at 10:06 a.m. LSW-A stated she was unaware of R189's preference for a early morning shower, despite several nursing staff being aware of the preference. LSW-A reiterated R189 does	F 242	regard to this tag requirement. This training was to remind them of the expectations the staff is held to in order to meet this tag requirement to choice regarding type of bath and time of day. This training was started on 08-11-2014 to be completed over approximately 2 weeks time - 08-22-2014 training - the staff as they come to work on their next scheduled days. Facility Case Managers will audit effectiveness of training through interviews with random resident samples per household to assure that the training is effective on a weekly basis for the first 30 days and periodically thereafter. The results of these audits will be discussed at the morning Team meeting and at the quarterly QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 6 not do well with changes to her daily routine and it can disrupt the residents whole day. When interviewed on 7/17/14, at 2:27 p.m., the director of nursing (DON) stated R189's desire for an early morning shower was, "Not something that is brand new." The DON stated choices and preferences are honored for each resident if possible. A Bathing and Grooming policy, dated 7/10, indicated "...Residents are bathed as often as necessary to maintain cleanliness, refresh, stimulate circulation, and provide some Range of Motion." The policy does not indicate if residents are allowed a choice in bathing frequency or type of bathing they have. A policy on choices and preferences was requested, but none was provided.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure access to a working call light for 1 of 40 residents (R246) in the Stage I sample who was at risk for falls and required a sensitive call light to alert staff of their tilting and transfer needs.	F 246	Good Shepherd Lutheran Home does assure that its residents receive services with reasonable accommodations of individual needs. The facility recognizes that during the survey, 1 of 40 residents □ Resident #62	8/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 7 Findings include: R246's quarterly Minimum Data Set (MDS) dated 6/30/14, identified the resident had an active diagnoses of a stroke. R246 had moderate cognitive impairment and required extensive assistance with toileting and transferring. R246's care plan dated 7/17/14, identified R246 was at risk for falls because of right sided weakness related to cerebrovascular accident (CVA), medication regimen, cognition and history of falls. Approaches listed for falls prevention included encourage R246 to ask for help and have the call light close by. During observation on 7/15/14, at 9:31 a.m. R246 had a non-functioning call light on her bed, which did not sound an audible or visible signal when pushed. The call light was a sensitive call light (flattened bulb style that is easier to push). The call light was taped into the wall unit with transparent tape. R246 stated the call light frequently fell out of the wall unit and she was not able to use it to call for help. R246 stated the call light had not been working for at least two weeks, and she sometimes had to call out, "Help, help," out her door to receive staff assistance. R246 stated she had reported this to a nurse and they had taped it to the wall. R246 stated she didn't like not being able to rely on her call light working because it made her, "Nervous." During interview on 7/15/14, at 9:43 a.m. nursing assistant (NA)-A and NA-B verified R246 was able to use her call light to request assistance. NA-A pressed R246's call light and verified the call light was not working. R246's call light was not sounding an audible alarm or showing on the	F 246	□ had a call light that was not working on the morning of 07-15 and was taped to the wall. The facility also notes that the supporting surveyor information states that the resident stated the call light had not been working for at least 2 weeks □- the facility pulled the electronic call light report for that resident back two weeks from the 15th. The call light report showed no calls from the call light from early night shift to approx. 9:30 PM on the 14th as would be consistent with the broken call light and its subsequent replacement of the call light at 9:47 AM on the 15th. All other times through the two weeks the call light report shows continual activity on the call light for resident # 62. Regarding resident # 62 the call light was repaired at the time of the survey and was working again by 9:47 AM on the 15th. The facility recognizes that; although it has a process for managing/alerting the need for repairs and the surveyor interviews with the staff present at the time of survey show that the staff interviewed knew the process; this one period of time the process did not assure that the call light was repaired timely. To assure this was not a concern for any of the other residents residing in the facility; the call lights for all the other residents were checked for working order on 07-25 and completed on 07-31-2014 - and there were no call lights found to not be in good working order Training for staff responsible to this regulation started on 08-11-2014 and was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 8 call light display on the unit. NA-A and NA-B could not recall how long R246's call light had been taped to the wall. During interview on 7/15/14, at 9:49 a.m. LPN-A stated they (staff) had noticed the tape on the R246 call light yesterday, and he, "Shoved it back in to the wall," and thought it would stay in place. The usual procedure for a call light repair was to fill out a maintenance request in the computer. During interview on 7/15/14, at 10:22 a.m. registered nurse (RN)-A stated staff should call maintenance for any urgent requests, or fill out a maintenance request for any broken or damaged items. During interview on 7/15/14, at 4:21 p.m. licensed practical nurse (LPN)-B stated R246 used the call light to request assistance and would sometimes call out for staff. LPN-B was not aware R246's call light had been taped to the wall and was not functioning. During interview on 7/17/14, at 8:30 a.m. NA-C stated she would remove broken or damaged equipment from a resident room and notify the nurse. During interview on 7/17/14, at 9:59 a.m. maintenance staff (MS)-A stated all nurses could submit a maintenance work order request via computer. During interview on 7/17/14, at 11:48 a.m. MS-B stated call lights were checked to ensure working order every other month by a visual examination. It was the expectation nursing would fill out a work order requisition for anything that happened	F 246	completed by 08-22-2014. Ongoing review of the facility residents and their needs and accommodation will continue to be reviewed in the AM stand-up meetings. The efficacy of this process will be monitored thru a joint effort by the nursing management team the social workers through resident/family concerns and maintenance personnel through work orders. Any ongoing concerns shall be reviewed through the facility s quarterly QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 9 in between those checks. MS-B stated the call light should had been repaired for R246 and should not have been taped. MS-B stated the call light should normally have a wall anchor underneath the base unit to prevent it from being pulled out which would have been the case if maintenance had installed it. MS-B stated a work order had never been filed for R246 in the computer system and he was not aware the call light had not been working. MS-B stated there was not a formalized policy on how to fill out a work order for a broken or malfunctioning piece of resident equipment, however, there were instructions available to staff online.	F 246		
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 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.	F 329		8/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R109) reviewed for unnecessary medication had necessary lab work monitored and did not receive duplicate dosages of medication. Findings include: R109's annual Minimum Data Set (MDS) dated 5/23/14, indicated R109 had diagnoses of heart failure, hypertension (high blood pressure), and renal disease. The MDS further indicated R109 received a diuretic medication during 6 of the 7 days reviewed for the assessment. R109's Physician Order Sheet dated 6/24/14, identified orders for the following: Lasix (a diuretic medication) 60 mg (milligrams) by mouth 2 times per day, started 8/27/13. Potassium chloride 10 mEq (milliequivalents) by mouth once daily, started 4/27/13. Ergocalciferol (Vitamin D2) 50,000 units by mouth 1 time per day every 28 days, started 2/22/14 Vitamin D2 50,000 units by mouth 1 time per day every 30 days, started 6/21/14. R109's Standing Orders for St. Cloud Area Skilled Nursing Facility dated 8/11/12, indicated an order to have serum K (potassium) lab values collected within 30 days of starting a diuretic, and then every 6 months thereafter. R109's EMAR (electronic medication administration record), dated May 2014, indicated R109 received ergocalciferol 50,000 units, listed	F 329	Good Shepherd Lutheran Home does monitor its resident□s drug regimen to assure that its residents are free from unnecessary drugs. The facility recognizes that during the survey it looked like; to the surveyor that a resident received a duplicate dose of Vitamin D as there was a duplicate order for 1 of the residents out of 5 residents reviewed. Regarding Resident # 109 □ A □ Duplicate order - During the facility□s investigation as to why this happened, it was noted that the MD had ordered the Vitamin D in February 2014 after a hospital return and had missed that there already was an order from April 2013. The facility recognizes that this human error was not caught in the electronic MAR (Medication Administration Record) and had not been clarified for a change to just one order for Vitamin D. Also note that during the facility□s investigation regarding this Vitamin D duplicate order the facility would like to clarify that the resident never received a duplicate dose of the Vitamin D in the months of May or June as stated in the deficiency and did receive the one dose of the Vitamin D in July although the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11 as an individual order, on 5/17/14, and vitamin D2 50,000 units, also listed as an individual order, on 5/21/14. R109's EMAR, dated June 2014, indicated R109 received ergocalciferol 50,000 units, listed as an individual order, on 6/14/14, and vitamin D2 50,000 units, also listed as an individual order, on 6/20/14. R109's EMAR, dated July 2014, indicated R109 received ergocalciferol 50,000 units, listed as an individual order, on 7/12/14, but had not yet received vitamin D2 yet this month. R109's last Chemistry 8 panel (a laboratory collection providing information about a patients potassium, sodium, calcium, and chloride within their blood), drawn 8/29/13 (11 months prior), and all checked levels were within normal limits. No further laboratory values were located to identify R109's potassium levels were being monitored every 6 months as directed. During interview on 7/16/14, at 12:41 p.m., licensed practical nurse (LPN)-C stated the most recent laboratory values are always kept in the chart. LPN-C stated R109 should have had another potassium level drawn since 8/29/13, according to his standing orders, however, she was unable to locate any further lab values. During interview on 7/16/14, at 1:05 p.m., registered nurse (RN)-D stated all laboratory results were kept in the resident's chart. RN-D stated R109's potassium level should have been monitored more closely given his high dose of Lasix, and history of renal disease. RN-D stated R109 appeared to be given double doses of vitamin D according to the Medication Administration Record (MAR). RN-D was unsure of any reason R109 would be on two doses of vitamin D and was unable to locate a physician order from 6/21/14, indicating R109 was to start	F 329	deficiency states that he never received it. Had the staff been asked to clarify the MAR and how to read it at the time of the survey it would have been clear that under the two orders for each months June and July - one order read NA □ which means not administered and the other order read A-which means that the order was administered. In July on the MAR it clearly states an A for the 12th of the month which shows the Vitamin D was administered □ and the duplicate order □ was not administered. Also the surveyor did receive copies of those MAR□s and there is a clarification legend on them which would also have help the surveyor best determine that the charted documentation supports that there was no duplication of this Vitamin D. The order has been clarified as of 08-06-2014 - with the resident□s Physician and there now is no duplicate order for the Vitamin D. In regards to the other 152 residents in the facility as of 08-06-2014 their Physician□s orders have been reviewed for duplicate orders and clarified as necessary. To assure that this human error does not occur again the facility re-educated the staff responsible for the entry of orders. As our electronic system does alert the staff if a duplicate order is already in the system, and asks if the staff wishes to continue; the facility has trained the staff to not override the computer alert without clarifying the duplicate conferring with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 an additional dose of Vitamin D monthly. During interview on 7/17/14, at 11:03 a.m., certified nurse practitioner (CNP)-A stated she was involved in the care of R109 and laboratory values are ordered as they are needed. CNP-A stated R109 had laboratory values drawn at the VA (Veteran Affairs) clinic in Minneapolis, however, she was unsure when the last potassium level was drawn and did not know if the results were within normal limits for R109. CNP-A stated R109's primary physician gets a copy of the results, and she would sometimes get a copy of the results. CNP-A did not know why R109 had two separate orders for vitamin D. R109's medical doctor Nursing Home Visit, dictated 6/24/14, indicated R109 had a diagnosis of osteoporosis, and was on ergocalciferol monthly. The report did not identify any review of R109's potassium levels, nor any reason for starting an additional dose of vitamin D2. During interview on 7/16/14, at 3:22 p.m., pharmacy consultant (PC)-A stated, "It sounds like the same medication was ordered twice," when referring to the vitamin D order being ordered twice for R109. PC-A stated the order, "Sounds a little strange." In addition, PC-A stated she could identify no obvious clinical reason to not draw a potassium level for R109 since 8/29/13, given his significant medical history. During interview on 7/17/14, at 2:22 p.m., the director of nursing (DON) stated she felt if there was a critical lab value identified, the VA would contact the facility and let them know about it.	F 329	nurse who does the double check on orders and clarifying with the physician regarding the duplicate order. Facility Case Managers will audit effectiveness of training through audits. Audits will be completed on a weekly basis for 4 weeks to assure efficacy of the training and periodically thereafter. The results of these audits will be reviewed at the facility□s quarterly QA meetings. B. Appropriate lab monitoring □ The facility recognizes that at the time of survey resident # 109 did not have a timely Serum Potassium level checked as per standing orders. Regarding this resident□s (109) potassium level; the residents serum potassium level was drawn 7-19-2014. Regarding all other residents in the facility who could be affected by this break in practice as directed in the standing orders; the residents medical records are being reviewed for current lab monitoring and orders obtained if necessary to assure that the standing orders for lab monitoring or current. This process along with the training of staff responsible to this regulation shall be completed by 08-22-2014. To assure that this oversight of 1 out of 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 A policy on lab monitoring was requested but not provided.	F 329	residents who missed a lab monitoring per standing orders does not reoccur; the facility has put in place a new tickler file process by which each Case Manager may better manage necessary lab draws. This tickler file shall also enhance the process by which the Consulting Pharmacist works with the Case Manager to manage the need for any lab monitoring. The Consulting Pharmacist was a part of this decision to change the process for monitoring labs to assure that all who have a part in this process agree to the benefit of this change. Audits shall be conducted by ongoing over the next month by the ADON for any lab follow-up needs and to measure the efficacy of this change. Results of these audits shall be reviewed at the facility□s quarterly QA meetings.	
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 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		8/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 14 by: Based on interview, and document review, the facility consulting pharmacist failed to identify drug irregularities related to monitoring potassium levels and duplicative medication orders for 1 of 5 residents (R109) reviewed for unnecessary medication. Findings Include: R109's annual Minimum Data Set (MDS) dated 5/23/14, indicated R109 had diagnoses of heart failure, hypertension (high blood pressure), and renal disease. R109's Physician Order Sheet dated 6/24/14, identified orders for the following: Lasix (a diuretic medication) 60 mg (milligrams) by mouth 2 times per day, started 8/27/13. Potassium chloride 10 mEq (milliequivalents) by mouth once daily, started 4/27/13. Ergocalciferol (Vitamin D2) 50,000 units by mouth 1 time per day every 28 days, started 2/22/14 Vitamin D2 50,000 units by mouth 1 time per day every 30 days, started 6/21/14. R109's Standing Orders for St. Cloud Area Skilled Nursing Facility dated 8/11/12, indicated an order to have serum K (potassium) lab values collected within 30 days of starting a diuretic, and then every 6 months thereafter. R109's last Chemistry 8 panel (a laboratory collection providing information about a patient's potassium, sodium, calcium, and chloride within their blood), drawn 8/29/13 (11 months prior), and all checked levels were within normal limits. No further laboratory values were located to identify R109's potassium levels were being monitored every 6 months as directed. Review of R109's consulting pharmacist Medication Regimen Review dated 6/24/14, 5/27/14, and 4/21/14, the pharmacist did not address R109's lab work not being completed,	F 428	Good Shepherd Lutheran Home does contract with a consulting Pharmacist who does monthly reviews of the resident□s drug regime and who reports irregularities to the attending physician and the director of nursing □ and the facility assures that they are acted upon.. The facility recognizes that during the survey it looked like; to the surveyor that a resident received a duplicate dose of Vitamin D as there was a duplicate order for 1 of the residents out of 5 residents reviewed. Regarding Resident # 109 □ A □ Duplicate order - During the facility□s investigation as to why this happened, it was noted that the MD had ordered the Vitamin D in February 2014 after a hospital return and had missed that there already was an order from April 2013. The facility recognizes that this human error was not caught in the electronic MAR (Medication Administration Record) and had not been clarified for a change to just one order for Vitamin D. Also note that during the facility□s investigation regarding this Vitamin D duplicate order the facility would like to clarify that the resident never received a duplicate dose of the Vitamin D in the months of May or June as stated in the deficiency and did receive the one dose of the Vitamin D in July although the deficiency states that he never received it. Had the staff been asked to clarify the MAR and how to read it at the time of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 15 nor was the duplicate Vitamin D dose addressed. During interview on 7/16/14, at 12:41 p.m., licensed practical nurse (LPN)-C stated the most recent laboratory values are always kept in the chart. LPN-C stated R109 should have had another potassium level drawn since 8/29/13, according to his standing orders, however, she was unable to locate any further lab values. During interview on 7/16/14, at 1:05 p.m., registered nurse (RN)-D stated all laboratory results were kept in the residents chart. RN-D stated R109's potassium level should have been monitored more closely given his high dose of Lasix, and history of renal disease. RN-D stated R109 appeared to be given double doses of vitamin D according to the Medication Administration Record (MAR). RN-D was unsure of any reason R109 would be on two doses of vitamin D and was unable to locate a physician order from 6/21/14, indicating R109 was to start an additional dose of Vitamin D monthly. During interview on 7/17/14, at 11:03 a.m., certified nurse practitioner (CNP)-A stated she was involved in the care of R109 and laboratory values are ordered as they are needed. CNP-A stated R109 had laboratory values drawn at the VA (Veteran Affairs) clinic in Minneapolis, however, she was unsure when the last potassium level was drawn and did not know if the results were within normal limits for R109. CNP-A stated R109's primary physician gets a copy of the results, and she would sometimes get a copy of the results. CNP-A did not know why R109 had two separate orders for vitamin D. R109's medical doctor Nursing Home Visit, dictated 6/24/14, indicated R109 had a diagnosis	F 428	survey it would have been clear that under the two orders for each months June and July - one order read NA □ which means not administered and the other order read A-which means that the order was administered. In July on the MAR it clearly states an A for the 12th of the month which shows the Vitamin D was administered □ and the duplicate order □ was not administered. Also the surveyor did receive copies of those MAR□s and there is a clarification legend on them which would also have help the surveyor best determine that the charted documentation supports that there was no duplication of this Vitamin D. The order has been clarified as of 08-06-2014 - with the resident□s Physician and there now is no duplicate order for the Vitamin D. In regards to the other 152 residents in the facility as of 08-06-2014 their Physician□s orders have been reviewed for duplicate orders and clarified as necessary. To assure that this human error does not occur again the facility re-educated the staff responsible for the entry of orders. As our electronic system does alert the staff if a duplicate order is already in the system, and asks if the staff wishes to continue; the facility has trained the staff to not override the computer alert without clarifying the duplicate conferring with the nurse who does the double check on orders and clarifying with the physician regarding the duplicate order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 16 of osteoporosis, and was on ergocalciferol monthly. The report did not identify any review of R109's potassium levels, nor any reason for starting an additional dose of vitamin D2. During interview on 7/16/14, at 3:22 p.m., pharmacy consultant (PC)-A stated, "It sounds like the same medication was ordered twice," when referring to the vitamin D order being ordered twice for R109. PC-A stated the order, "Sounds a little strange." In addition, PC-A stated she could not identify obvious clinical reason to not draw a potassium level for R109 since 8/29/13, given his significant medical history. In addition, PC-A stated she did not identify irregularities with R109's medication regimen if it was not noted on her monthly Medication Regimen Review form(s). During interview on 7/17/14, at 2:22 p.m. the director of nursing (DON) stated her expectation was for the consulting pharmacist to appropriately manage the resident medication records. The DON stated an expectation for the clinical managers and pharmacist to touch base when she is on site at the facility to review any concerns with resident medications. A Medication Administration policy, dated 9/2010, indicated medications are reviewed by the consultant pharmacist and nurse manager to work towards continuous medication reduction.	F 428	Facility Case Managers will audit effectiveness of training through audits. Audits will be completed on a weekly basis for 4 weeks to assure efficacy of the training and periodically thereafter. The results of these audits will be reviewed at the facility□s quarterly QA meetings. B. Appropriate lab monitoring □ The facility recognizes that at the time of survey resident # 109 did not have a timely Serum Potassium level checked as per standing orders. Regarding this resident□s (109) potassium level; the residents serum potassium level was drawn 7-19-2014. Regarding all other residents in the facility who could be affected by this break in practice as directed in the standing orders; the residents medical records are being reviewed for current lab monitoring and orders obtained if necessary to assure that the standing orders for lab monitoring or current. This process along with the training of staff responsible to this regulation shall be completed by 08-22-2014. To assure that this oversight of 1 out of 5 residents who missed a lab monitoring per standing orders does not reoccur; the facility has put in place a new tickler file process by which each Case Manager may better manage necessary lab draws.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 17	F 428	This tickler file shall also enhance the process by which the Consulting Pharmacist works with the Case Manager to manage the need for any lab monitoring. The Consulting Pharmacist was a part of this decision to change the process for monitoring labs to assure that all who have a part in this process agree to the benefit of this change. Audits shall be conducted by ongoing over the next month by the ADON for any lab follow-up needs and to measure the efficacy of this change. Results of these audits shall be reviewed at the facility□s quarterly QA meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Shepherd Lutheran Home, Building 01 was not found 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: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: 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. The facility was inspected as four separate	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/11/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 buildings: Good Shepherd Home, Building 01, is a 1-story building with a partial basement. The building was constructed at 5 different times: The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1969, an addition was added to the east that was determined to be of Type II (111) construction. In 1980, an addition was added to the northwest that was determined to be Type V (111). In 1997, an addition was added to the west that was determined to be of Type V (111) construction. In 2002, an addition was added to the Main Dining Room that was determined to be of Type V (111) construction. Due to the Type II (111) construction also complying to the requirements of Type V (111), Building 01 is surveyed as one building. In 2010 the facility added 3 additions: A two story addition, Building 02, that was determined to be of Type II (111) construction located on the southwest corner of the facility. A two story addition, Building 03, that was determined to be of Type II (111) construction located on the northeast corner of the facility. A one story addition, Building 04, that was determined to be of Type V (111) construction located north of the chapel. The building is fully sprinkler protected and the sprinkler system is installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (1999 edition) The facility has	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code"·(1999 edition). The facility has a capacity of 162 beds and had a census of 159 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 interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect some patients. Findings include: During facility tour between 10:30 AM and 1:30	K 029	On July 16, 2014 the facility had its annual fire safety survey. During the walk through, the fire marshal had noted that the soiled linen door would not close and latch on the 800 wing. The soiled linen room door was repaired on July 16, 2014 at 2:20 PM. The upper hinge was adjusted so the door would close and latch.	8/8/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 PM on 07/15/2014, observation revealed that the soiled linen room door in the 800 wing does not fully close and latch. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 029	All of the soiled linen room doors will be added on our monthly check list with the fire doors throughout our building to ensure that the doors get the proper maintenance to close and latch. The maintenance supervisor will schedule the work and make sure it is completed on a monthly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **02 - TWO-STORY ADDITION** B. WING _____	**07/16/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Shepherd Lutheran Home, Building 02,was found 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 18 New Health Care. Good Shepherd Lutheran Home's building 02 is a 2-story addition with partial basement. The addition was constructed in 2010 and was determined to be Type II (111). The addition is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 162 beds and had a census of 159 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

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

Electronically Signed | 08/11/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **03 - NORTH EAST ADDTION** B. WING _____	**07/16/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Shepherd Lutheran Home, Building 03 ,was found 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 18 New Health Care. Good Shepherd Lutheran Home's building 03 is a 2-story addition without a basement. The addition was constructed in 2010 and was determined to be Type II (111). The addition is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 162 beds and had a census of 159 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

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

Electronically Signed | 08/11/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING **04 - FALLOWSHIP HALL** B. WING _____	**07/16/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Shepherd Lutheran Home, Building 04 ,was found 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 18 New Health Care. Good Shepherd Lutheran Home's building 04 is a 1-story addition without a basement. The addition was constructed in 2010 and was determined to be Type V (111). The addition is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 162 beds and had a census of 159 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/11/2014

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