Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 12, 2025

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: CCN: 245269
Cycle Start Date: April 17, 2025

Dear Administrator:

On June 11, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 29, 2025

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: CCN: 245269
Cycle Start Date: April 17, 2025

Dear Administrator:

On April 17, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 July 17, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by October 17, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	C 04/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/14/25 to 4/17/25 a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/14/25 to 4/17/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52692808C (MN110051), H52692887C (MN104472). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 05/08/2025

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

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 3 resident s (R5) who were observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R5's annual Minimum Data Set (MDS) dated 4/2/25, indicated R5 was cognitively intact and had diagnosis which included arthritis, hypertension (elevated blood pressure) and chronic obstructive pulmonary disease (COPD/chronic lung disease that cause airflow and breathing problems). Further, R5 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. R5's care plan dated 3/4/24, identified R5 had an activity of daily living (ADL) self-care performance deficit related to activity intolerance. R5's care plan interventions included dependence on staff for bathing, dressing, and personal hygiene. Directed staff to administer medications as ordered. Review of R5's electronic health record (EHR) revealed a self-administration of medication (SAM) assessment dated 3/4/24, and identified R5 did not wish to self- administer medications.	F 554	The facility does have a process in place to ensure residents have the right to self-administer medications if they choose and if the interdisciplinary team as well as the primary care provider has determined that this practice is clinically appropriate. Regarding resident 5, the facility recognizes the resident was observed to self-administer 2 nebulizer treatments after the TMA set up the nebulizer medications. At the time of the survey, there was not an order in place for R5 to self-administer nebulizers and an assessment had not been completed for R5 to self-administer the nebulizers. R5 will be assessed for self-administration of the nebulizer as well as receive an order from the primary provider if assessment indicates appropriate to self-administer the nebulizer treatment. R5’s care plan will be reviewed and updated accordingly. Regarding all other residents this deficient practice may affect, an audit will be completed for all residents who wish to self-administer their nebulizer medications to ensure an assessment as well as an order from the primary provider is in place. Staff who complete medication administration will be re-educated to their	5/30/25

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F 554	Continued From page 2 R5's Order Summary Report dated 2/18/25, directed staff to administer Albuterol Sulfate inhalation nebulizer 2.5 MG/3 ML via nebulizer twice daily for chronic cough. Further, it directed staff to administer Budesonide inhalation suspension 0/5 MG/2 ML via nebulizer twice daily for chronic cough. R5's Order Summary Report lacked an order to self administer medication. During a continuous observation on 4/15/25 at 9:33 a.m., R5 was seated in her wheelchair in her room and trained medication aide (TMA)-A entered R5's room with a vial containing albuterol nebulizer solution. (TMA)-A poured the solution into a nebulizer mask, placed the mask on R5's face, and told R5 she would return in 10 minutes to place the second nebulizer. TMA-tuned on the nebulizer machine, left R5's room, and returned to medication cart in the hallway which was not within visual sight of R5's room. At 9:43 a.m., TMA-A entered R5's room and the nebulizer mask was lying on R5's bedside table. TMA-A picked up the nebulizer mask and rinsed it out with water in R5's bathroom. TMA-A placed the budesonide nebulizer solution in the nebulizer mask. TMA-A placed the nebulizer mask on R5's face and told R5 she would return in 10 minutes to remove the nebulizer mask. TMA-returned to her medication cart in the hallway not within visual sight of R5's room. At 9:50 TMA-A entered R5's room and the nebulizer mask was lying on R5's bedside table with solution still coming from the mask. TMA-A picked up the nebulizer mask, turned the nebulizer machine off and placed the nebulizer mask on the nebulizer machine.	F 554	responsibility of this regulation with enhanced focus to monitor and ensure that residents who are not determined eligible to or do not wish to self-administer their nebulizer medications remain supervised during the duration of their nebulizer treatment. The facility will review the medication administration policy and will revise if necessary. To assure effectiveness of staff re-education to the requirement, the facility QA team/designee will conduct routine audits of residents self-administering their medication daily for one week, weekly for two weeks, monthly for two months and periodically thereafter. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings	

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F 554	Continued From page 3 During an interview on 4/15/25 at 10:05 a.m., TMA-A verified she had placed the nebulizer treatment on R5 and exited the room. TMA-A stated she was unsure if a SAM assessment had been completed for R5. TMA-A stated she was unsure what the process was for a resident that did not have an order to self-administer medications. During an interview on 4/15/25 at 10:10 a.m., registered nurse (RN)-A confirmed R5's SAM dated 3/4/24, identified R5 had not wished to self-administer medications. RN-A stated her expectation was nursing staff would have stayed in the room with R5 while she received the nebulizer treatments to ensure R5 received the nebulizer treatments appropriately. During an interview on 4/16/25 at 1:05 p.m., director of nursing (DON) verified R5 was not safe to self-administer medications. DON stated if a resident had not been assessed to safely self-administer medication or have a physician order to self administer medications staff were expected to remain with the resident the entire nebulizer treatment. Review of a facility policy titled Medication Administration revised 6/2024, identified medications ordered by the physician would be set up and administered within the established guidelines. Identified the resident must take the medications when the nurse/TMA is present unless the resident has completed Medication Self-Administration Assessment and noted to be safe.	F 554		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		5/30/25

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F 658	Continued From page 4 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration of an inhalation medication for 1 of 3 residents (R5) observed for medication administration. Findings include: R5's annual Minimum Data Set (MDS) dated 4/2/25, indicated R5 was cognitively intact and had diagnosis which included arthritis, hypertension (elevated blood pressure) and and chronic obstructive pulmonary disease (COPD/chronic lung disease that cause airflow and breathing problems). Indicated R5 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. R5's care plan dated 3/4/24, identified R5 had an activity of daily living (ADL) self-care performance deficit related to activity intolerance. R5's care plan interventions included dependence on staff for bathing, dressing, and personal hygiene. Directed staff to administer medications as ordered. R5's Order Summary Report dated 2/18/25, directed staff to administer Budesonide inhalation suspension 0/5 MG/2 ML via nebulizer twice daily for chronic cough. Identified to rinse mouth with water and spit after use, if unable to rinse and spit	F 658	The facility does have a process in place to ensure medications are administered in a way that meets professional standards of quality. Regarding resident 5, the facility recognizes it was observed, that the TMA did not instruct R5 to rinse their mouth with water and spit after administration of the budesonide nebulizer. The facility does note the order was in place to complete the rinse and spit but was not followed by the TMA. R5 has since been assessed to assure no signs or symptoms of thrush are noted from not rinsing after the nebulizer. Regarding all other residents this deficient practice may affect, an audit will be completed for all residents to receive an inhaled steroid to ensure an order is in place and is followed to rinse and spit after the inhalation administration of the steroid medication. An assessment of each resident who may be affected to assure no s/s of thrush are present will be conducted. Staff who complete medication administration will be reeducated to their responsibility of the regulation with enhanced focus to ensure the residents rinse and spit after medication administration and if the resident is not	

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F 658	Continued From page 5 mouth should be swabbed. During an observation on 4/15/25 at 9:43 a.m., trained medication aide (TMA)-A entered R5's room and the nebulizer mask was lying on R5's bedside table. TMA-A picked up the nebulizer mask and rinsed it out with water in R5's bathroom. TMA-A placed the budesonide nebulizer solution in the nebulizer mask. TMA-A placed the nebulizer mask on R5's face and told R5 she would return in 10 minutes to remove the nebulizer mask. TMA-returned to her medication cart in the hallway not within visual sight of R5's room. At 9:50 TMA-A entered R5's room and the nebulizer mask was lying on R5's bedside table. TMA-A picked up the nebulizer mask, turned the nebulizer machine off and placed the nebulizer mask on the nebulizer. R5 was not observed to rinse her mouth out and TMA-A had not instructed R5 to rinse mouth out as ordered after taking the Budenoside nebulizer. During an interview on 4/15/25 at 10:05 a.m., TMA-A confirmed she had not instructed R5 to rinse her mouth after receiving the Budesonide nebulizer. TMA-A stated she had not seen the order instructions to rinse mouth after use. TMA-A stated it was not her usual process to instruct R5 to rinse her mouth after the Budesonide nebulizer. During an interview on 4/15/25 at 10:10 a.m. registered nurse (RN)-A verified R5 had an order to rinse and spit after the Budesonide nebulizer. RN-A indicated it was important to rinse the mouth after a steroid nebulizer was received to prevent any infections. During an interview on 4/15/25 at 10:39 a.m.,	F 658	able to spit, then their mouth shall be swabbed to prevent thrush. The facility will review the medication administration policy and update if necessary. To assure effectiveness of staff re-education to the requirement, the facility QA team/designee will conduct routine audits of residents who receive inhaled steroids to ensure a rinse and spit was completed daily for one week, weekly for two weeks, monthly for two months and periodically thereafter. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings	

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F 658	Continued From page 6 pharmacy consultant (PC)-A stated it was important to rinse the mouth after receiving Budesonide nebulizer because it was a steroid. PC-A indicated it could cause thrush, a fungal infection inside the mouth. PC-A stated it was her expectation nursing staff would instruct the resident to rinse their mouth after each use. During an interview on 4/16/25 at 1:05 p.m. director of nursing (DON(confirmed R5's Budesonide nebulizer physician orders included instructions to rinse mouth after use. DON stated it was important for residents to rinse their mouth after use to prevent infections in the mouth. DON stated her expectation was nursing staff to instruct R5 to rinse mouth after receiving the Budesonide nebulizer. R5's Budesonide nebulizer box instructions indicated Budesonide was indicated for chronic respiratory conditions. Indicated Patients should rinse the mouth after inhalation of budesonide inhalation suspension to prevent fungal infections. Review of a facility policy titled Medication Administration revised 6/2024, identified medications ordered by the physician will be set up and administered within the established guidelines and given according to physician orders.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		5/30/25

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F 686	Continued From page 7 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 4 residents (R12) with a current pressure ulcer and at risk for further development of pressure ulcers. Findings include: R12's quarterly Minimum Data Set (MDS) dated 1/10/25, identified R12 had intact cognition and diagnosis which included arthritis, anxiety disorder and paraplegia (paralysis of the legs and lower body). Identified R12 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting R12's annual Care Area Assessment (CAA) dated 8/2/24, identified R12 was a at risk for skin breakdown and had a pressure ulcer to her left gluteal fold. Identified R12 required extensive assistance to reposition in bed and wheelchair. she required a regular turning schedule. R12's care plan revised 10/4/24, identified R12 had a chronic wound to her right gluteal fold. Care plan directed staff to reposition R12 every	F 686	The facility does have a process in place to ensure residents receive care consistent with professional standards and a resident with a pressure ulcer receives necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. Regarding resident 12, the facility recognizes R12 was repositioned after 2 hours and 54 minutes when the plan of care indicates R12 should be repositioned every two hours while in bed. R12 had a skin check completed at the time of the prolonged reposition time and noted no negative outcome from being repositioned after more than two hours. The facility has completed a skin assessment for R12 to ensure no new areas of impairment have occurred. R12 has been assessed to determine that 2 hours between repositioning is still appropriate and meets their needs. R12's plan of care has been reviewed, and no new updates are needed at this time. Regarding all other residents who may be affected by this deficient practice, all	

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F 686	Continued From page 8 two hours when in bed. R12's weekly wound assessment dated 4/8/25, identified R13 had a chronic pressure ulcer to her right gluteal fold which measured 3 centimeters (CM) in length and 2.2 cm in width. Identified pressure ulcer was a stage 3 (a deep, open wound that penetrates through the dermis and into the subcutaneous tissue, exposing fat but not bone, muscle, or tendon) and required a foam dressing. R12's current physician orders dated 4/14/25, identified wound to right sacrum -cleanse wound with wound cleanser and pat dry. Apply skin prep around the wound and allow to dry then place Santyl to the wound base and cover with adhesive foam dressing daily and as needed. During an interview on 4/14/25 at 1:26 p.m., R 12 stated she had a sore on her bottom and required staff assistance to turn and reposition off of her bottom. During a continuous observation on 4/15/25 at 1:41 p.m., nursing assistant (NA)-A and NA-B exited R12's room with a hoyer lift. NA-A sanitized the hoyer lift and placed the lift at the end of the hallway. -1:42 p.m., R12 was lying in bed on her back. -2:00 p.m., R12 remained lying in bed on her back. -2:20 p.m., R12 remained lying in bed on her back. -2:48 p.m., R12 remained lying in bed on her back. -3:17 p.m., R12 remained lying in bed on her back. -3:47 p.m. R12 remained lying in bed on her	F 686	residents who have a pressure-related skin injury will have an audit completed to ensure their plan of care reflects how frequently they need to be repositioned. Staff who are responsible for repositioning residents will be re-educated on their responsibility to this standard with enhanced focus to ensure residents are repositioned as per their plan of care and the importance in doing so. The facility does not have a specific repositioning policy. The facility standard is to follow the individualized resident plan of care. To assure effectiveness of staff re-education to the requirement, the facility QA team/designee will conduct routine audits of repositioning timeframes daily for one week, weekly for two weeks, monthly for two months and periodically thereafter. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings	

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F 686	Continued From page 9 back. -4:10 p.m., R12 remained lying in bed on her back. -4:35 p.m., R12 remained lying on her back and surveyor requested NA-C to reposition R12 after R12 remained lying in bed on her back and not repositioned for almost 3 hours. During an observation on 4/15/25 at 4:38 p.m., NA-C, NA-D, and registered nurse (RN)-A sanitized hands, put a gown and gloves on and entered R12's room, changed R12's incontinent product, wound bandage, and repositioned R12. During an interview on 4/15/25 at 4:48 p.m., NA-C stated R12 required staff assistance to reposition and was to be repositioned every two hours because she has a pressure ulcer. NA-C stated according to the day shift's documentation the the last time R12 had been repositioned was around 1:45 p.m. NA-C stated R12 should have been repositioned around 3:45 p.m. During an interview on 4/15/25 at 4:53 p.m., RN-A verified R12 had a pressure ulcer and required staff assistance to reposition. RN-A stated R12 was at continued risk of developing further skin breakdown and should have been repositioned every two hours while in bed. RNA stated her expectation was that R12's care plan would have been followed to help prevent any further skin breakdown. During an interview on 4/16//25 at 1:08 p.m., director of nursing (DON) verified R2 required staff assistance to reposition. DON stated R2 had a pressure ulcer on her right gluteal fold and was at risk for further skin breakdown. DON stated her expectation was that R12's care plan for	F 686		

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F 686	Continued From page 10 repositioning would have been followed. A repositioning policy was requested and was not received. .	F 686		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		5/30/25

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F 732	Continued From page 11 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all required data were included on the nurse staffing information posted daily. This had the potential to affect all 114 residents residing in the facility and their visitors who may wish to view the information. Findings include: On 4/14/25 at 1:21 p.m., the posted nurse staffing information dated 4/14/25, was observed in a clear, plastic cover on the "visitor sign-in" table. However, the nurse staffing information lacked the total number and the actual hours worked by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Additionally, the nurse staffing information lacked the resident census. On 4/15/25 at 2:12 p.m., the posted nurse staffing information dated 4/15/25, lacked the total number, and the actual hours worked by categories of licensed and unlicensed nursing staff directly responsible for resident care per	F 732	The facility does post nurse staffing information on a daily basis. The facility does recognize that information related to resident census and the total number and actual hours worked was missing on the postings for 4/14, 4/15, 4/16 and 4/17. Regarding all residents who may be affected by this deficient practice, the facility has enhanced their posting format to include all of the required data including facility name, current date, total number and actual hours worked by the categories of registered nurse, licensed practical nurse, certified nurse aides and resident census. The process for keeping the posting updated has been reviewed and revised to maintain the best workflow for those completing the form. Those responsible for maintaining the form will be re-educated with a focus on the form updates and their responsibility to the regulation.	

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F 732	Continued From page 12 shift. Additionally, the posting lacked resident census. On 4/16/25 at 7:18 a.m., the posted nurse staffing information dated 4/16/25, lacked the total number and the actual hours worked by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Additionally, the posting lacked resident census. On 4/17/25 at 7:58 a.m., the posted nurse staffing information lacked the total number, and the actual hours worked, by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift, and resident census. Additionally, the posted nurse staffing information was dated 4/16/25. On 4/17/25 at 10:10 a.m., the director of nursing (DON) stated she was unaware the information on the nurse staffing information postings lacked required information. The DON stated the nurse staffing post was expected to be updated and posted with correct information and was important so that residents and visitors knew who was in the facility providing care. On 4/16/25 at 8:56 a.m., DON verified the facility did not have a nurse staffing information policy.	F 732	To assure effectiveness of staff re-education to the requirement, the facility QA team/designee will conduct routine audits of the posting form daily for one week, weekly for two weeks, monthly for two months and periodically thereafter. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		5/30/25

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F 761	Continued From page 13 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain safe storage of medications when medication carts were left unlocked and unattended in 2 of 7 medication carts. Findings include: On 4/15/25 at 9:12 a.m., medication cart on locked memory care unit was observed to be unlocked. Medication cart was in a common area. Medication cart remained unlocked while staff walked past unlocked medication cart. On 4/15/25 at 2:44 p.m., medication cart on 100 wing of the facility was observed being unlocked. At 2:46 p.m., staff walked past medication cart to pass water. Cart remained unlocked.	F 761	The facility does have a process in place to label, and store drugs and biologicals in accordance with currently accepted professional procedures. The facility recognizes that on 4/15/2025, it was noted the medication cart was not locked properly when a nursing staff member walked away and left that cart unattended on two households. The facility has reviewed the current practice and expectations related to medication storage and believes these are isolated incidents and are outside of the facilities' standard of practice. The facility will provide one-on-one re-education and corrective action with the nurses who left the medication carts	

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F 761	Continued From page 14 At 2:48 p.m., staff walked past cart with housekeeping cart. Cart remained unlocked. At 2:49 p.m., registered nurse (RN)-B was observed coming out of spa room and walking down hall away from medication cart. Medication cart remained unlocked. At 2:50 p.m., RN-B re-entered locked spa room. Cart remained unlocked. AT 2:53 p.m., RN-B walked from spa to nurse's office out of direct eyesite of medication cart. Cart remained unlocked. At 2:54 p.m., staff passed medication cart while pushing a resient in a wheelchair. Cart remained unlocked. At 2:55 p.m., licensed practical nurse (LPN)-A walked past medication cart. Cart remained unlocked. At 2:57 p.m., RN-B locked the cart. During interview on 4/15/25 at 2:57 p.m., RN-B confirmed the medication cart was unlocked for an unknown amount of time. RN-B confirmed she did not have the medication cart direct eyesight during that time. During interview on 4/16/25 at 2:39 p.m., director of nursing (DON) stated she expected medication carts to be locked any time the nurse is away and out of eye site of them for any amount of time. DON stated this was important to make sure no one had access to items in the cart they should not have access to. The DON confirmed this was especially important in on the dementia until where residents had memory impairments. The DON confirmed the do complete regular audits to ensure medication carts were locked. A policy was requested, but none provided.	F 761	unlocked while unattended. Regarding anyone else who may be affected by this deficient practice, the facility will provide re-education to all staff who have access to the medication storage carts of the standards and their responsibility to the regulation, with an enhanced focus on the crucial need for medication to be stored correctly. In addition, education will expand facility wide across multiple departments. If a medication cart is noted to be unlocked any staff would be expected to lock it and notify nursing staff of the finding. To ensure continued compliance the facility's QA team/designee will conduct routine audits for staff knowledge/understanding of this enhancement daily for one week, weekly for two weeks, monthly for two months and periodically after that to ensure ongoing compliance. Audits will also be conducted to ensure medication carts remain locked when the individual responsible for the medication cart is not present. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings.	

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F 804	Continued From page 15	F 804		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 3 of 3 residents (R 5, R16, and R13) who resided on the North shore unit, reviewed for food. This deficient practice had the potential to affect all 21 residents residing on this unit. Findings include: R5's annual Minimum Data Set (MDS) dated 4/2/25, indicated R5 had intact cognition ad was able to feed herself after staff set up her tray. R16's significant change MDS dated 3/29/25, indicated R16 had intact cognition and could feed herself after staff set up her tray. R13's admission MDS dated 2/27/25, indicated R13 had intact cognition and could feed himself after staff set up his tray. During an interview on 4/14/25 at 2:00 p.m. R5 stated the food was not always hot by the time they were served on this unit.	F 804	The facility does provide food and drink that is palatable, attractive and at a safe and appetizing temperature. The facility does recognize that on 4/14/2025 residents 5, 16, and 13 responded that food was not always served hot. The facility also recognizes that on 4/14/2025 a test tray that did not temp at an adequate temperature and was cold or lukewarm to taste. Regarding residents 5, 16 and 13, they will all be interviewed to determine if there are continued occurrences in which their food is not served hot. Regarding all other residents who may be affected by this deficient practice, the facility will pick 2 random residents per facility household to interview related to the temperature of the food. A test tray will be audited for temperature in each household at each meal daily x 5 days to ensure it is maintained at no less than 140 degrees Fahrenheit. Staff who are responsible for dishing and serving food will be educated to their	5/30/25

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F 804	Continued From page 16 During an interview on 4/14/25 at 3:56 p.m., R16 stated the food was not always served very hot especially the meat and potatoes. During an interview on 4/14/25 at 4:09 p.m. R13 stated the food was usually only "lukewarm". During an observation on 4/14/25 at 6:24 p.m., food was being dished up onto plates and placed on a plate warmer from the steam table in the main kitchen. The plates were placed on trays and put into a cart. As the last plate was being placed into the cart a test tray was requested and placed into the cart. The meal consisted of a hamburger patty, a chicken patty, baby potatoes, and cauliflower. -at 6:24 the cart was wheeled to the north shore unit. -at 6:36 p.m. as the last tray was being passed dietary aide (DA)-A tested the food temperatures and the temps were as follows: -Hamburger was 121 degrees Fahrenheit (F). -chicken was 118 degrees Fahrenheit (F). - baby potatoes were 131 degrees Fahrenheit (F). -cauliflower was 120 degrees Fahrenheit (F). Surveyor tasted the food from the tray: the hamburger and chicken were cold, the baby potatoes, and cauliflower were lukewarm. Dietary aide (DA-A) confirmed the hamburger and chicken were cold and the remaining items were barely warm. During an interview on 4/14/25 at 6:48 p.m. DA-A stated she was unsure of what the food temperatures should be but would find out. During an interview on 4/14/25 at 6:55 p.m., R13	F 804	responsibility of this regulation with enhanced focus on standards for food temperatures. To ensure continued compliance the facility's QA team/designee will conduct routine audits for staff knowledge/understanding of this enhancement daily for one week, weekly for two weeks, monthly for two months and periodically after that to ensure ongoing compliance. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings.	

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F 804	Continued From page 17 stated his chicken was only lukewarm as always. During an interview on 4/14/25 at 7:00 p.m., R16 stated her chicken was cold tonight but she ate it because she was hungry. During an interview on 4/14/25 at 7:04 p.m., dietary manager stated her expectation was that food holding temps should be at least 140 degrees Fahrenheit (F). Review of a facility policy titled Food Service and Delivery undated, identified, hot food was to be held at 140 degrees Fahrenheit (F). or higher.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		5/30/25

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F 812	Continued From page 18 Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators and freezers were labeled, dated and discarded properly. In addition, the facility failed to maintain the ice machines in a sanitary manner to prevent potential food-borne illness. This deficient practice had the potential to affect all 116 residents who received food, beverages, and ice from the refrigerators, kitchen and ice machine. Findings include: On 4/14/25 at 10:44 a.m., during the kitchen tour with the dietary supervisor (DS), the following concerns were identified: Produce cooler: -1/4 container of yogurt without notation of an open date. -3/4 container tartar sauce without notation of an open date. -1/4 container mayonnaise without notation of an open date or an expiration date, and a foul odor when container was opened. Stand up freezer: -1/4 bag of sausage without notation of an open date or expiration date. -3/4 bag of pepperoni without notation of an open date or expiration date. -1/2 container of pork Salisbury steak without notation of an open date or expiration date. Stand up cooler: -1/4 container of yogurt without notation of an open date. -two bowls of yogurt without notation of an open date.	F 812	The facility does store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility does recognize there were 2 coolers and a freezer in the dietary kitchen that had opened food stored without a label containing the open or expiration dates. The facility recognizes it was noted three facility household refrigerators had personal resident food stored without dates or dates that were outside of the 7-day allowance for stored food. In addition, the facility recognizes on 4/14/2025 2 of 2 facility ice machines had a white calcium build up on the drip tray and machine cover. Regarding the dietary kitchen coolers and freezer, the items found out of compliance were disposed of immediately. Regarding the ACE, Mille Lacs Lake and Sunny Lake households, the items found out of compliance were disposed of immediately. Regarding all other households that may be affected by this deficiency, an audit has been completed as of 5/8/2025 and all 7 household refrigerators are noted to be free from unlabeled, undated and or open food items. Food storage policies will be reviewed and revised as needed. The dietary daily check log will be updated to include an area for dietary staff to sign after the daily refrigerator checks have been completed. A reminder posting on each household refrigerator has been placed indicating	

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	245269	A. BUILDING _____ B. WING _____	C 04/17/2025

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F 812	Continued From page 19 -1/4 whip topping no open date or expiration date -1/4 container yogurt -2 bowls of yogurt without notation of an open date. Resident fridge on Ace unit: -bowl of chicken noodle soup without notation of a date. Resident fridge on Sunny Lake unit: -one bowl of potato soup without notation of a date. -two blueberry muffins dated 3/31/25. - one bowl of chicken rice soup dated 4/3/25. Resident fridge on Milacs Lake unit: -One piece of fish in a Styrofoam container without notation of a date. Ice Machines: During an observation on 4/14/25 at 11:00 a.m., the ice machine located outside of the kitchen had a large white flaky substance approximately one half to one inch thick on the ice machine cover and the drip tray. In addition, the drip tray had a large orange buildup around the edge of the tray. During an observation on 4/14/25 at 11:15 a.m., the ice machine located on the Ace unit had a large white flaky substance approximately one half to one inch thick on the ice machine cover. During an interview on 4/14/25 at 11:30 a.m., (DS) verified the above findings during the kitchen tour. DS stated his expectation was that all food should have been dated when opened and placed in fridge or freezer and thrown away	F 812	that all food placed in them must be dated and labeled. Labeling supplies were also added to each refrigerator to make the process of labeling more convenient for residents and staff to increase compliance. Dietary and nursing staff will be educated to this process change and will be re-educated to their responsibility to the regulation with enhanced focus on resident food labeling and storage in household refrigerators. Regarding the ice machines, a new protective and cleanable surface has been applied to the ice machine outside of the kitchen. Both ice machines have had a deep cleaning to remove white calcium buildup. The water line that supplies the ice machine outside of the kitchen has been updated to address the hard water contributing to the buildup. The ice machines serving the ACE household and the kitchen have been scheduled for daily cleaning by housekeeping staff. Inspection of the ice machines will be conducted on a weekly basis by the VP of Environmental Services /designee. Staff responsible for cleaning and maintaining the ice machines will be re-educated to their responsibility to this regulation with an enhanced focus of the importance of preventing buildup on the surface of the machines. The maintenance scale removal and Food Handling Standards and procedures will be reviewed and updated as needed. To ensure continued compliance the facility's QA team/designee will conduct routine audits for staff	

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F 812	Continued From page 20 after seven days of being opened or prior to the expiration date. During an interview on 4/14//25 at 6:39 p.m., dietary manager (DM) stated her expectation was that all food items would have been dated once opened and thrown away after the shelf life or the expiration date to prevent a food borne illness. DM stated maintenance cleans the ice machine quarterly and her expectation was that there was no build up on the ice machines. During an interview on 4/15/25 at 1:45 p.m. maintenance director (MD) verified the buildup on the ice machines. MD stated his expectation was that the ice machines would not have any build up on them Review of a facility policy titled maintenance: Scale Removal dated 12/2014, identified scale removal was performed on all ice machines at least twice yearly, every three months or as necessary to maintain a sanitary unit. Review of a facility policy titled Food Handling Standards and Procedures dated 2024, identified all food needs to be dated once opened and discarded within seven days or prior to the expiration dates.	F 812	knowledge/understanding of this enhancement daily for one week, weekly for two weeks, monthly for two months and periodically after that to ensure ongoing compliance. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	F 867		5/30/25

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F 867	Continued From page 21 procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,	F 867		

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F 867	Continued From page 22 and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope	F 867		

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F 867	Continued From page 23 and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement Program (QAPI) committee effectively sustained ongoing compliance related to repeat citations from past surveys regarding drug storage. This had the potential to affect all 114 residents residing in the facility. Findings include: Review of the facility CASPER Report dated	F 867	The facility does establish and implements written policies and procedures for feedback, data collection systems and monitoring to identify problems that are high risk, high volume, or problem prone and opportunities for improvement. The facility recognizes the system was not successful in ongoing prevention of a repeat citation from a past survey regarding drug storage. The facility has completed and root cause	

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F 867	Continued From page 24 3/17/25, indicated the facility was cited F761 for drug storage on the survey exited 5/2/24. See F761: Based on observation and interview, the facility failed to maintain safe storage of medications when medication carts were left unlocked and unattended in 2 of 7 medication carts. The facility's QAPI meeting minutes dated 3/13/25, lacked ongoing data related to the above repeat citation. On 4/17/25 at 10:45 a.m., the quality assurance registered nurse (RN)-B acknowledged the importance of continued monitoring of prior Performance Improvement Projects (PIPS). RN-B stated formal auditing and then more periodic auditing, chart review, and observational audits, were completed to ensure improvements were sustained. The facility's Quality Assurance and Performance Improvement Program policy, revised 4/15/24, indicated the facility monitors the effectiveness of its performance improvement activities to ensure improvements are sustained.	F 867	analysis of the deficient practice and feels the approach and education was too narrow to succeed in long term improvement, therefore opening the facility to the possibility of continued deficient practice. In regard to the F761 deficient practice the facility has expanded the education to more departments to assist in holding the staff responsible for maintaining the medication carts accountable and creating more of a culture change to assist with ongoing compliance. In regard to this and other topics that may be affected by the deficient practice, the facility will also make a standing agenda item for the Quality Assurance meetings to ensure ongoing discussion and collaboration with the governing body in regard to survey deficiency directed quality improvement focused items in addition to other topics already being reviewed. Staff who participate in quality assurance development will be re-educated to their responsibility to this regulation with enhanced focus on long term sustainability. The facility quality assurance program will be reviewed and revised if necessary. This enhanced practice will be audited quarterly for one year and periodically after that to ensure ongoing compliance. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/30/25

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F 880	Continued From page 25 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 26 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper personal protective equipment (PPE) was used when providing cares for 1 of 1 residents (R80) reviewed for enhanced barrier precautions (EBP). Findings include: R80's admission Minimum Data Set dated 3/27/25, included R80 had moderate cognitive impairment. R80 had diagnosis of COVID-19,	F 880	The facility does have an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility recognizes that two staff did not wear appropriate PPE while assisting resident 80 with ADL cares. Regarding R80, the resident requires EBP	

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F 880	Continued From page 27 depression, and metabolic encephalopathy (a condition causing altered metal status). R80's undated care plan, included R80 was on EBP due to a pressure ulcer on buttocks. Care plan included to wear a gown and gloves when providing high contact cares. On 4/15/25 at 9:21 a.m., licensed practical nurse (LPN)-B was observed in R80's room cutting her toenails. LPN-B was not wearing a gown and was leaning on foot of bed. During interview on 4/15/25 at 9:25 a.m., LPN-B confirmed R80 was on EBP for a pressure ulcer. LPN-B confirmed she had received education on EBP and should be wearing PPE whenever providing close contact cares. LPN-B confirmed she should have been wearing a gown. On 4/15/25 at 9:48 a.m., physical therapy assistant (PTA)-F was observed assisting R80 with walking in her room and transferring to her bed. PTA-F was observed assisting R80 adjust the covers on her bed to cover R80's lower body. During interview on 4/15/25 at 9:51 a.m., PTA-F stated she had received training on EBP and R80 was on EBP. PTA-F stated PPE should have been worn whenever assisting with personal cares, such as dressing or toileting. During interview on 4/16/25 at 8:22 a.m., clinical manager (CM)-A confirmed R80 was on EBP and staff should wear PPE whenever providing close contact cares, such as transferring, toileting and repositioning. CM-A confirmed staff should have been wearing a gown and gloves while clipping toenails, assisting with physical therapy, and	F 880	related to a pressure ulcer. A skin assessment has been completed, and the wound is not closed. This resident continues to have the need for EBP. No changes have been noted in resident conditions indicating there was not a negative outcome related to staff non-compliance. Resident's care plan will be reviewed to assure indication for EBP use is indicated. An audit to ensure appropriate signage and supplies was completed for residents' living space and was noted to be appropriate and stocked. The facility has re-educated the two staff involved in the deficient practice on the correct process and the importance of compliance. Regarding all other residents who have the potential of negative impact due to the deficient practice, an audit for all residents who require EBP will be completed to ensure EBP indications remain clinically indicated. Supplies and signage will be audited to ensure appropriate and stocked. Resident care plans will be reviewed to ensure they include resident needs and indication for EBP use. The infection prevention plan will be reviewed and will be revised if necessary. Facility wide staff will be educated on their responsibility to the regulation with enhanced focus on the Enhanced Barrier Precautions process, when it needs to be utilized and compliance importance. To ensure continued compliance the facility's QA team/designee will conduct routine audits for staff knowledge/understanding of this enhancement daily for one week, weekly	

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F 880	Continued From page 28 adjusting covers on the bed. During interview on 4/16/25 at 12:59 p.m., infection control prevention nurse (IP)-G stated all staff are trained on EBP and the facility follows center for disease (CDC) guideline for precautions. IP-G confirmed gown and gloves should have been worn when clipping toenails and providing therapy assistance. IP-G confirmed all departments including therapy was trained on EBP. During interview on 4/16/25 at 1:16 p.m., director of nursing (DON) stated PPE should be worn any time a staff person is completing hands on care for a resident on EBP. The DON stated this was important to protect all residents and staff. Facility infection control and prevention manual dated October 2024, included EBP involved gown and glove use during high-contact resident care activities.	F 880	for two weeks, monthly for two months and periodically after that to ensure ongoing compliance. To ensure ongoing compliance, results from these audits will be reviewed at the facility Quality Assurance meetings.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on 04/15/2025. At the time of this survey, Good Shepherd Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the NFPA 101 (2012 edition), Life Safety Code, Chapter 19 Existing Health Care, and the NFPA 99 (2012 edition), Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/08/2025

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

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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 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as one building: Good Shepherd Home is a 2-story building with a partial basement. The building was constructed at 6 different times: The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1969, an addition was added to the east that was determined to be of Type II (111) construction. In 1980, an addition was added to the northwest that was determined to be Type V (111). In 1997, an addition was added to the west that was determined to be of Type V	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 _____	**04/15/2025**

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

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K 000	Continued From page 2 (111) construction. In 2002, an addition was added to the Main Dining Room that was determined to be of Type V (111) construction. In 2010 a two story addition was added that was determined to be of Type II (111) construction located on the southwest corner of the facility. In 2010 a two story addition was added that was determined to be of Type II (111) construction located on the northeast corner of the facility. In 2010 a one story addition was added that was determined to be of Type V (111) construction located north of the chapel. The building is fully sprinkler protected and the facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 162 beds and had a census of 115 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		5/30/25

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 _____	**04/15/2025**

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K 353	Continued From page 3 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(5), and 5.2.1.2. These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 04/15/2025 between 8:30 and 11:30 AM, it was revealed by observation that sprinkler heads in the Silver Bay Spa Room, North Shore Spa Room, and Canary Creek Spa Room were covered in a layer of lint and debris. 2. On 04/15/2025 between 8:30 and 11:30 AM, it was revealed by observation that a sidewall sprinkler head in Storage Room B25 was blocked by items being stored on the top shelf of a storage rack. Violation was corrected at the time of discovery. An interview with the VP of Environmental Services verified these deficient findings at the time of discovery.	K 353	The sprinkler heads in violation were cleaned on April 16, 2025. Inspection of sprinkler heads for contaminants, integrity and proper clearances will be monitored through the environmental rounding process, monthly. Findings will be reviewed at the monthly safety meeting. The VP of Environmental Services will oversee this process and ensure that deficiencies are corrected in a timely manner.	

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	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/15/2025**

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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		5/30/25

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K 363	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1, and 19.3.6.3.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 04/15/2025 between 8:30 and 11:30 AM, it was revealed by observation that the doors for resident rooms 305 and 603 did not latch when they were closed. An interview with the VP of Environmental Services verified these deficient findings at the time of discovery.	K 363	The resident room doors in violation were corrected on April 16. 2025. Inspection of resident room corridor doors for proper closure and latching will be monitored through the environmental rounding process, monthly. Findings will be reviewed at the monthly safety meeting. The VP of Environmental Services will oversee this process and ensure that deficiencies are corrected in a timely manner.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245269	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**4/15/2025**

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 70, (2011 edition), National Electrical Code, section 400.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/15/2025 between 8:30 and 11:30 AM, it was revealed by observation that there was a blue extension cord plugged into an outlet and running through a hole in the wall to a sump pump in the next room. Violation was corrected at the time of discovery. An interview with the VP of Environmental Services verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents