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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VLF8

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 **05/27/2015** (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 :
Mary Rogers, HFE NE II 05/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/28/2015 (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 06/10/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/28/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245269
June 3, 2015

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 June 18, 2015 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 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
Health Regulations Division
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
June 3, 2015

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

RE: Project Number S5269022

Dear Mr. Glanzer:

On April 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 9, 2015. 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 May 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 11, 2015 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 April 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 9, 2015, effective May 18, 2015 and therefore remedies outlined in our letter to you dated April 21, 2015, 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
Health Regulations Division
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	5/27/2015

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 **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/18/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/18/2015**
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	06/03/2015	29437	05/27/2015
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
4/9/2015			

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 A. Building B. Wing	(Y3) Date of Revisit
245269	01 - MAIN BUILDING 01	5/11/2015

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

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	04/30/2015	ID Prefix Reg. # NFPA 101 LSC K0062	04/30/2015	ID Prefix Reg. # NFPA 101 LSC K0147	04/30/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	06/03/2015	34764	05/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
4/7/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245269	A. Building B. Wing **02 - TWO-STORY ADDITION**	5/11/2015

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0011	**04/30/2015**	ID Prefix Reg. # **NFPA 101** LSC K0050	**04/30/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/KJ	**Date:** 06/03/2015	**Signature of Surveyor:** 34764	**Date:** 05/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/7/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245269	03 - NORTH EAST ADDTION	5/11/2015

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 K0050	Correction Completed 04/30/2015	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: 06/03/2015	Signature of Surveyor: 34764	Date: 05/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/7/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245269	A. Building B. Wing 04 - FALLOWSHIP HALL	5/11/2015

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 K0050	Correction Completed 04/30/2015	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: 06/03/2015	Signature of Surveyor: 34764	Date: 05/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/7/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VLF8

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 **04/09/2015** (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:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Nicolle Marx, HFE NE II 05/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/28/2015 (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 05/28/2015 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
April 21, 2015

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

RE: Project Number S5269022

Dear Mr. Glanzer:

On April 9, 2015, 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)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 19, 2015, 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 May 19, 2015 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 July 9, 2015 (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 October 9, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
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 _____	04/09/2015

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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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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident was safe to self administer medications for 1 of 8 residents (R116) observed during medication administration. Findings include: R116 was admitted to the facility on 3/4/11. R116's Resident Disease History identified diagnoses including generalized muscle weakness, macular degeneration, and	F 176	Good Shepherd Lutheran Home does ensure that its residents are safe to self-administer drugs through comprehensive record review and assessment. The facility recognizes that during the survey one nurse, left one resident□s pills in front of him/her at the dinner table while the nurse set up the next resident□s medication. She was in the same vicinity and felt she could watch the resident take her medicine from the cart position. This	5/18/15

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

Electronically Signed | 05/01/2015

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F 176	Continued From page 1 hemiplegia. During an observation on 4/8/15, at 8:40 a.m. licensed practical nurse (LPN)-A set up R116's medications and brought them to the dining room table. LPN-A placed R116's medications on her placemat, and R116 took one pill out of the cup at a time, and placed it in her mouth. At 8:56 a.m. LPN-A left the dining room and went to the adjacent room where the med cart was parked, and began setting up medications for R182, who was eating breakfast at the same table as R116. When LPN-A returned to the table with R182's medications, R116 was noted to have one white pill remaining on the placemat. Review of R116's Medication Administration Record (MAR) dated 4/15, indicated LPN-A administered R116 Aspirin 81 milligrams (mg), metoprolol 50 mg, multivitamin 1 tablet, omeprazole 20 mg, preservation areds 1 capsule, and senokot-S 8.6 mg for the morning medications. A Self Administration of Medications form for R116 dated 3/4/11, indicated R116 did not wish to self administer medications, and the rest of the assessment remained blank. There was no indication the resident was assessed to be safe to self administer medications. During interview on 4/9/15, at 2:47 p.m. registered nurse (RN)-A stated according to the facility policy, the medication nurse should be staying with a resident while taking their medication, unless the resident had a self administration assessment completed indicating they were able to safely self administer medications. RN-A stated R116 had not been	F 176	is not the facility□s expectation of medication pass practice. Regarding resident #116 the facility re-assessed the resident for the ability to self-administer his/her medications as it is something the resident wants to do after set up. The resident feels better having the medications set up for him/her and likes them at the table during the meal or in the room when necessary. To assure this practice was not occurring on the other households without self-administration assessment or affecting the residents; as would be indicated by the fact that this was an isolated instance during the medication survey review; the facility audited its other households for medication pass practices outside of the facility□s expectation. Although the facility did not find the deficient practice elsewhere, the facility completed a re-training for all nurses regarding medication pass expectations. Re-training will be completed to assure all staff responsible to this tag will have this practice well imbedded. This training will be completed by 5/18/2015. To assure ongoing efficacy of the correction of this practice the facility will, through its Case Managers, complete medication pass audits monthly for the first three months and periodically thereafter to assure the deficient practice does not reoccur. The results of the audits will be reviewed for practice change efficacy through the facility QA meetings.	

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F 176	Continued From page 2 assessed to be safe to self administer medications. During interview on 4/9/15, at approximately 3:15 p.m. assistant director of nursing (ADON) stated a resident should not be left alone with medications if they did not have an individual assessment completed indicating they were capable of self administering medications. The facility policy titled Medication Administration dated 4/11, indicated the resident must take the medications when the nurse/trained medication aide is present unless otherwise ordered by the physician, or if the resident has completed medication self-administration assessment and had been noted to be safe.	F 176		
F 241 SS=E	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 staff treated residents in a dignified manner when entering the resident rooms for 3 of 3 residents (R242, R180, R241). In addition, the facility failed to ensure toileting assistance was provided in a dignified manner for 2 of 2 residents (R242 and R212) reviewed for timely response to call light requests.	F 241	Good Shepherd Lutheran Home does promote care for its 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. Privacy: The facility recognizes that during the survey there was the possibility that staff may have not waited long enough before	5/18/15

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F 241	Continued From page 3 Findings include: R242's social services assessment dated 4/3/15, indicated the resident had no cognitive impairment. R242 care plan dated 3/27/15, identified R242 had potential of having problems of feeling secure, and staff was instructed to be active listeners, build trusting relationships, and if R242 had a concern, they should discuss it. During observation on 4/6/15, at 3:41 p.m. nursing assistant (NA)-A quickly knocked twice on R242's room, and without waiting for a reply, immediately entered R242's room. R242 stated he did not like it when staff didn't wait for him to tell them they could come in his room. R242 said, "I used to be a mortician, and I know they are suppose to wait until they're invited in." R180's significant change Minimum Data Set (MDS) dated 3/20/15, indicated R180 had moderate cognitive impairment. R180's care plan dated 3/24/15, identified, "I will feel secure in my neighborhood ..." During observation on 4/6/15, at 4:23 p.m. R180's door to the room was closed and NA-B entered R180's room without knocking. R180 stated It bothered him when staff walked in his room without knocking and requesting permission to come in. R180 stated, "I don't like it." R241's Social Services Assessment dated 4/6/15, indicated the resident had severe cognitive impairment.	F 241	entering. The facility recognizes that this is very subjective but always strives to promote the residents privacy. This said in regard to residents # 241-242-180; as it is not the facility expectation; all staff will be re-trained to assure that these three residents and any other resident residing here at Good Shepherd have their privacy respected; the facility chose to re-train the staff in regards to making sure they give the resident time to answer their knock prior to entering the room. Training will be completed by 5/18/2015 to assure re-training was covered for all staff responsible to this tag. Dignity: The facility recognizes that, just like all facilities at this time, there is a staffing challenge due to the difficulty in hiring within the industry. The facility has a process by which it makes sure that staff is sufficient to cover the needs of its residents. Regarding the concerns cited in the deficiency regarding resident # 242 the resident uses his urinal for voiding independently. Regarding the report that the resident stated he had to call his wife at 3:00 AM; the facility reviewed the call light reports from 12:00 midnight to 6 AM over a period of one week and found one call light being on for 26 min on one morning at 5AM. Resident #242 had a bladder monitoring put in place to assess his continence the data shows that the resident remains continent at every two hours. Regarding resident #212 the facility did	

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F 241	Continued From page 4 R241 Care plan dated 3/31/15, indicated, "I will feel secure in my neighborhood..." During a family interview on 4/6/15, at 4:07 p.m. NA-A knocked twice on R241's door while opening the door at the same time without waiting for a response before entering. During interview on 4/8/15, at 12:58 p.m. RN-C stated staff were expected to knock on residents doors, and wait at the door at least three seconds for a response before they walked into the room. RN-C stated the facility wants the residents to feel like they are at home, and staff should not be walking into their 'homes' without knocking. RN-C stated it was not acceptable to enter a residents room without knocking and staff had been trained on that issue for the dignity of the residents. During interview on 4/8/15, at 1:27 p.m. the director of nursing (DON) stated staff was trained to knock on a residents door, wait a few seconds for a response, and if there is no response peek in the residents room to ensure the resident is alright. R242's social services assessment dated 4/3/15, indicated the resident had no cognitive impairment. During interview on 4/6/15, at 3:41 p.m. R242 stated he did not feel like he was treated with dignity by the staff because he has to wait for a long time at night to have his call light answered, and he has to wet the bed. R242 stated he feels bad when he wets the bed, and he feels "embarrassed" when he wets the bed. R242 stated last week sometime he could not get any	F 241	review the call light report for this resident for these cited times of concern and did find one call light which was on for 15 minutes. Resident # 212 □ the resident was hospitalized after the survey team left for an unrelated concern. The resident returned on 4/28 and the Case Manager started a bladder monitoring to identify if the resident is still capable of remaining continent. Since return the data has shown that the resident is consistently continent when toileted every two hours and urinates well when toileted at those times. With this information of those call lights that were on longer than 15 minutes the facility chose to audit call lights to assure timely response times for all it residents. Also the staff will be trained on call light response with completion of training on 5/18/2015 To assure ongoing efficacy of the correction of this practice the facility, through its Case Managers/Team Leaders, will complete call light audits monthly for the first three months and periodically thereafter to assure the deficient practice does not reoccur. The results of the audits will be reviewed for practice change efficacy through the facility QA meetings.	

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F 241	Continued From page 5	F 241		

staff to come help him, so he called his wife at 3:00 a.m. to call the facility and ask a nurse to come to his room to assist him.

During interview on 4/8/15, at 5:52 a.m. registered nurse (RN)-B stated R242 complained of wetting the bed due to waiting so long for assistance in the night, however, RN-B was unable to give specific examples of times or days this had occurred.

R212's 14 day Hospital Return Assessment dated 4/8/15, indicated R212 had no cognitive impairment, was continent of bowel, and occasionally incontinent of bladder.

A progress note dated 4/8/15, indicated R212 was at risk for incontinence due to polypharmacy (use of multiple medications), decreased mobility, and needed assistance of one staff with toileting needs and peri care. The progress note indicated R212 was able to alert staff when needing to use the restroom, used a urinal at night, and was able to choose his own toileting schedule.

R212's care plan dated 3/5/15, indicated R212 was totally dependent on staff for all activities of daily living (ADL's), including assistance of two staff with dressing. R212 was at risk for incontinence of bowel and bladder, and staff were directed to monitor the resident for incontinent episodes and provide peri care after each episode.

During interview on 4/6/15, at 4:32 p.m. R212 stated he did not feel staff treated him with respect or dignity because the facility was often short staffed and were not able to provide him with timely toileting assistance. R212 stated the

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F 241	Continued From page 6	F 241		

facility was especially short staffed over a recent holiday weekend, and he had his call light on because he needed help after being incontinent of urine. R212 stated he was forced to sit in his own urine three separate times while waiting an extended amount of time for staff to answer his call light. R212 stated a (unidentified) staff member, "Even made a comment that I didn't have to complain about it [about having to wait a long time sitting in his urine]."

A Nursing Progress Note dated 4/4/15, at 11:16 p.m. written by RN-E indicated, "Staff reported that resident stated that he'd been waiting for three hours after he turned on his call light. Staff also stated that resident was mean to them regarding waiting for three hours and let him sit in his pee."

During interview on 4/9/15, at 9:38 a.m., RN-D stated, "[R212] told me he had to wait so long that he peed his pants...It's hard because residents don't always have a good sense of time."

During a follow up interview on 4/9/15, at 1:52 p.m., R212 stated on Friday afternoon, 4/3/15, he needed to go to the bathroom and there was some maintenance people working on his wheelchair. The maintence saw his call light was on, and they told him they would tell the nurse. R212 stated he tried to use his urinal but had trouble getting it in place fast enough, and was incontinent. R212 stated when the nurse "finally" came into his room, she told him she was doing report and that is why she wasn't able to assist him sooner. R212 stated he had two similar incidents on Saturday (4/4/15), late afternoon and after he went to bed that evening. R212 stated staff didn't come for a long time after he put on

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F 241	Continued From page 7 his call light so he had to sit in his pee. R212 stated, "Having to sit in pee is what bothers me...It's very dehumanizing." During interview on 4/9/15, at 2:05 p.m., RN-E stated she didn't recall R212 having an incontinent episode over the weekend. During interview on 4/9/15, at 2:33 p.m., ADON stated she was not aware of any complaints from residents regarding staffing or having to wait for long periods of time for toileting assistance. When ADON was asked about the facility policy on resident dignity, she stated, "It's a given...we want our residents to be treated with respect and dignity. It's in our mission statement." A policy related to dignity was requested and not provided.	F 241		
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	F 329		5/18/15

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F 329	Continued From page 8 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure there was a comprehensive sleep assessment and monitoring conducted related to the use of Trazodone (an antidepressant) and Melatonin (a hormone that regulates sleep) to treat insomnia for 1 of 5 residents (R155) whose drug regimen was reviewed. Findings include: R155's quarterly Minimum Data Set (MDS) dated 1/21/15, identified R155 was cognitively intact, had trouble falling asleep, staying asleep, sleeping too much, and was not identified as taking a hypnotic or antidepressent medication. The frequency of sleeping difficulty was not identified on the MDS. R155 Care Area Assessment (CAA) dated 8/15/14, identified R155 used a sedative/hypnotic, specifically Melatonin at bedtime to assist with sleep. The CAA indicated R155 often chose to sleep in the recliner because he slept better, and the interdisciplinary team (IDP) was to monitor R155's sleep quarterly to ensure appropriate dosing of medications.	F 329	Good Shepherd Lutheran Home does assure that its residents drug regimens are free of unnecessary drugs. The facility recognizes that at the time of the survey resident # 155 had been started on Trazodone for sleep prior to a sleep study being completed. Through the facility s ongoing assessment and review of resident # 155 s medications the nurse manager had stated that although the resident continued to take Melatonin for sleep; the resident had indicated that he still was awake at night occasionally. The physician after review of the assessment decided to add Trazadone to the resident s regime. The facility recognizes in this isolated instance that a sleep log for assessment was not completed post medication use to determine efficacy of the medication. A sleep log was put in place to assess resident # 155 s response to the hypnotic medication on 04/15/2015. To assure that no other residents were affected by this practice oversight; those residents using hypnotic had their plans	

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F 329	Continued From page 9 R155's current physician orders indicated orders for Melatonin 3 milligrams (mg) at bedtime for sleep, and Trazodone 50 mg at bedtime for sleep. R155 was initially started on 1 mg of Melatonin at bedtime for sleep on 5/28/14, and the Melatonin was increased on 11/19/14, to 3 mg at bedtime. R155 was prescribed Trazadone 50 mg at bedtime on 3/10/15. R155's medical record lack evidence of any individual comprehensive sleep assessment, nor was there any monitoring of R155's sleep patterns before or after any of the medications had been started, changed, or added. A Psychopharmacological Drug Assessment dated 8/14, indicated R155 received 1 mg of Melatonin for difficulty initiating sleep. The assessment was reviewed and signed by the physician on 9/8/14, and no changed were made at that time to R155's drug regimen. Another Psychopharmacological Drug Assessment was completed on 1/27/15, which indicated R155's Melatonin had been increased to 3 mg at bedtime for sleep. The form indicated R155's behavior/mood had remained unchanged, and R155 had difficulty sleeping. The Drug assessment did not indicate R155's current sleeping difficulties, or the residents sleep pattern before or after the Melatonin was started, or when it was increased. The form was reviewed and signed by the physician on 2/20/15, with a new medication order to add Trazodone 50 mg at bedtime for sleep. A physician's office visit note dated 2/6/15, indicated R155's insomnia was improved with	F 329	of care reviewed and revised as necessary. Since survey the consultant pharmacist completed a review on all residents using hypnotics in the facility on 4/27 and 4/28 and follow up care plan revisions were completed as needed by the Case Managers. To assure that this isolated oversight is not likely happen again the facility completed re-training, to those staff responsible for this regulation, in regard to assessing sleep patterns prior to starting a hypnotic and post assessment for efficacy of the medication. The facility will continue with its ongoing monitoring of the use of these medications. Training will be completed 5/18/2015 for all staff responsible to this tag. To assure ongoing efficacy of the correction of this practice, the facility will complete hypnotic use/assessment audits of those residents on hypnotics on a monthly basis ongoing with the collaboration of the pharmacist. The results of the audits will be reviewed for practice change efficacy through the facility 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 _____	04/09/2015

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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F 329	Continued From page 10	F 329		

Melatonin. The note indicated R155 was satisfied with his sleep quality, did not have difficulty falling asleep or staying asleep, did not wake a few hours after sleep onset, and did not have any daytime hypersomnolence. Although on 2/6/15, the physician office note indicated R155 was having no problems sleeping, on 2/20/15, 14 days later, another sleep medication was added with no assessment or justification of the addition of another sleep medication.

On 6/14/14, the consulting pharmacist noted the start of Melatonin on 5/28/14, but did not note any irregularities which needed to be addressed. On 11/25/14, the consulting pharmacist noted the Melatonin had been increased on 11/19/14, and no irregularities were noted for the physician or facility to address. On 3/31/15, the consulting pharmacist noted Trazodone 50 mg had been started for sleep, and no irregularities were noted for the physician or facility to address.

During interview on 4/8/15, at 8:19 a.m. Registered nurse (RN)-E stated the facility would complete occasional sleep log assessments on residents who had difficulty sleeping, however, R155 did not have a comprehensive sleep assessment had been completed. RN-E stated the IDP team had completed the Psychopharmacological drug assessments for R155 and then faxed them to the physician for review. RN-E stated the IDP team documented R155 had difficulty sleeping because his statement to the nurses was he sometimes got up from bed during the night to sleep in the chair. RN-E stated the facility had not completed a individual sleep assessment for R155 to determine his actual sleep patterns.

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F 329	Continued From page 11 During interview on 4/8/15, at 8:41 a.m. R155 stated he "Sometimes" had difficulty sleeping, but he would move from the bed to the chair and then fall back asleep. R155 was unaware if his medication regimen for sleep had recently changed. During interview on 4/8/15, at 2:46 p.m. assistant director of nursing (ADON) stated nursing staff should be completing a sleep assessment on any resident having difficulty sleeping, or after a medication was added or changed for sleep to ensure the medication was effective. The ADON stated a comprehensive sleep assessment would include an hourly log of whether or not the resident was asleep or awake, which would then be summarized in a progress note. ADON stated R155 did not have a comprehensive sleep assessment completed, and the facility did not have any policies related to sleep assessments. During interview on 4/9/15, at 3:40 p.m. the consulting pharmacist (P)-A stated the facility should be completing periodic reviews of a residents sleep patterns. P-A stated she had reviewed R155's nursing and physician notes, as well as the Psychopharmacological assessment, and felt the documentation of R155 stating he had difficulty sleeping was sufficient to justify the multiple medications for sleep.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		5/18/15

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F 371	Continued From page 12 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene practices were followed to minimize the risk of foodborne illness during meal service. This had the potential to affect 19 of 20 residents who ate meals in the Mille Lacs unit dining room. Findings include: During observation of the evening meal service on 4/6/15, at 5:37 p.m. in the Mille Lacs household unit, most of the residents were being served grilled cheese sandwiches, personal pizzas, and tomato soup. At approximately 5:40 p.m. dietary aide (DA)-A was observed throwing trash away at the garbage can. DA-A had gloves on, lifted the lid of the garbage can with her hands, and threw away the trash. Immediately after, DA-A walked back to the steam table and began to place food on the residents plates without removing her gloves and doing any hand hygiene after touching the garbage. DA-A also picked up multiple ready to eat grilled cheese sandwiches, and put them on plates with the same gloves she had been wearing when she had thrown the garbage away. At 5:49 p.m. DA-A walked over to the garbage again and lifted the lid with her gloved hands and threw away some trash. DA-A did not remove the gloves or complete hand hygiene, and returned to	F 371	Good Shepherd Lutheran Home does store, produce, distribute and serve food under sanitary conditions. The facility recognizes that on one day of the survey, during one meal, one dietary aide did not replace her gloves after using her hand to open the cover on the trash bin rather that use the foot pedal opener. The facility recognizes the supporting data sited in the deficiency indicates that the dietary aide soiled her gloves two times without removing the gloves before returning to serving food. The facility does monitor its staff for proper hand hygiene and does not normally see this practice. The facility believes this error in practice may have been due to the stress of the survey. That said, the facility does promote proper hand hygiene and glove use always, and recognizes this isolated instance can be used to re-train all staff who handle food for our residents The facility has conducted hand hygiene/glove use audits to assure that this deficient practice is not seen elsewhere and is re-training staff to assure continued good practice. Training will be completed for all staff responsible to this tag. This training will	

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F 371	Continued From page 13 the steam table and continued to serve the ready to eat grilled cheese sandwiches, personal pizzas, and slices of bread with the same gloves she had worn when touching the garbage both times. During interview on 4/8/15, at 10:16 a.m. dietary manager (DM)-A stated dietary staff were expected to wear gloves when handling ready to eat foods, and the gloves needed to be changed in between duties, and complete hand hygiene between glove changes. DM-A stated DA-A should have changed gloves and completed hand hygiene after touching the lid of the garbage can and before touching resident food. The facility policy titled Hand Washing and Glove Use and Food Service dated 4/4/12, instructed staff to change gloves in between tasks.	F 371	be completed by 5/18/2015. To assure ongoing efficacy of the correction of this practice the facility will complete hand hygiene/glove use audits monthly for the first three months and periodically thereafter to assure the deficient practice does not reoccur. The results of the audits will be reviewed for practice change efficacy through the facility 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 by: Based on interview and document review, the consulting pharmacist failed to identify the lack of	F 428	Good Shepherd Lutheran Home does contract with a consulting Pharmacist who	5/18/15

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F 428	Continued From page 14 adequate monitoring and indications for the use of multiple sleep medications (Melatonin and Trazodone) being used to treat insomnia for 1 of 5 residents (R155) whose drug regimen was reviewed. Findings include: R155's quarterly Minimum Data Set (MDS) dated 1/21/15, identified R155 was cognitively intact, had trouble falling asleep, staying asleep, sleeping too much, and was not identified as taking a hypnotic or antidepressant medication. The frequency of sleeping difficulty was not identified on the MDS. R155 Care Area Assessment (CAA) dated 8/15/14, identified R155 used a sedative/hypnotic, specifically Melatonin at bedtime to assist with sleep. The CAA indicated R155 often chose to sleep in the recliner because he slept better, and the interdisciplinary team (IDP) was to monitor R155's sleep quarterly to ensure appropriate dosing of medications. R155's current physician orders indicated orders for Melatonin 3 milligrams (mg) at bedtime for sleep, and Trazodone 50 mg at bedtime for sleep. R155 was initially started on 1 mg of Melatonin at bedtime for sleep on 5/28/14, and the Melatonin was increased on 11/19/14, to 3 mg at bedtime. R155 was prescribed Trazadone 50 mg at bedtime on 3/10/15. R155's medical record lack evidence of any individual comprehensive sleep assessment, nor was there any monitoring of R155's sleep patterns before or after any of the medications had been started, changed, or added.	F 428	does monthly reviews of all its residents drug regimens 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 at the time of the survey 1 of 5 residents, whose drug regimen lacked assessment for sleep post medication order and that the consultant Pharmacist missed notifying the facility of this lack of assessment. A sleep log was put in place to assess resident # 155s response to the hypnotic medication on 04/15/2015. To assure that no other residents were affected by this practice oversight; those residents using hypnotic had their plans of care reviewed and revised as necessary. Since survey the consultant pharmacist completed a review on all resident using hypnotics in the facility on 4/27 and 4/28 and follow up care plan revisions were completed as needed by the Case Managers. To assure this requirement is not missed in the future the Case Managers will be expected to use their computerized medical record to review new orders daily in the AM and use this information to assure that new orders for sedative/hypnotics are assessed for appropriateness and sleep logs are completed for medication efficacy. The Consultant Pharmacist has conferred with the facility to assure that he/she will	

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F 428	Continued From page 15 A Psychopharmacological Drug Assessment dated 8/14, indicated R155 received 1 mg of Melatonin for difficulty initiating sleep. The assessment was reviewed and signed by the physician on 9/8/14, and no changed were made at that time to R155's drug regimen. Another Psychopharmacological Drug Assessment was completed on 1/27/15, which indicated R155's Melatonin had been increased to 3 mg at bedtime for sleep. The form indicated R155's behavior/mood had remained unchanged, and R155 had difficulty sleeping. The Drug assessment did not indicate R155's current sleeping difficulties, or the residents sleep pattern before or after the Melatonin was started, or when it was increased. The form was reviewed and signed by the physician on 2/20/15, with a new medication order to add Trazodone 50 mg at bedtime for sleep. A physician's office visit note dated 2/6/15, indicated R155's insomnia was improved with Melatonin. The note indicated R155 was satisfied with his sleep quality, did not have difficulty falling asleep or staying asleep, did not wake a few hours after sleep onset, and did not have any daytime hypersomnolence. Although on 2/6/15, the physician office note indicated R155 was having no problems sleeping, on 2/20/15, 14 days later, another sleep medication was added with no assessment or justification of the addition of another sleep medication. On 6/14/14, the consulting pharmacist noted the start of Melatonin on 5/28/14, but did not note any irregularities which needed to be addressed. On 11/25/14, the consulting pharmacist noted the	F 428	print out a list of all sedative/hypnotics currently in use when the pharmacist is in the facility for monthly review (see above recent review dates); and use this as a second tool to assure that the Pharmacist doesn□t through human error miss a hypnotic. Training will be completed for all staff responsible to this tag. This training will be completed by 5/18/2015. To assure ongoing efficacy of the correction of this practice the facility will complete hypnotic use/assessment audits monthly for the first three months and periodically thereafter to assure the deficient practice does not reoccur. The results of the audits will be reviewed for practice change efficacy through the facility QA meetings.	

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F 428	Continued From page 16	F 428		

Melatonin had been increased on 11/19/14, and no irregularities were noted for the physician or facility to address. On 3/31/15, the consulting pharmacist noted Trazodone 50 mg had been started for sleep, and no irregularities were noted for the physician or facility to address.

During interview on 4/8/15, at 8:19 a.m. Registered nurse (RN)-E stated the facility would complete occasional sleep log assessments on residents who had difficulty sleeping, however, R155 did not have a comprehensive sleep assessment had been completed. RN-E stated the IDP team had completed the Psychopharmacological drug assessments for R155 and then faxed them to the physician for review. RN-E stated the IDP team documented R155 had difficulty sleeping because his statement to the nurses was he sometimes got up from bed during the night to sleep in the chair. RN-E stated the facility had not completed a individual sleep assessment for R155 to determine his actual sleep patterns.

During interview on 4/8/15, at 8:41 a.m. R155 stated he "Sometimes" had difficulty sleeping, but he would move from the bed to the chair and then fall back asleep. R155 was unaware if his medication regimen for sleep had recently changed.

During interview on 4/8/15, at 2:46 p.m. assistant director of nursing (ADON) stated nursing staff should be completing a sleep assessment on any resident having difficulty sleeping, or after a medication was added or changed for sleep to ensure the medication was effective. The ADON stated a comprehensive sleep assessment would include an hourly log of whether or not the

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F 428	Continued From page 17 resident was asleep or awake, which would then be summarized in a progress note. ADON stated R155 did not have a comprehensive sleep assessment completed, and the facility did not have any policies related to sleep assessments. During interview on 4/9/15, at 3:40 p.m. the consulting pharmacist (P)-A stated the facility should be completing periodic reviews of a residents sleep patterns. P-A stated she had reviewed R155's nursing and physician notes, as well as the Psychopharmacological assessment, and felt the documentation of R155 stating he had difficulty sleeping was sufficient to justify the multiple medications for sleep.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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	F 431		5/18/15

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F 431	Continued From page 18 have access to the keys. 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, interview, and document review, the facility failed to ensure safe and secure medication storage during 1 of 8 medication passes observed. This had the potential to affect all 19 residents residing on the memory care unit. Findings include: During observation of medication administration on 4/6/15, at 7:06 p.m. licensed practical nurse (LPN)-B set-up two senna tablets for R230. LPN-B then indicated R230 only received one tablet vs two, and removed one of the pills from the cup and disposed of it in the trash on the side of the medication cart. The lid on the trash can remained open. LPN-B locked the medication cart, but left the bottle of senna on top of the cart, and walked out of sight of the medication cart to the TV room to administer R230's medications. The medication cart was out of sight of LPN-B at this time, and two residents were observed in the area of the medication cart which had pills sitting	F 431	Good Shepherd Lutheran Home does assure that all drugs are stored in locked compartments as required by this tag. The facility recognizes that at the time of survey one nurse disposed of one non-scheduled II (non-narcotic) medication (Senna-stool softener) in a manner that is not consistent with facility practice. Also the nurse left the Senna bottle on top of the cart and left the area. To assure that this practice was not occurring on other households the facility completed medication pass process audits and did not find this practice elsewhere. All though this practice is not consistent with the practices at Good Shepherd, the facility chose to retrain the staff	

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F 431	Continued From page 19 on top of the medication cart, and a pill in the open garbage can. During interview on 4/9/15, at approximately 3:15 p.m. assistant director of nursing (ADON) stated the medication nurse should not leave any medication in the trash or on top of the medication cart unattended. The facility policy titled Medication Administration dated 4/11, indicated the medication cart, residents medication drawer, and medication room, must be locked at all times when staff is not in attendance.	F 431	responsible to this requirement will be trained by 5/18/2015. To assure ongoing efficacy of the correction of this practice the facility will complete medication pass process audits monthly for the first three months and periodically thereafter to assure the deficient practice does not reoccur. The results of the audits will be reviewed for practice change efficacy through the facility QA meetings.	

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	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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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 | 04/30/2015

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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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 _____	**04/07/2015**

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 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was confirmed the facility failed to conduct one or more fire drills on each shift, during each quarter of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. In a fire emergency, this deficient practice could adversely affect 158 of 162 residents. FINDINGS INCLUDE:	K 050	Maintenance staff will initiate and perform fire drills one per shift per quarter and have proper documentation that supports each drill.	4/30/15

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 _____	**04/07/2015**

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 050	Continued From page 3 On 04/07/20/15 at 12:15pm, while reviewing fire drill reports for the previous year, documentation showed no Day shift drill for the 1 quarter of 2015. This deficient practice was confirmed with the VP of Enviromental Services (BD).	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1 and 2-2.2. This deficient practice could affect all 158 out 162 residents. Findings include: On facility tour between 12:15pm and 5:45pm on 04/07/2015, observation revealed that the following were found: 1. The kitchen and dishwashing area has corroded sprinkler heads. 2. There are multiple sprinkler heads that had	K 062	Maintenance staff have cleaned the sprinkler heads in the kitchen and dishwashing area and the escutcheon covers have been replaced. VP of Environmental Services will add the sprinkler head cleaning to the preventive maintenance schedule to be cleaned on an annual basis.	4/30/15

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	245269	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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K 062	Continued From page 4 dust and debris on them throughout the facility.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include: On facility tour between the hours of 12:15 PM and 5:45 PM on 04/07/2015, observations revealed that in the Ace Office there was a refrigerator plugged into an electrical power strip. This deficient practice was verified by the VP of Environmental Services Director (BD).	K 147	The VP of Environmental Services removed the refrigerator plug from the power strip and plugged it into the outlet. VP of Environmental Services will inform staff to follow the policy on the use of power strips. VP of Environmental Services will follow up with the Safety Committee to add the power strip check to the safety audit check list.	4/30/15

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 _____	**04/07/2015**

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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 not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New 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.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/30/2015

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 **02 - TWO-STORY ADDITION** B. WING _____	**04/07/2015**

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 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 158 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain a required two-hour fire separation in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. This deficient practice could adversely affect the safety of all patient's, visitor's and staff. FINDINGS INCLUDE: On 04/07/2015 at 12:15pm to 5:45pm, observation revealed building wiring penetrating	K 011	The door exiting the nursing home to Shepherd Court Apartments has a penetration above the door from a computer wire. VP of Environmental Services has repaired the penetration with fire caulk. VP of Environmental Services will inform maintenance staff and contractors that the are responsible for sealing around wires, piping and duct work with fire caulk when any work is performed.	4/30/15

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 _____	**04/07/2015**

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K 011	Continued From page 2 the two-hour fire wall separating the nursing home from a senior apartment building. In the concealed space above the lay-in ceiling, directly above the fire door leading from the nursing home to the senior apartment building, and the interstitial space surrounding the wiring/cabling was not properly sealed with a listed fire-rated intumescent caulk or other approved method. This finding was verified with the VP of Enviromental Services (BD) at the time of discovery.	K 011	The VP of Environmental Services will inspect any and all work performed at Good Shepherd to make sure that all completed work meets all building and state fire codes.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was confirmed the facility failed to conduct one or more fire drills on each shift, during each quarter of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. In a fire emergency, this deficient practice could adversely affect 158 of 162 residents.	K 050	Maintenance staff will initiate and perform fire drills one per shift per quarter and have proper documentation that supports each drill.	4/30/15

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	245269	A. BUILDING **02 - TWO-STORY ADDITION** B. WING _____	**04/07/2015**

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K 050	Continued From page 3 FINDINGS INCLUDE: On 04/07/20/15 at 12:15pm, while reviewing fire drill reports for the previous year, documentation showed no Day shift drill for the 1 quarter of 2015. This deficient practice was confirmed with the VP of Enviromental Services (BD).	K 050		

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 _____	**04/07/2015**

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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 not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New 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.	K 000	EPOC	

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Electronically Signed		04/30/2015

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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 _____	**04/07/2015**

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K 000	Continued From page 1 Good Shepherd Lutheran Home's building 03 is a two story addition, Building 03, that was determined to be of Type II (111) construction located on the northeast corner of the facility. 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 158 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was confirmed the facility failed to conduct one or more fire drills on each shift, during each quarter of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. In a fire emergency, this deficient	K 050	Maintenance staff will initiate and perform fire drills one per shift per quarter and have proper documentation that supports each drill.	4/30/15

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	245269	A. BUILDING **03 - NORTH EAST ADDTION** B. WING _____	**04/07/2015**

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K 050	Continued From page 2 practice could adversely affect 158 of 162 residents. FINDINGS INCLUDE: On 04/07/20/15 at 12:15pm, while reviewing fire drill reports for the previous year, documentation showed no Day shift drill for the 1 quarter of 2015. This deficient practice was confirmed with the VP of Enviromental Services (BD).	K 050		

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 _____	**04/07/2015**

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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 not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New 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.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 04/30/2015

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K 000	Continued From page 1 A one story addition, Building 04, that was determined to be of Type V (111) construction located north of the chapel. 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 158 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was confirmed the facility failed to conduct one or more fire drills on each shift, during each quarter of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and	K 050	Maintenance staff will initiate and perform fire drills one per shift per quarter and have proper documentation that supports each drill.	4/30/15

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K 050	Continued From page 2 CMS policy. In a fire emergency, this deficient practice could adversely affect 158 of 162 residents. FINDINGS INCLUDE: On 04/07/20/15 at 12:15pm, while reviewing fire drill reports for the previous year, documentation showed no Day shift drill for the 1 quarter of 2015. This deficient practice was confirmed with the VP of Enviromental Services (BD).	K 050		