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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Z701
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 **07/18/2016** (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 :
Brenda Fischer, Unit Supervisor 07/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/15/2016 (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 08/17/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/01/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245269
August 15, 2016

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

Dear Mr. Glanzer:

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

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

Effective June 24, 2016 the above facility is certified for or recommended for:

162 Skilled Nursing Facility/Nursing Facility Beds

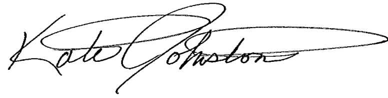
Your facility's Medicare approved area consists of all 162 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 15, 2016

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

RE: Project Number S5269023

Dear Mr. Glanzer:

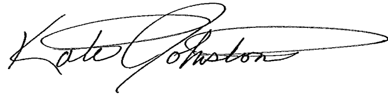
On June 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 26, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 24, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 26, 2016, effective June 24, 2016 and therefore remedies outlined in our letter to you dated June 9, 2016, 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
Program Assurance Unit
Licensing and Certification Program
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P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245269		7/18/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0166 Reg. # 483.10(f)(2) LSC	Correction Completed 06/17/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/17/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/24/2016
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 06/24/2016	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/24/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 06/17/2016
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 (INITIALS) BF/KJ	DATE 08/15/2016	SIGNATURE OF SURVEYOR 33925	DATE 07/18/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/26/2016	☐ 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

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(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 **05/26/2016** (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

X 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: **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 :
Austin Fry, HFE NE II 06/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/29/2016 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 9, 2016

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

RE: Project Number S5269023, H5269048

Dear Mr. Glanzer:

On May 26, 2016, 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. In addition, at the time of the May 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5269048. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5269048 that was found to be unsubstantiated.

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 26, 2016 (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 November 26, 2016 (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 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 ______	05/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. At the time of the survey, complaint #H5269048 was investigated and found to be unsubstantiated. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a voiced family grievance was acted upon timely for 1 of 1 residents (R86) who's family complained about not having water available at all times. Findings include: R86's quarterly Minimum Data Set (MDS) dated	F 166	Good Shepherd does assure that the residents receive prompt resolution to their grievances. The facility recognizes that on the week of survey a family member of resident #86 expressed a concern that the facility did not respond to her request that the resident have water available at all times. That said, the facility was never alerted to	6/17/16

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

Electronically Signed | 06/17/2016

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 ______ B. WING ______	05/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 1 3/16/16, identified R86 had intact cognition and received a mechanically altered diet. During interview on 5/23/16, at 2:38 p.m. family member (FM)-A stated (R86) was a, "Swallow risk" and was supposed to have water in her room at all times, "In case something gets caught" in her throat. FM-A stated the staff remove the provided water pitchers in the morning and do not return them until mid-afternoon, causing R86 to go several hours without having water available at times. FM-A stated they had told the staff to have a water pitcher available for R86 at all times, however it still was not being done, so FM-A was buying soda and bringing it in for R86 so she, "Always has something" to drink. R86's room was observed during the interview and no water mug was available, there was a small bottle of 7UP soda on her bedside table which FM-A stated they supplied. During a subsequent observation on 5/25/16, at 1:42 p.m. R86 was seated in her room watching television. R86 did not have a water pitcher in her room. On 5/25/16, at 1:43 p.m. nursing assistant (NA)-A and NA-B were interviewed and stated the morning shift removes the water pitchers after lunch, and the evening shift (starting at 2:00 p.m.) supplies new ones. NA-B stated R86's, "Family has said before" they would like R86 to have water available at all times, but the staff were still removing the pitchers and R86 was going a, "Period of time" without her pitcher each day. Further, NA-A and NA-B stated they had not forwarded the concerns of R86's family to management but were aware of the request to	F 166	this request the family member stated she told an NAR. Also, the facility practice is such that during the short time period that water pitchers are picked up and exchanged for new pitchers and fresh water, the resident/family can request a glass of water at any time during this exchange of pitchers. Water pitchers are to be picked up at the end of the day shift and exchanged for fresh water and clean pitchers at the beginning of the evening shift. The facility recognizes and is pleased that during the week the survey team was here this was the only concern brought to their attention from residents/family regarding the waters pitcher exchange period. The facility recognizes that although it has a process in place to assure that grievances are brought forward timely and consistently; this request was not brought forward for this resident/family concern. a. Regarding resident #86, the Case Manager for this resident contacted the daughter and discussed her concern and talked to the daughter about the facility s process to ensure that concerns are brought forward. b. As this deficient practice has the potential to affect all the residents who reside here; the facility feels that with the changes put in place for resident #86; all other residents will benefit from the change. c. To assure the deficient practice will not re-occur a check-off form will be implemented with an area for staff to indicate if any concerns/grievances were	

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F 166	Continued From page 2 keep a pitcher at R86's bedside. When interviewed on 5/25/16, at 1:51 p.m. registered nurse (RN)-A stated the resident water pitchers were picked up on the morning shift, and replaced on the evening shift, "That is our procedure." RN-A stated R86 had a history of dysphagia (trouble swallowing) and choking on her food, but was unaware of any family concerns regarding the lack of a water pitcher in her room. RN-A stated NA staff should be bringing any voiced concerns to her so they could be addressed timely. A facility Resident Grievance Procedure policy dated 7/11, identified the, "Staff supervisor" should be contacted to, "Discuss your concern." If unresolved, the grievance would be further passed to the social services department to be addressed at a higher management level.	F 166	brought forward during their shift. This form will be signed off by the NAR staff working on each shift and will be reviewed by the LPN team leader. If there has been a concern identified during the shift the Team Leader and staff member will utilize the Shift Happenings form already in place for this process to assure that the concern is acted upon by the Case Manager. Staff responsible to the tag will be trained regarding their responsibility by 6/17/2016. d. To assure interventions are effective, the facility will complete random audits thru the IDP meeting utilizing the new check-off sheets and Shift Happenings forms to assure proper follow through with information gathered at the IDP meeting. The audits will be conducted weekly for the first 4 weeks post IDP review and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. e. Continued compliance to this tag is the responsibility of DON, ADON and IDP team. Completion date 6/17/2016.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		6/17/16

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F 282	Continued From page 3 Based on observation, interview and document review the facility failed to ensure toileting was provided as directed by the care plan for 2 of 4 residents (R53 & R177) who were reviewed for urinary incontinence. Findings include: R53's quarterly Minimum Data Set (MDS) dated 3/18/16, identified R53 had severe cognitive impairment, and was frequently incontinent of urine. R53's care plan dated 3/31/16, identified R53 had incontinence of bladder, and directed staff to assist her to the bathroom and check for urinary incontinence at least every two hours. During continuous observation 5/25/16, from 7:01 a.m. to 10:00 a.m. (total of 2 hours and 59 minutes) R53 was not assisted to the toilet, nor had any incontinence care provided as directed by her plan of care. During interview 5/25/16, at 9:41 a.m. nursing assistant (NA)-C stated she had given R53 a bath in the morning and she was last assisted with toileting and incontinence care at 6:45 a.m. (2 hours and 56 earlier) that morning. Further, NA-C stated R53 should be assisted with toileting every two hours. During observation and interview 5/25/16, at 10:00 a.m. licensed practical nurse (LPN)-A assisted R53 to the bathroom and checked her for urinary incontinence. LPN-A stated R53 had been moderately incontinent of urine, and then voided a moderate amount into the toilet. R53, had not received incontinence care from 6:45	F 282	Good Shepherd does assure that residents receive toileting as directed by the plan of care. Regarding residents #177 and 53, the facility recognizes that during the week of survey that the comprehensive assessment was in place; however, was not being followed by direct care staff as indicated in plan of care/task list. To assure that the toileting program in place continues to be accurate a new comprehensive assessment has been completed and the care plan revised as necessary. These two residents have been re-assessed and plan of care revised as necessary as of 6/10/2016. Regarding all other residents who have potential to be affected by the same deficient practice, they will have their current assessments and care plans reviewed and revised as necessary by 6/24/2016. To improve care delivery by the direct care staff especially those who have not been consistently compliant with resident plan of care, training was provided regarding the importance of maintaining urinary continence if possible and timely response to toileting needs to promote dignity and quality of life. All staff responsible for compliance of this tag will be trained regarding their responsibility to this tag. The training will be completed by 6/17/2016. Random audits will be completed to assure compliance to the tag's requirement that residents remain dry unless unavoidable. The audits will be conducted weekly for	

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F 282	Continued From page 4 until 10:00 a.m., 3 hours and 15 minutes, even though the care plan directed staff to toilet R53 every 2 hours. During interview 5/25/16, at 1:34 p.m. registered nurse (RN)-B stated R53 should have been toileted with in two hours according to her care plan. R177 quarterly MDS dated 3/5/16, identified R177 had severe cognitive impairment, required extensive assistant with toileting, and was always incontinent of bladder. R177's care plan dated 3/14/16, identified R177 was incontinent of bladder and used a commode for toileting. Further, the care plan directed staff to, "Offer assistance to toilet every two hours and as needed." During observation on 5/24/16, at 6:53 p.m. nursing assistant (NA)-D assisted R177 to stand using a mechanical lift, and changed his soiled incontinence product at the bedside, despite a commode being positioned next to the bathroom. NA-D then assisted R177 to bed without offering or assisting R177 to use the commode as directed by his care plan. When interviewed on 5/25/16, at 9:26 a.m. NA-D stated staff should check and change R177 every two hours according to his care plan. Further, NA-D stated R177 had used the commode in the past, but she was unsure why staff had stopped using the commode as of late to toilet R177. During interview on 5/25/16, at 9:53 a.m. registered nurse (RN)-B stated R177 was	F 282	the first 4 weeks and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. Continued compliance to this tag is the responsibility of the DON, ADON and IDP team. Completion date is 6/17/2016.	

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F 282	Continued From page 5 forgetful at times and staff should be, "Offering the commode every time" they check and changed him as directed by his care plan. A facility policy on care plans was requested, but none was provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper leg support was provided while in a wheelchair for 1 of 2 residents (R117) reviewed for wheel chair positioning. Findings include: R117's quarterly Minimum Data Set (MDS) dated 4/21/16, identified R117 had severe cognitive impairment, and required extensive assistance with activities of daily living (ADLs). During observation on 5/25/16, at 7:35 a.m. R117 was seated in her wheelchair in her room. R117's feet were un-supported in the wheelchair, causing them to dangle towards the floor being suspended approximately 3-4 inches from the	F 309	Good Shepherd does assure that all residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well- being, in accordance with the comprehensive assessment and plan of care. The facility recognizes that on the week of the survey; 1 resident out of the 55 residents in the surveyor's review was noted to be in a wheel chair in which the resident did not have their feet supported while self-propelling their wheelchair. Although the resident's toes and front of their foot touched the floor the resident's heels did not. The facility also recognizes that although resident #117 lacked the foot support at	6/24/16

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F 309	Continued From page 6	F 309		

floor, and her feet and lower legs were edematous (fluid build up in the tissue). During subsequent observation on 5/25/16, at 1:04 p.m. R117 was seated in her wheelchair in the dining room for the noon meal. R117's feet continued to be un-supported causing them to dangle with only R117's toes touching the floor, her feet and lower legs were edematous.

When interviewed on 5/25/16, at 2:02 p.m. nursing assistant (NA)-F stated R117 had previously used wheelchair pedals to help support her feet, and NA-F was unaware when they had been discontinued.

During interview on 5/25/16, 2:07 p.m. registered nurse (RN)-D stated R117 had a medical condition which caused her feet to swell with fluid. R117 had been trialed in a shorter wheelchair approximately a year ago, however R117 had not been comfortable in the chair so it was not implemented. Further, RN-D stated R117's current wheelchair, without the use of pedals to support her feet, was appropriate because it allowed R117 the ability to self propel herself. During subsequent interview on 5/26/16, at 8:50 a.m. RN-D stated they had trialed R117 in the shorter wheelchair one year prior which had been completed by nursing. Therapy was not consulted to ensure the best wheel chair positioning for R117. Further, RN-D stated R117's ability to complete physical activities, including transferring and self propelling in her wheelchair, varied throughout the day.

When interviewed on 5/26/16, at 9:30 a.m. occupational therapist (OT)-A stated R117 had last been seen for therapies in 2014, and at that time she could self propel herself in a wheelchair

the heels the resident remained able to independently move about the household as they wished to do so, the resident also had no impairments related to lack of support of the heels.
Resident #117 medical record was reviewed and notes that OT had assessed the resident's wheel chair positioning and ability to independently propel wheelchair. The assessment was completed at a time when resident was regularly wearing shoes with an approximately 1 inch heel. Since the assessment resident has chosen to no longer wear those shoes when propelling wheelchair. The facility recognizes that a re-assessment without shoes would have benefitted the resident's positioning and assured no risk for impairment although there was no impairment.
a. Regarding resident #117, a visual assessment was completed on May 26th per RN case manager and consultation with therapy director. The chair height was changed at that time and lowered by 2 inches. A follow up assessment was completed per RN case manager on 6/1/2016, indicating that the resident has the ability to rest feet flat on the floor while seated in the wheelchair, the resident maintains the ability to self-propel wheel chair independently and is able to have a slightly quicker momentum while propelling. The care plan has been revised as of 6/1/2016.
b. All other residents who self-propel in their wheelchairs have had their medical records reviewed and revised as necessary as of 6/24/2016 to assure

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F 309	Continued From page 7 up to 45 feet. OT-A observed R117 seated in her wheelchair with her feet un-supported during this time. OT-A stated R117's wheelchair seat should be lowered to allow her feet and heels to contact the floor, so her feet were supported and it would make it easier for (R117) to propel her wheelchair. During interview on 5/26/16, at 9:38 a.m. RN-D stated she would have R117's wheelchair seat lowered as directed by OT-A, and complete a therapy evaluation if further intervention were needed. A facility policy on wheelchair positioning was requested, but none was provided.	F 309	proper wheelchair positioning. c. To assure the deficient practice will not reoccur the IDP team will review any significant wheelchair need changes or new wheel chair needs at the daily IDP meeting. All staff responsible for this F tag will be trained by 6/17/2016. d. To assure interventions are effective the facility will complete random visual audits regarding positioning with data collected from the IDP meeting to assure proper follow through with information gathered at the meeting. The audits will be conducted weekly for the first 4 weeks post IDP review and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. e. Continued compliance to this tag is the responsibility of DON, ADON and IDP team. Completion date 6/24/2016.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with shaving for 1 of 3 residents (R94) reviewed for activities of daily living (ADLs) whom were dependent on staff for care.	F 312	Good Shepherd does assure that any resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral	6/24/16

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F 312	Continued From page 8 Findings include: R94's quarterly Minimum Data Set (MDS) dated 5/4/16, identified R94 had severe cognitive impairment and was totally dependent on staff for personal hygiene cares. During observation on 5/24/16, at 12:10 p.m. R94 was seated in her wheelchair in the commons area. R94 has visible black facial hair on her upper lip which appeared to be several millimeters (mm) in length. During subsequent observations on 5/25/16, at 8:45 a.m. and 5/26/16, at 9:07 a.m. R94 continued to have the visible black facial hair present on her upper lip. R94's care plan dated 5/24/16, identified R94 required, "Extensive assistance" with grooming, and should, "Look nice and be clean every day." During interview on 5/26/16, at 9:12 a.m. nursing assistant (NA)-C stated shaving should be completed every morning, especially if, "Whiskers" are noted on a female resident. NA-C stated R94 was not resistive with cares. NA-C observed R94 and stated she noticed the black facial hair and R94, "Needs to be shaved." Further, NA-C stated R94 did not have a razor at the facility and staff should have notified the registered nurse (RN) so one could be obtained to ensure she gets shaved. When interviewed on 5/26/16, at 9:33 a.m. RN-A stated she was not aware of any preference of R94 to have facial hair and it should of been removed. Further, RN-A stated she was unaware R94 did not have a razor, and would notify the family to obtain one.	F 312	hygiene. The facility recognizes that on the week of the survey resident #94 was noted to have a small number of facial hairs on her upper lip and of the 3 residents that were in the survey sample resident #94 was the only one noted to have facial hair. a. Regarding resident #94 her facial hair was removed the same day that it was noted by the surveyor. The record was reviewed and revised to assure the Plan of Care and Task List direct staff to monitor for and remove as needed any facial hair on 6/1/2016. b. All other residents who may be affected by this deficient practice have had their medical records reviewed and revised as necessary to assure their Plan of Care and Task List reflect the need for monitoring and removal of facial hair as needed by 6/24/2016. c. To assure the deficient practice will not re- occur a checkoff form will be implemented with a listing of basic AM and PM cares highlighting “checking and removal of facial hair”. This form will be signed off by the person completing the cares on the AM shift indicating that the listed tasks were completed. They will be reviewed by the Team Leader for that shift prior to the staff member leaving their shift. All staff responsible for this F tag will be trained by 6/17/2016. d. To assure interventions are effective the facility will complete random visual audits regarding facial hair and the proper utilization of the new ADL completion	

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F 312	Continued From page 9 A facility policy on grooming was requested, but none was provided.	F 312	tracking form. The audits will be conducted weekly for the first 4 weeks and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. e. Continued compliance to this tag is the responsibility of DON, ADON and IDP team. Completion date 6/24/2016.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop and implement interventions to promote urinary continence for 3 of 4 residents (R135, R53, R177) reviewed for urinary incontinence. Findings include: R135's admission Minimum Data Set (MDS) dated 1/13/16, identified R135 had severe cognitive impairment, required supervision with	F 315	Good Shepherd does assure that residents receive comprehensive assessments to develop and consistently implement interventions to promote urinary continence. Regarding resident #135 the facility recognizes that during the week of survey it was noted that the comprehensive assessment did not accurately meet the resident's need to promote continence after an increase in urinary incontinence was noted. The facility also recognizes	6/24/16

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toileting, and was occasionally (less than seven episodes) incontinent of bladder.

R135's quarterly MDS dated 4/6/16, identified R135 now required limited assistance with toileting, and was frequently (more than seven episodes) incontinent of bladder.

R135's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 1/14/16, identified R135 to be, "Incontinent of urine several times," but will, "Ask for assistance to the bathroom when needed."

R135's Bowel & (and) Bladder Assessment dated 1/28/16, identified R135 had ability to, "Call for assistance to use the toilet" and was occasionally incontinent of bladder. Further, a section titled, "Bladder Program Selection" was provided to identify what type of incontinence R135 had, along with a program selection space to help maintain or improve bladder function was provided. However, these areas were left blank.

R135's medical record was reviewed. There was no comprehensive assessment identified to determine why R135 had a change in continence, going from occasionally incontinent on admission to frequently incontinent with in three months.

During observation on 5/25/16, at 6:58 a.m. nursing assistant (NA)-C opened R135's bedroom door carrying a clear plastic bag with a soiled incontinence product visible inside the bag.

When interviewed on 5/25/16, at 7:00 a.m. NA-C stated R135 had been incontinent of urine just prior. NA-C stated the staff help R135 to the bathroom, "Every two hours" like the other

F 315

that the comprehensive care plan did not identify the incontinence or interventions to promote bladder continence. This resident has had a full assessment completed to reflect accurate needs. The plan of care has been revised as necessary.
Regarding resident #177 the facility recognizes that during the week of survey that the comprehensive assessment was in place however was not being followed by direct care staff as indicated in plan of care. To assure that the toileting program in place continues to be accurate a new comprehensive assessment has been completed and the care plan revised as necessary.
Regarding resident #53 the facility recognizes that during the week of survey the comprehensive assessment did not accurately meet the resident's need to promote continence after an increase in urinary incontinence was noted. The facility also recognizes that the plan of care was not being followed by direct care staff as it was indicated. To assure the toileting program is accurate a new comprehensive assessment has been completed and plan of care revised as necessary.
These three residents have been re-assessed and plan of care revised as necessary as of 6/10/2016.
Regarding all other residents who have potential to be affected by the same deficient practice will have their current assessments and care plans reviewed and revised as necessary by 6/24/2016.
Each resident who has a noted significant

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 11 residents, but added R135 will, "Tell you" when she needs to use the bathroom, "Most of the time." R135 was, "Usually" incontinent in the mornings but typically will, "Void again" after being assisted to the toilet, even after being incontinent. R135's care plan dated 4/22/16, did not identify R135 had a problem with incontinence, or were there any interventions for staff to follow to promote bladder continence. During interview on 5/25/16, at 9:16 a.m. licensed practical nurse (LPN)-A stated staff, "Helps her [R135]" with toileting. R135 has continent and incontinent voiding at times and is, "Sometimes" able to verbalize the need to use the restroom. Further, LPN-A stated R135 will still void even after being incontinent if helped to the toilet by staff. On 5/25/16, at 9:38 a.m. registered nurse (RN)-A and RN-C were interviewed. RN-C stated residents were comprehensively assessed for continence upon admission and annually thereafter. If a resident has a change in continence, like R135 had, they should be reassessed to, "Look into what might be causing that." RN-A reviewed the collected data which was used to determine R135's continence for the completed MDS entries and stated R135 had only two episodes of incontinence during her admission assessment completed on 1/13/16, however had 11 episodes of incontinence during her quarterly assessment completed on 4/6/16. Further, RN-A stated that last time R135 was comprehensively assessed for her bladder incontinence was upon admission, and not when she had the significant change in her continence.	F 315	change in condition by the case managers or noted recurrent urinary tract infections as monitored through infection control tracking process will be reviewed at the daily IDP meetings to determine the need for a re-assessment of resident's incontinence. All staff responsible for compliance of this tag will be trained to the new process expectations. The training will be completed by 6/17/2016. Random audits will be completed to assure compliance to the new process. The audits will be conducted weekly for the first 4 weeks and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. Continued compliance to this tag is the responsibility of the DON, ADON and IDP team. Completion date is 6/24/2016.	

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 ______	05/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 Both RN-A and RN-C identified R135 should have been reassessed for her bladder incontinence. R53's admission Minimum Data Set (MDS) dated 12/23/15, indicated she was always continent of urine. R53's quarterly MDS dated 3/18/16, indicated she was now frequently incontinent of urine. R53's care area assessment (CAA) dated 12/28/15, indicated "Resident is currently continent of bowel and bladder. Resident is at risk for incontinence related to impaired mobility, polypharmacy (several medications), and diuretic use. Resident recognizes urge to void/pass bowel movement; she alerts staff when she needs assistance. Resident wears pull-up style brief; is able to manage brief with supervision from staff. Staff assist with peri-cares q (every) AM, PM and PRN (as needed)." R53's care plan dated 3/31/16, indicated she was continent and incontinent of bladder. The care plan indicated staff to assist to the bathroom, check for incontinence every two hours and change pad as needed. R53's CNA (certified nursing assistant) Task List Assignment that was kept in the residents room dated 3/29/16, indicated check and change every two hours and encourage to toilet every two hours. R53's Bowel & Bladder Risk Assessment dated 12/22/15, indicated she was continent of bowel and bladder. During continuous observation 5/25/16, from 7:01 a.m. to 10:00 a.m. (total of 2 hours and 59 minutes) R53 was not assisted to the toilet or provided incontinence care.	F 315		

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	245269	A. BUILDING ______ B. WING ______	05/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 13	F 315		

During interview 5/25/16, at 9:41 a.m. nursing assistant (NA)-C stated she had given R53 a bath in the morning and she was last assisted with toileting and incontinence care at 6:45 a.m. (2 hours and 56 earlier) that morning. Further, NA-C stated R53 should be assisted with toileting every two hours.

During observation and interview 5/25/16, at 10:00 a.m. licensed practical nurse (LPN)-A assisted R53 to the bathroom and checked her for urinary incontinence. LPN-A stated R53 had been moderately incontinent of urine, and then voided a moderate amount into the toilet. R53, had not received incontinence care from 6:45 until 10:00 a.m., 3 hours and 15 minutes, even though the care plan directed staff to toilet R53 every 2 hours.

During interview 5/25/16, at 1:34 p.m. registered nurse (RN)-B stated the previous case manager to the unit had recently left and she was covering the unit. RN-B stated the bladder assessment should be completed on admission and quarterly. RN-B stated she had checked the computer and was unable to find R53's quarterly bladder assessment. RN-B further stated she did find a progress note on 3/18/16, that indicated resident was now frequently incontinent of urine but was unable to find a voiding pattern assessment to indicate if there was a specific pattern with her incontinence.

Although R53's quarterly MDS indicated a change from being continent to frequently incontinent of urine there was no assessment completed to determine why there was a change. In addition R53 was to be toileted/or checked and changed

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	245269	A. BUILDING ______ B. WING ______	05/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 14	F 315		

every two hours R53 but went 3 hours and 15 minutes without being toileted/or checked and changed.

R177 quarterly Minimum Data Set (MDS) dated 3/5/16, identified R177 had severe cognitive impairment, required extensive assistant with toileting, was not on a scheduled toileting program and was always incontinent of bladder.

R177's Urinary Incontinence and Indwelling Catheter Care Assessment (CAA) dated 9/24/15, identified R177 was frequently incontinent of bladder. R177 was at risk for skin breakdown, odor and infection related to incontinence, required assistance of two staff members for toileting needs and utilized the commode in his bathroom. R177 doesn't always know when he had to use the bathroom.

R177's care plan updated 3/14/16, identified R177 was incontinent of bladder, and directed staff to, "offer assistance to toilet every two hours and as needed" and "I use the commode in the bathroom."

During observation of evening personal cares on 5/24/16, at 6:53 p.m. Nursing assistant NA-D assisted the resident with evening cares. NA-D changed R177 incontinent product which was visibly soiled with a small amount of urine and assisted him to bed for the night. R177's commode was positioned in residents room near the bathroom. NA-D did not offer or attempt to assist R177 toileting as directed by his care plan.

When interviewed on 5/25/16, at 9:26 a.m. NA-D stated staff should check and change resident

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	245269	A. BUILDING ______ B. WING ______	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 15 every two hours according to his care plan. NA-D stated that she was aware that resident needed to be offered the commode every two hours, but was unsure of the last time she had actually offered R177 the commode. During observation of morning personal cares on 5/25/16, at 7:28 a.m. NA-E assisted R177 with personal cares. R177's incontinence pad was dry and NA-E assisted R177 to his wheelchair. NA-E did not attempt or offer toileting to R177. During observation on 5/25/16, at 9:21 a.m. NA-E assisted R177 to lay down after breakfast. R177's incontinent product was visibly soiled with a large amount of urine. NA-E did not attempt to offer toileting assistance to R177. When interviewed on 5/25/16, at 10:05 a.m. NA-E stated R177 was capable of using the commode and should be offered the commode every two hours as directed by his care plan. NA-E stated "he [R177] can't always remember to ask" and had fragile skin. During interview on 5/25/16, at 9:53 a.m. registered nurse (RN)-B stated R177 should be offered the commode every two hours and checked/change according to his care plan. Further, RN-B stated R177 was forgetful at times because of his dementia and staff should be "offering the commode every time" they check and changed resident according to his care plan. A facility policy titled, "Bowel and Bladder Assessment Procedure" dated 10/2010, stated assessment of bladder incontinence will be completed upon admission, significant change and with annual review. RN case manager to	F 315		

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	245269	A. BUILDING ______ B. WING ______	05/26/2016

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 315	Continued From page 16 monitor the documentation for assessment and incontinence management. Care plan will be updated for incontinence needs.	F 315		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		6/17/16

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	245269	A. BUILDING ______ B. WING ______	05/26/2016

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 441	Continued From page 17 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement appropriate infection control standards related to cleaning soiled bed pans. This had the potential to affect 13 of residents 157 (R24, R148, R73, R113, R89, R88, R170, R15, R12, R159, R262, R102 and R8) in the facility who utilize a bed pans. Findings include: The facility provided a list of residents that utilized bed pans in the facility. The list indicated R24,R148,R73,R113,R89, R88, R170,R15,R12,R159,R262, R102 and R8 used a bed pan. During an anonymous family interview on 5/25/16, at 1:00 p.m. family member (FM)-A stated she does not like that the staff are cleaning her family members bed pan in the bathroom. FM-A stated they had complained about this before to staff, and felt staff should be going across the hall to the utility room and cleaning them. FM-A stated the staff continued to clean bed pans in the bathroom for nearly a year now. FM-A further stated she just doesn't feel it is right that they are cleaning the bed pans in a bathroom where her family member brushes their teeth. During interview 5/25/16, at 1:09 p.m. NA-G who stated if a resident uses the bed pain we use wipes to wipe it out and get water from the	F 441	Good Shepherd does have and maintains an established infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. The facility recognizes that during the survey it was identified that there was a possibility that staff were not fully and carefully following the facility s process for the emptying and rinsing of bedpans. Regarding the 13 residents identified as consistently utilizing a bed pan, the facility has chosen to change the current practice. For all other residents who have a potential to be affected by this practice the process change will be beneficial as well. See process change below. Each resident utilizing a bed pan consistently will have a container (graduate) in the bathroom, solely for the purpose of gathering water from the residents sink to be used for rinsing the bed pan after use. The container will be marked water only/bed pan rinse. Staff will utilize the container to gather water from the residents sink which will be used to rinse the bed pan over the toilet to prevent any contamination of the sink area. This process will also be implemented for any resident with new bed pan use.	

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F 441	Continued From page 18 bathroom sink and then go over to the toilet and dump it. The facility does not have a spray nozel by the toilet like some facilities have to rinse the bed pan over the toilet. During interview 5/25/16, at 1:16 p.m. NA-I stated if a resident used a bed pan we wipe it out with wipes and get water from the bathroom sink to rinse it out in the toilet. During observation of R159's room on 5/25/16, at 1:19 p.m. a bed pan was hanging in a clear plastic bag on a rail next to the toilet. The bathroom sink was approximately two feet away from the toilet. During observation 5/25/16, at 1:20 p.m. on Sunny Lake unit there was a soiled utility room in the hall that had a hopper with a sink that flushes which can be used for cleaning soiled bed pans. During interview 5/25/16, at 2:52 p.m. registered nurse (RN)-E stated she does the infection control program in the facility and the protocol for cleaning the bed pans is to dump what's in the bed pan in the toilet, rinse with water from the sink and dump that into the toilet in the residents room. She further stated if the bed pan is uncleanable they throw it away. RN-E then stated this process was fine because the staff got water from a sink which was only two to four feet away and they do not touch anything but carry the bedpan to the resident toilet. During interview 5/26/16, at 8:28 a.m. NA-J stated if a resident uses the bed pan we dump the contents into their toilet and if they had a bowel movement she would clean it in the soiled utility room. NA-J further stated there were	F 441	All staff responsible for compliance to this tag has been trained to the new process expectations. This training will be completed with staff prior to their next assigned shift over the next two weeks. Completion date will be 6/17/2016. Random audits will be completed to assure compliance to the new process. The audits will be conducted weekly for the first 4 weeks and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. Continued compliance to this tag is the responsibility of the DON, ADON and IDP team. Completion date is 6/17/2016.	

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 ______	**05/26/2016**

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 441	Continued From page 19 chemicals in the clean utility room for staff to use for cleaning the floor, and housekeeping cleans the residents sinks. NA-J stated they do not clean the resident sink, but could if it was dirty, she would use a wet wash cloth. During interview 5/26/16, at 8:37 a.m. with RN-E who stated it was her understanding the protocol of cleaning a bed pan was not a problem but the protocol was old. She further stated there are soiled utility room to clean soiled resident items on each of the eight households. RN-E then stated housekeeping staff were in the facility Monday thru Sunday and work from 7:30 -4:00 p.m. The housekeeping staff clean the bathrooms daily and she was unsure of how nursing staff would clean the sinks if substance from the bed pan would splash onto the sink after the house keepers left for the day. Review of the Good Shepherd Lutheran Home Giving and Removing Bedpan protocol revised 4/10, indicated "Dispose of contents of bedpan. Empty bedpan into toilet without splashing. Rinse bedpan with cool water end empty into toilet without splashing. Replace bedpan to proper place (if bedpan is soiled, use peri wipe to clean if unable to clean or very soiled, dispose of bedpan and replace a new one in residents storage area.) Dispose of gloves in wastebasket wash hands according to accepted procedure."	F 441		

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

F5269024

FORM APPROVED
OMB NO. 0938-0391

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 ______	**05/24/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home, Building 04,was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Good Shepherd Lutheran Home's Building 04, 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 157 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

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

F5269024

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 ______	05/24/2016

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home, Building 01 was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as four separate 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.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	(X3) DATE SURVEY COMPLETED **05/24/2016**

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

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K 000	Continued From page 1 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 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 157 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

F5269024

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

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 ______	**05/24/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home, Building 02,was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

Good Shepherd Lutheran Home's Building 02 is a 2-story addition with partial basement. The addition was constructed in 2010 and was determined to be Type II (111). The addition is fully sprinkler protected throughout.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 162 beds and had a census of 157 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

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

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

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

F5269024

FORM APPROVED
OMB NO. 0938-0391

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 ________	05/24/2016

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home, Building 03,was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Good Shepherd Lutheran Home's Building 03 is a 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 157 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 9, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5269023, H5269048

Dear Mr. Glanzer:

The above facility was surveyed on May 23, 2016 through May 26, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5269048. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Brenda Fischer at (320) 223-7338 or emnail: brenda.fischer@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00023	A. BUILDING: ______ B. WING ______	05/26/2016

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 23 - 26, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. At the time of the survey, complaint #H5269048 was investigated and found to be unsubstantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure toileting was provided as directed by the care plan for 2 of 4 residents (R53 & R177) who were reviewed for urinary incontinence. Findings include: R53's quarterly Minimum Data Set (MDS) dated 3/18/16, identified R53 had severe cognitive impairment, and was frequently incontinent of urine. R53's care plan dated 3/31/16, identified R53 had incontinence of bladder, and directed staff to assist her to the bathroom and check for urinary incontinence at least every two hours. During continuous observation 5/25/16, from 7:01 a.m. to 10:00 a.m. (total of 2 hours and 59 minutes) R53 was not assisted to the toilet, nor had any incontinence care provided as directed by her plan of care. During interview 5/25/16, at 9:41 a.m. nursing	2 565	Good Shepherd does assure that residents receive toileting as directed by the plan of care. Regarding residents #177 and 53, the facility recognizes that during the week of survey that the comprehensive assessment was in place; however, was not being followed by direct care staff as indicated in plan of care/task list. To assure that the toileting program in place continues to be accurate a new comprehensive assessment has been completed and the care plan revised as necessary. These two residents have been re-assessed and plan of care revised as necessary as of 6/10/2016. Regarding all other residents who have potential to be affected by the same deficient practice, they will have their current assessments and care plans reviewed and revised as necessary by 6/24/2016. To improve care delivery by the direct care staff especially those who have not been	6/17/16

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2 565	Continued From page 3 assistant (NA)-C stated she had given R53 a bath in the morning and she was last assisted with toileting and incontinence care at 6:45 a.m. (2 hours and 56 earlier) that morning. Further, NA-C stated R53 should be assisted with toileting every two hours. During observation and interview 5/25/16, at 10:00 a.m. licensed practical nurse (LPN)-A assisted R53 to the bathroom and checked her for urinary incontinence. LPN-A stated R53 had been moderately incontinent of urine, and then voided a moderate amount into the toilet. R53, had not received incontinence care from 6:45 until 10:00 a.m., 3 hours and 15 minutes, even though the care plan directed staff to toilet R53 every 2 hours. During interview 5/25/16, at 1:34 p.m. registered nurse (RN)-B stated R53 should have been toileted with in two hours according to her care plan. R177 quarterly MDS dated 3/5/16, identified R177 had severe cognitive impairment, required extensive assistant with toileting, and was always incontinent of bladder. R177's care plan dated 3/14/16, identified R177 was incontinent of bladder and used a commode for toileting. Further, the care plan directed staff to, "Offer assistance to toilet every two hours and as needed." During observation on 5/24/16, at 6:53 p.m. nursing assistant (NA)-D assisted R177 to stand using a mechanical lift, and changed his soiled incontinence product at the bedside, despite a	2 565	consistently compliant with resident plan of care, training was provided regarding the importance of maintaining urinary continence if possible and timely response to toileting needs to promote dignity and quality of life. All staff responsible for compliance of this tag will be trained regarding their responsibility to this tag. The training will be completed by 6/17/2016. Random audits will be completed to assure compliance to the tag's requirement that residents remain dry unless unavoidable. The audits will be conducted weekly for the first 4 weeks and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. Continued compliance to this tag is the responsibility of the DON, ADON and IDP team. Completion date is 6/17/2016.	

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2 565	Continued From page 4 commode being positioned next to the bathroom. NA-D then assisted R177 to bed without offering or assisting R177 to use the commode as directed by his care plan. When interviewed on 5/25/16, at 9:26 a.m. NA-D stated staff should check and change R177 every two hours according to his care plan. Further, NA-D stated R177 had used the commode in the past, but she was unsure why staff had stopped using the commode as of late to toilet R177. During interview on 5/25/16, at 9:53 a.m. registered nurse (RN)-B stated R177 was forgetful at times and staff should be, "Offering the commode every time" they check and changed him as directed by his care plan. A facility policy on care plans was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff on following the individualized plan of care, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and	2 830		6/24/16

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2 830	Continued From page 5 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper leg support was provided while in a wheelchair for 1 of 2 residents (R117) reviewed for wheel chair positioning. Findings include: R117's quarterly Minimum Data Set (MDS) dated 4/21/16, identified R117 had severe cognitive impairment, and required extensive assistance with activities of daily living (ADLs). During observation on 5/25/16, at 7:35 a.m. R117 was seated in her wheelchair in her room. R117's feet were un-supported in the wheelchair, causing them to dangle towards the floor being suspended approximately 3-4 inches from the floor, and her feet and lower legs were edematous (fluid build up in the tissue). During subsequent observation on 5/25/16, at 1:04 p.m. R117 was seated in her wheelchair in the dining room for the noon meal. R117's feet continued to be un-supported causing them to dangle with only R117's toes touching the floor, her feet and lower legs were edematous. When interviewed on 5/25/16, at 2:02 p.m. nursing assistant (NA)-F stated R117 had	2 830	Good Shepherd does assure that all residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well- being, in accordance with the comprehensive assessment and plan of care. The facility recognizes that on the week of the survey; 1 resident out of the 55 residents in the surveyor's review was noted to be in a wheel chair in which the resident did not have their feet supported while self-propelling their wheelchair. Although the resident's toes and front of their foot touched the floor the resident's heels did not. The facility also recognizes that although resident #117 lacked the foot support at the heels the resident remained able to independently move about the household as they wished to do so, the resident also had no impairments related to lack of support of the heels. Resident #117 medical record was reviewed and notes that OT had assessed the resident's wheel chair positioning and ability to independently propel wheelchair. The assessment was completed at a time when resident was regularly wearing	

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2 830	Continued From page 6	2 830		

previously used wheelchair pedals to help support her feet, and NA-F was unaware when they had been discontinued.

During interview on 5/25/16, 2:07 p.m. registered nurse (RN)-D stated R117 had a medical condition which caused her feet to swell with fluid. R117 had been trialed in a shorter wheelchair approximately a year ago, however R117 had not been comfortable in the chair so it was not implemented. Further, RN-D stated R117's current wheelchair, without the use of pedals to support her feet, was appropriate because it allowed R117 the ability to self propel herself. During subsequent interview on 5/26/16, at 8:50 a.m. RN-D stated they had trialed R117 in the shorter wheelchair one year prior which had been completed by nursing. Therapy was not consulted to ensure the best wheel chair positioning for R117. Further, RN-D stated R117's ability to complete physical activities, including transferring and self propelling in her wheelchair, varied throughout the day.

When interviewed on 5/26/16, at 9:30 a.m. occupational therapist (OT)-A stated R117 had last been seen for therapies in 2014, and at that time she could self propel herself in a wheelchair up to 45 feet. OT-A observed R117 seated in her wheelchair with her feet un-supported during this time. OT-A stated R117's wheelchair seat should be lowered to allow her feet and heels to contact the floor, so her feet were supported and it would make it easier for (R117) to propel her wheelchair.

During interview on 5/26/16, at 9:38 a.m. RN-D stated she would have R117's wheelchair seat lowered as directed by OT-A, and complete a therapy evaluation if further intervention were

shoes with an approximately 1 inch heel. Since the assessment resident has chosen to no longer wear those shoes when propelling wheelchair. The facility recognizes that a re-assessment without shoes would have benefitted the resident's positioning and assured no risk for impairment although there was no impairment.

a. Regarding resident #117, a visual assessment was completed on May 26th per RN case manager and consultation with therapy director. The chair height was changed at that time and lowered by 2 inches. A follow up assessment was completed per RN case manager on 6/1/2016, indicating that the resident has the ability to rest feet flat on the floor while seated in the wheelchair, the resident maintains the ability to self-propel wheel chair independently and is able to have a slightly quicker momentum while propelling. The care plan has been revised as of 6/1/2016.

b. All other residents who self-propel in their wheelchairs have had their medical records reviewed and revised as necessary as of 6/24/2016 to assure proper wheelchair positioning.

c. To assure the deficient practice will not reoccur the IDP team will review any significant wheelchair need changes or new wheel chair needs at the daily IDP meeting. All staff responsible for this F tag will be trained by 6/17/2016.

d. To assure interventions are effective the facility will complete random visual audits regarding positioning with data collected from the IDP meeting to assure proper follow through with information

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2 830	Continued From page 7 needed. A facility policy on wheelchair positioning was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit residents for proper positioning, and inservice staff on identifying positioning concerns and how to correct them. The DON could then complete audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830	gathered at the meeting. The audits will be conducted weekly for the first 4 weeks post IDP review and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. e. Continued compliance to this tag is the responsibility of DON, ADON and IDP team. Completion date 6/24/2016.	
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 910	Good Shepherd does assure that	6/24/16

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GOOD SHEPHERD LUTHERAN HOME	**1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379**

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2 910	Continued From page 8 review, the facility failed to comprehensively assess, develop and implement interventions to promote urinary continence for 3 of 4 residents (R135, R53, R177) reviewed for urinary incontinence. Findings include: R135's admission Minimum Data Set (MDS) dated 1/13/16, identified R135 had severe cognitive impairment, required supervision with toileting, and was occasionally (less than seven episodes) incontinent of bladder. R135's quarterly MDS dated 4/6/16, identified R135 now required limited assistance with toileting, and was frequently (more than seven episodes) incontinent of bladder. R135's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 1/14/16, identified R135 to be, "Incontinent of urine several times," but will, "Ask for assistance to the bathroom when needed." R135's Bowel & (and) Bladder Assessment dated 1/28/16, identified R135 had ability to, "Call for assistance to use the toilet" and was occasionally incontinent of bladder. Further, a section titled, "Bladder Program Selection" was provided to identify what type of incontinence R135 had, along with a program selection space to help maintain or improve bladder function was provided. However, these areas were left blank. R135's medical record was reviewed. There was no comprehensive assessment identified to determine why R135 had a change in continence, going from occasionally incontinent on admission to frequently incontinent with in three months.	2 910	residents receive comprehensive assessments to develop and consistently implement interventions to promote urinary continence. Regarding resident #135 the facility recognizes that during the week of survey it was noted that the comprehensive assessment did not accurately meet the resident's need to promote continence after an increase in urinary incontinence was noted. The facility also recognizes that the comprehensive care plan did not identify the incontinence or interventions to promote bladder continence. This resident has had a full assessment completed to reflect accurate needs. The plan of care has been revised as necessary. Regarding resident #177 the facility recognizes that during the week of survey that the comprehensive assessment was in place however was not being followed by direct care staff as indicated in plan of care. To assure that the toileting program in place continues to be accurate a new comprehensive assessment has been completed and the care plan revised as necessary. Regarding resident #53 the facility recognizes that during the week of survey the comprehensive assessment did not accurately meet the resident's need to promote continence after an increase in urinary incontinence was noted. The facility also recognizes that the plan of care was not being followed by direct care staff as it was indicated. To assure the toileting program is accurate a new comprehensive assessment has been completed and plan of care revised as	

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2 910	Continued From page 9 During observation on 5/25/16, at 6:58 a.m. nursing assistant (NA)-C opened R135's bedroom door carrying a clear plastic bag with a soiled incontinence product visible inside the bag. When interviewed on 5/25/16, at 7:00 a.m. NA-C stated R135 had been incontinent of urine just prior. NA-C stated the staff help R135 to the bathroom, "Every two hours" like the other residents, but added R135 will, "Tell you" when she needs to use the bathroom, "Most of the time." R135 was, "Usually" incontinent in the mornings but typically will, "Void again" after being assisted to the toilet, even after being incontinent. R135's care plan dated 4/22/16, did not identify R135 had a problem with incontinence, or were there any interventions for staff to follow to promote bladder continence. During interview on 5/25/16, at 9:16 a.m. licensed practical nurse (LPN)-A stated staff, "Helps her [R135]" with toileting. R135 has continent and incontinent voiding at times and is, "Sometimes" able to verbalize the need to use the restroom. Further, LPN-A stated R135 will still void even after being incontinent if helped to the toilet by staff. On 5/25/16, at 9:38 a.m. registered nurse (RN)-A and RN-C were interviewed. RN-C stated residents were comprehensively assessed for continence upon admission and annually thereafter. If a resident has a change in continence, like R135 had, they should be reassessed to, "Look into what might be causing that." RN-A reviewed the collected data which was used to determine R135's continence for the	2 910	necessary. These three residents have been re-assessed and plan of care revised as necessary as of 6/10/2016. Regarding all other residents who have potential to be affected by the same deficient practice will have their current assessments and care plans reviewed and revised as necessary by 6/24/2016. Each resident who has a noted significant change in condition by the case managers or noted recurrent urinary tract infections as monitored through infection control tracking process will be reviewed at the daily IDP meetings to determine the need for a re-assessment of resident's incontinence. All staff responsible for compliance of this tag will be trained to the new process expectations. The training will be completed by 6/17/2016. Random audits will be completed to assure compliance to the new process. The audits will be conducted weekly for the first 4 weeks and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. Continued compliance to this tag is the responsibility of the DON, ADON and IDP team. Completion date is 6/24/2016.	

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2 910	Continued From page 10	2 910		

completed MDS entries and stated R135 had only two episodes of incontinence during her admission assessment completed on 1/13/16, however had 11 episodes of incontinence during her quarterly assessment completed on 4/6/16. Further, RN-A stated that last time R135 was comprehensively assessed for her bladder incontinence was upon admission, and not when she had the significant change in her continence. Both RN-A and RN-C identified R135 should have been reassessed for her bladder incontinence.

R53's admission Minimum Data Set (MDS) dated 12/23/15, indicated she was always continent of urine. R53's quarterly MDS dated 3/18/16, indicated she was now frequently incontinent of urine. R53's care area assessment (CAA) dated 12/28/15, indicated "Resident is currently continent of bowel and bladder. Resident is at risk for incontinence related to impaired mobility, polypharmacy (several medications), and diuretic use. Resident recognizes urge to void/pass bowel movement; she alerts staff when she needs assistance. Resident wears pull-up style brief; is able to manage brief with supervision from staff. Staff assist with peri-cares q (every) AM, PM and PRN (as needed)."

R53's care plan dated 3/31/16, indicated she was continent and incontinent of bladder. The care plan indicated staff to assist to the bathroom, check for incontinence every two hours and change pad as needed. R53's CNA (certified nursing assistant) Task List Assignment that was kept in the residents room dated 3/29/16, indicated check and change every two hours and encourage to toilet every two hours.

R53's Bowel & Bladder Risk Assessment dated 12/22/15, indicated she was continent of bowel

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2 910	Continued From page 11 and bladder. During continuous observation 5/25/16, from 7:01 a.m. to 10:00 a.m. (total of 2 hours and 59 minutes) R53 was not assisted to the toilet or provided incontinence care. During interview 5/25/16, at 9:41 a.m. nursing assistant (NA)-C stated she had given R53 a bath in the morning and she was last assisted with toileting and incontinence care at 6:45 a.m. (2 hours and 56 earlier) that morning. Further, NA-C stated R53 should be assisted with toileting every two hours. During observation and interview 5/25/16, at 10:00 a.m. licensed practical nurse (LPN)-A assisted R53 to the bathroom and checked her for urinary incontinence. LPN-A stated R53 had been moderately incontinent of urine, and then voided a moderate amount into the toilet. R53, had not received incontinence care from 6:45 until 10:00 a.m., 3 hours and 15 minutes, even though the care plan directed staff to toilet R53 every 2 hours. During interview 5/25/16, at 1:34 p.m. registered nurse (RN)-B stated the previous case manager to the unit had recently left and she was covering the unit. RN-B stated the bladder assessment should be completed on admission and quarterly. RN-B stated she had checked the computer and was unable to find R53's quarterly bladder assessment. RN-B further stated she did find a progress note on 3/18/16, that indicated resident was now frequently incontinent of urine but was unable to find a voiding pattern assessment to indicate if there was a specific pattern with her incontinence.	2 910		

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2 910	Continued From page 12	2 910		

Although R53's quarterly MDS indicated a change from being continent to frequently incontinent of urine there was no assessment completed to determine why there was a change. In addition R53 was to be toileted/or checked and changed every two hours R53 but went 3 hours and 15 minutes without being toileted/or checked and changed.

R177 quarterly Minimum Data Set (MDS) dated 3/5/16, identified R177 had severe cognitive impairment, required extensive assistant with toileting, was not on a scheduled toileting program and was always incontinent of bladder.

R177's Urinary Incontinence and Indwelling Catheter Care Assessment (CAA) dated 9/24/15, identified R177 was frequently incontinent of bladder. R177 was at risk for skin breakdown, odor and infection related to incontinence, required assistance of two staff members for toileting needs and utilized the commode in his bathroom. R177 doesn't always know when he had to use the bathroom.

R177's care plan updated 3/14/16, identified R177 was incontinent of bladder, and directed staff to, "offer assistance to toilet every two hours and as needed" and "I use the commode in the bathroom."

During observation of evening personal cares on 5/24/16, at 6:53 p.m. Nursing assistant NA-D assisted the resident with evening cares. NA-D changed R177 incontinent product which was visibly soiled with a small amount of urine and assisted him to bed for the night. R177's commode was positioned in residents room near

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2 910	Continued From page 13	2 910		

the bathroom. NA-D did not offer or attempt to assist R177 toileting as directed by his care plan.

When interviewed on 5/25/16, at 9:26 a.m. NA-D stated staff should check and change resident every two hours according to his care plan. NA-D stated that she was aware that resident needed to be offered the commode every two hours, but was unsure of the last time she had actually offered R177 the commode.

During observation of morning personal cares on 5/25/16, at 7:28 a.m. NA-E assisted R177 with personal cares. R177's incontinence pad was dry and NA-E assisted R177 to his wheelchair. NA-E did not attempt or offer toileting to R177.

During observation on 5/25/16, at 9:21 a.m. NA-E assisted R177 to lay down after breakfast. R177's incontinent product was visibly soiled with a large amount of urine. NA-E did not attempt to offer toileting assistance to R177.

When interviewed on 5/25/16, at 10:05 a.m. NA-E stated R177 was capable of using the commode and should be offered the commode every two hours as directed by his care plan. NA-E stated "he [R177] can't always remember to ask" and had fragile skin.

During interview on 5/25/16, at 9:53 a.m. registered nurse (RN)-B stated R177 should be offered the commode every two hours and checked/change according to his care plan. Further, RN-B stated R177 was forgetful at times because of his dementia and staff should be "offering the commode every time" they check and changed resident according to his care plan.

A facility policy titled, "Bowel and Bladder

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2 910	Continued From page 14 Assessment Procedure" dated 10/2010, stated assessment of bladder incontinence will be completed upon admission, significant change and with annual review. RN case manager to monitor the documentation for assessment and incontinence management. Care plan will be updated for incontinence needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff on ensure accurate and comprehensive assessments of bladder elimination are completed, and identified interventions are implemented on a consistent basis. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with shaving for 1 of 3 residents (R94) reviewed for activities of daily living (ADLs) whom were dependent on staff for care.	2 920	Good Shepherd does assure that any resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	6/24/16

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2 920	Continued From page 15 Findings include: R94's quarterly Minimum Data Set (MDS) dated 5/4/16, identified R94 had severe cognitive impairment and was totally dependent on staff for personal hygiene cares. During observation on 5/24/16, at 12:10 p.m. R94 was seated in her wheelchair in the commons area. R94 has visible black facial hair on her upper lip which appeared to be several millimeters (mm) in length. During subsequent observations on 5/25/16, at 8:45 a.m. and 5/26/16, at 9:07 a.m. R94 continued to have the visible black facial hair present on her upper lip. R94's care plan dated 5/24/16, identified R94 required, "Extensive assistance" with grooming, and should, "Look nice and be clean every day." During interview on 5/26/16, at 9:12 a.m. nursing assistant (NA)-C stated shaving should be completed every morning, especially if, "Whiskers" are noted on a female resident. NA-C stated R94 was not resistive with cares. NA-C observed R94 and stated she noticed the black facial hair and R94, "Needs to be shaved." Further, NA-C stated R94 did not have a razor at the facility and staff should have notified the registered nurse (RN) so one could be obtained to ensure she gets shaved. When interviewed on 5/26/16, at 9:33 a.m. RN-A stated she was not aware of any preference of R94 to have facial hair and it should of been removed. Further, RN-A stated she was unaware R94 did not have a razor, and would notify the family to obtain one. A facility policy on grooming was requested, but	2 920	The facility recognizes that on the week of the survey resident #94 was noted to have a small number of facial hairs on her upper lip and of the 3 residents that were in the survey sample resident #94 was the only one noted to have facial hair. a. Regarding resident #94 her facial hair was removed the same day that it was noted by the surveyor. The record was reviewed and revised to assure the Plan of Care and Task List direct staff to monitor for and remove as needed any facial hair on 6/1/2016. b. All other residents who may be affected by this deficient practice have had their medical records reviewed and revised as necessary to assure their Plan of Care and Task List reflect the need for monitoring and removal of facial hair as needed by 6/24/2016. c. To assure the deficient practice will not re- occur a checkoff form will be implemented with a listing of basic AM and PM cares highlighting “checking and removal of facial hair”. This form will be signed off by the person completing the cares on the AM shift indicating that the listed tasks were completed. They will be reviewed by the Team Leader for that shift prior to the staff member leaving their shift. All staff responsible for this F tag will be trained by 6/17/2016. d. To assure interventions are effective the facility will complete random visual audits regarding facial hair and the proper utilization of the new ADL completion tracking form. The audits will be conducted weekly for the first 4 weeks and	

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2 920	Continued From page 16 none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff on completing routine grooming, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920	then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. e. Continued compliance to this tag is the responsibility of DON, ADON and IDP team. Completion date 6/24/2016.	
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement appropriate infection control standards related to cleaning soiled bed pans. This had the potential to affect 13 of residents 157 (R24, R148, R73, R113, R89, R88, R170, R15, R12, R159, R262, R102 and R8) in the facility who utilize a bed pans. Findings include: The facility provided a list of residents that utilized bed pans in the facility. The list indicated R24,R148,R73,R113,R89, R88, R170,R15,R12,R159,R262, R102 and R8 used a bed pan. During an anonymous family interview on 5/25/16, at 1:00 p.m. family member (FM)-A	21375	Good Shepherd does have and maintains an established infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. The facility recognizes that during the survey it was identified that there was a possibility that staff were not fully and carefully following the facility s process for the emptying and rinsing of bedpans. Regarding the 13 residents identified as consistently utilizing a bed pan, the facility has chosen to change the current practice. For all other residents who have a potential to be affected by this practice the process change will be beneficial as well. See process change below.	6/17/16

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21375	Continued From page 17 stated she does not like that the staff are cleaning her family members bed pan in the bathroom. FM-A stated they had complained about this before to staff, and felt staff should be going across the hall to the utility room and cleaning them. FM-A stated the staff continued to clean bed pans in the bathroom for nearly a year now. FM-A further stated she just doesn't feel it is right that they are cleaning the bed pans in a bathroom where her family member brushes their teeth. During interview 5/25/16, at 1:09 p.m. NA-G who stated if a resident uses the bed pain we use wipes to wipe it out and get water from the bathroom sink and then go over to the toilet and dump it. The facility does not have a spray nozel by the toilet like some facilities have to rinse the bed pan over the toilet. During interview 5/25/16, at 1:16 p.m. NA-I stated if a resident used a bed pan we wipe it out with wipes and get water from the bathroom sink to rinse it out in the toilet. During observation of R159's room on 5/25/16, at 1:19 p.m. a bed pan was hanging in a clear plastic bag on a rail next to the toilet. The bathroom sink was approximately two feet away from the toilet. During observation 5/25/16, at 1:20 p.m. on Sunny Lake unit there was a soiled utility room in the hall that had a hopper with a sink that flushes which can be used for cleaning soiled bed pans. During interview 5/25/16, at 2:52 p.m. registered nurse (RN)-E stated she does the infection control program in the facility and the protocol for cleaning the bed pans is to dump what's in the bed pan in the toilet, rinse with water from the	21375	Each resident utilizing a bed pan consistently will have a container (graduate) in the bathroom, solely for the purpose of gathering water from the residents sink to be used for rinsing the bed pan after use. The container will be marked water only/bed pan rinse. Staff will utilize the container to gather water from the residents sink which will be used to rinse the bed pan over the toilet to prevent any contamination of the sink area. This process will also be implemented for any resident with new bed pan use. All staff responsible for compliance to this tag has been trained to the new process expectations. This training will be completed with staff prior to their next assigned shift over the next two weeks. Completion date will be 6/17/2016. Random audits will be completed to assure compliance to the new process. The audits will be conducted weekly for the first 4 weeks and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. Continued compliance to this tag is the responsibility of the DON, ADON and IDP team. Completion date is 6/17/2016.	

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21375	Continued From page 18 sink and dump that into the toilet in the residents room. She further stated if the bed pan is uncleanable they throw it away. RN-E then stated this process was fine because the staff got water from a sink which was only two to four feet away and they do not touch anything but carry the bedpan to the resident toilet. During interview 5/26/16, at 8:28 a.m. NA-J stated if a resident uses the bed pan we dump the contents into their toilet and if they had a bowel movement she would clean it in the soiled utility room. NA-J further stated there were chemicals in the clean utility room for staff to use for cleaning the floor, and housekeeping cleans the residents sinks. NA-J stated they do not clean the resident sink, but could if it was dirty, she would use a wet wash cloth. During interview 5/26/16, at 8:37 a.m. with RN-E who stated it was her understanding the protocol of cleaning a bed pan was not a problem but the protocol was old. She further stated there are soiled utility room to clean soiled resident items on each of the eight households. RN-E then stated housekeeping staff were in the facility Monday thru Sunday and work from 7:30 -4:00 p.m. The housekeeping staff clean the bathrooms daily and she was unsure of how nursing staff would clean the sinks if substance from the bed pan would splash onto the sink after the house keepers left for the day. Review of the Good Shepherd Lutheran Home Giving and Removing Bedpan protocol revised 4/10, indicated "Dispose of contents of bedpan. Empty bedpan into toilet without splashing. Rinse bedpan with cool water end empty into toilet without splashing. Replace bedpan to proper place (if bedpan is soiled, use peri wipe to clean if	21375		

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	00023	A. BUILDING: ______ B. WING ______	05/26/2016

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21375	Continued From page 19	21375		

unable to clean or very soiled, dispose of bedpan and replace a new one in residents storage area.) Dispose of gloves in wastebasket wash hands according to accepted procedure."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could inservice staff on the proper cleaning of bed pans, then audit to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights	21880		6/17/16

Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall

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21880	Continued From page 20 have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a voiced family grievance was acted upon timely for 1 of 1 residents (R86) who's family complained about not having water available at all times. Findings include: R86's quarterly Minimum Data Set (MDS) dated 3/16/16, identified R86 had intact cognition and received a mechanically altered diet. During interview on 5/23/16, at 2:38 p.m. family member (FM)-A stated (R86) was a, "Swallow risk" and was supposed to have water in her room at all times, "In case something gets caught" in her throat. FM-A stated the staff	21880	Good Shepherd does assure that the residents receive prompt resolution to their grievances. The facility recognizes that on the week of survey a family member of resident #86 expressed a concern that the facility did not respond to her request that the resident have water available at all times. That said, the facility was never alerted to this request the family member stated she told an NAR. Also, the facility practice is such that during the short time period that water pitchers are picked up and exchanged for new pitchers and fresh water, the resident/family can request a glass of water at any time during this exchange of pitchers. Water pitchers are	

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21880	Continued From page 21 remove the provided water pitchers in the morning and do not return them until mid-afternoon, causing R86 to go several hours without having water available at times. FM-A stated they had told the staff to have a water pitcher available for R86 at all times, however it still was not being done, so FM-A was buying soda and bringing it in for R86 so she, "Always has something" to drink. R86's room was observed during the interview and no water mug was available, there was a small bottle of 7UP soda on her bedside table which FM-A stated they supplied. During a subsequent observation on 5/25/16, at 1:42 p.m. R86 was seated in her room watching television. R86 did not have a water pitcher in her room. On 5/25/16, at 1:43 p.m. nursing assistant (NA)-A and NA-B were interviewed and stated the morning shift removes the water pitchers after lunch, and the evening shift (starting at 2:00 p.m.) supplies new ones. NA-B stated R86's, "Family has said before" they would like R86 to have water available at all times, but the staff were still removing the pitchers and R86 was going a, "Period of time" without her pitcher each day. Further, NA-A and NA-B stated they had not forwarded the concerns of R86's family to management but were aware of the request to keep a pitcher at R86's bedside. When interviewed on 5/25/16, at 1:51 p.m. registered nurse (RN)-A stated the resident water pitchers were picked up on the morning shift, and replaced on the evening shift, "That is our procedure." RN-A stated R86 had a history of dysphagia (trouble swallowing) and choking on her food, but was unaware of any family concerns	21880	to be picked up at the end of the day shift and exchanged for fresh water and clean pitchers at the beginning of the evening shift. The facility recognizes and is pleased that during the week the survey team was here this was the only concern brought to their attention from residents/family regarding the waters pitcher exchange period. The facility recognizes that although it has a process in place to assure that grievances are brought forward timely and consistently; this request was not brought forward for this resident/family concern. a. Regarding resident #86, the Case Manager for this resident contacted the daughter and discussed her concern and talked to the daughter about the facility s process to ensure that concerns are brought forward. b. As this deficient practice has the potential to affect all the residents who reside here; the facility feels that with the changes put in place for resident #86; all other residents will benefit from the change. c. To assure the deficient practice will not re-occur a check-off form will be implemented with an area for staff to indicate if any concerns/grievances were brought forward during their shift. This form will be signed off by the NAR staff working on each shift and will be reviewed by the LPN team leader. If there has been a concern identified during the shift the Team Leader and staff member will utilize the Shift Happenings form already in place for this process to assure that the concern is acted upon by the Case Manager. Staff responsible to the tag will be trained	

Minnesota Department of Health

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21880	Continued From page 22 regarding the lack of a water pitcher in her room. RN-A stated NA staff should be bringing any voiced concerns to her so they could be addressed timely. A facility Resident Grievance Procedure policy dated 7/11, identified the, "Staff supervisor" should be contacted to, "Discuss your concern." If unresolved, the grievance would be further passed to the social services department to be addressed at a higher management level. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff on forwarding resident and/or family stated concerns to mangement for review. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880	regarding their responsibility by 6/17/2016. d. To assure interventions are effective, the facility will complete random audits thru the IDP meeting utilizing the new check-off sheets and Shift Happenings forms to assure proper follow through with information gathered at the IDP meeting. The audits will be conducted weekly for the first 4 weeks post IDP review and then bi-monthly for the next month and randomly thereafter. The results of these audits will be reviewed at the quarterly QA meeting. e. Continued compliance to this tag is the responsibility of DON, ADON and IDP team. Completion date 6/17/2016.	