DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL		D: Z701
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	F	acility ID: 00023
1. MEDICARE/MEDICAID PROVIDER N (L1) 245269	Э.	3. NAME AND ADI (L3) GOOD SHEP			Ξ	 TYPE OF ACTION: Initial 	<u>7 (</u> L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 686240300		(L4) 1115 4TH AV (L5) SAUK RAPII			(L6) 56379	 Termination Validation 	 CHOW Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey After Co 	9. Other mplaint
6. DATE OF SURVEY 07/18/	2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		DATE (1.25)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a):		X A. In Complian	nce With		And/Or Approved Waivers Of The	e Following Requirements:	
To (b) :		Program Red Compliance			2. Technical Personnel 3. 24 Hour RN	6. Scope of Servi	
12. Total Facility Beds	162 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room S	Size
13.Total Certified Beds	162 (L17)	B. Not in Com	pliance with Program	1	5. Life Safety Code	9. Beds/Room	
	. ,		and/or Applied Waiv		* Code: A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
162							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AF	PPROVAL	Date:
Brenda Fischer, U	Jnit Supervi	sor	07/18/2016	(L19)	Kate JohnsTon, Pr	ogram Specialis	t08/15/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SINGLE STAT	FE AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH C	IVIL	21. 1. Statement of Finance		
X 1. Facility is Eligible to Part	icipate	RIGE	ITS ACT:		 Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA	4-1513)
2. Facility is not Eligible	(L21)						
	(121)						
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	ENT	26. TERMINATION ACTION:	()	L30)
OF PARTICIPATION 07/01/1984	BEGINNING	DATE	ENDING DATI	E	VOLUNTARY 0 01-Merger, Closure 0		<u>ARY</u> eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Me	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS	(-)		03-Risk of Involuntary Termination	OTHER	
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider	Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active	
		F	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION C	OF APPROVAL DAT	ΓE	Posted 08/17/2016 Co.		
	(L32)	07/01/2016		(L33)	DETERMINATION APPRC	OVAL	



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.

Good Shepherd Lutheran Home August 15, 2016 Page 2

Sincerely,

ate Comston ¥

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.

Good Shepherd Lutheran Home August 15, 2016 Page 2

Sincerely,

X

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

Enclosure cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building B. Wing	Y2	7/18/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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).

ITE	Μ	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0166	Correction	ID Prefix F02	282	Correction	ID Prefix	F0309		Correction
Reg. #	483.10(f)(2)	Completed	483. Reg. #	.20(k)(3)(ii)	Completed	Reg. #	483.25		Completed
LSC		06/17/2016	LSC		06/17/2016	LSC			06/24/2016
ID Prefix	F0312	Correction	ID Prefix F03	315	Correction	ID Prefix	F0441		Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	.25(d)	Completed	Reg. #	483.65		Completed
LSC		06/24/2016			06/24/2016	LSC			06/17/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		-	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		-	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		-	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) BF/KJ	date 08/15/201	SIGNATURE OF SU		33925		date 07	7/18/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWI 5/26/2010	JP TO SURVEY CO	DMPLETED ON		OR ANY UNCORRECTE					5 🗌 NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	ICARE/MEDICAID CERTIFICAT		ID: Z701
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245269 2.STATE VENDOR OR MEDICAID NO. (L2) 686240300 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	 NAME AND ADDRESS OF FACILITY (L3) GOOD SHEPHERD LUTHERAN (L4) 1115 4TH AVENUE NORTH (L5) SAUK RAPIDS, MN 7. PROVIDER/SUPPLIER CATEGORY 		Facility ID: 00023 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
6. DATE OF SURVEY 05/26/2016 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 03 SNF/NF/Distinct 07 X-Ray 11	NF 14 CORF ICF/IID 15 ASC RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 162 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 162 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SCIENCY REMARKS)	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: ICF IID (L42) (L43) SHOW LTC CANCELLATION DATE):	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY AP	PROVAL Date:
Austin Fry, HFE NE II	06/28/2016	(L19) Kate JohnsTon, Pr	ogram Specialist 06/29/2016 (L20)
PART II - TO	BE COMPLETED BY HCFA REGI	ONAL OFFICE OR SINGLE STAT	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 07/01/1984 (L24)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>O(</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNATIV A. Suspension (L27) B. Rescind Sus	of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
28. TERMINATION DATE: 25 (L28)	. INTERMEDIARY/CARRIER NO. 03001	30. REMARKS	
31. RO RECEIPT OF CMS-1539 32 (L32)	DETERMINATION OF APPROVAL DATE	L33) DETERMINATION APPRO	WAL.



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:

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

<u>Electronic Plan of Correction</u> - 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

Good Shepherd Lutheran Home June 9, 2016 Page

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

Good Shepherd Lutheran Home June 9, 2016 Page 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

Good Shepherd Lutheran Home June 9, 2016

Page

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Good Shepherd Lutheran Home June 9, 2016 Page Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark meath

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

	-	AND HUMAN SERVICES		FC	DRM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB	NO. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G (X3)	DATE SURVEY COMPLETED
		245269	B. WING		05/26/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SI	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	o	
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.			
	At the time of the su was investigated an unsubstantiated.	urvey, complaint #H5269048 nd found to be			
F 166 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with TO PROMPT EFFORTS TO INCES	F 16	6	6/17/16
	facility to resolve gr	ight to prompt efforts by the ievances the resident may se with respect to the behavior			
	by: Based on observat review, the facility fa family grievance wa residents (R86) who not having water av Findings include:	NT is not met as evidenced tion, interview and document ailed to ensure a voiced as acted upon timely for 1 of 1 o's family complained about vailable at all times.		Good Shepherd does assure that the residents receive prompt resolution to their grievances. The facility recognizes that on the wee survey a family member of resident #8 expressed a concern that the facility di not respond to her request that the resident have water available at all time That said, the facility was never alerted	6 d es. d to
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				06/17/2016

Electronically Signed

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.

PRINTED: 06/28/2016

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245269	B. WING			05/26/2016	
AME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
iood s	HEPHERD LUTHERA	N HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 166		-	F 1	66			
	3/16/16, identified F received a mechan	R86 had intact cognition and ically altered diet.			this request the family member since she told an NAR. Also, the facility practice is such that		
me risl roc ca rer	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				during the short time period that wa pitchers are picked up and exchange	ter	
					new pitchers and fresh water, the resident/family can request a glass water at any time during this exchar		
	remove the provide morning and do not	d water pitchers in the treturn them until			pitchers. Water pitchers are to be p up at the end of the day shift and	bicked	
	without having wate	sing R86 to go several hours er available at times. FM-A I the staff to have a water			exchanged for fresh water and clea pitchers at the beginning of the eve shift.		
	pitcher available for	r R86 at all times, however it done, so FM-A was buying			The facility recognizes and is please during the week the survey team wa		
	has something" to o	t in for R86 so she, "Always drink. R86's room was			this was the only concern brought to attention from residents/family rega	rding	
	was available, there	e interview and no water mug e was a small bottle of 7UP e table which FM-A stated			the waters pitcher exchange period The facility recognizes that although a process in place to assure that		
	they supplied.				grievances are brought forward time consistently; this request was not be	rought	
	1:42 p.m. R86 was	nt observation on 5/25/16, at seated in her room watching not have a water pitcher in			forward for this resident/family conc a. Regarding resident #86, the Cas Manager for this resident contacted daughter and discussed her concer	e the	
	On 5/25/16, at 1:43	p.m. nursing assistant (NA)-A			talked to the daughter about the fac process to ensure that concerns are brought forward.	ility s	
	morning shift removing shift removing shift removing the second strain strain shift and the second strain s	ves the water pitchers after ning shift (starting at 2:00 p.m.)			b. As this deficient practice has the potential to affect all the residents w	/ho	
	has said before" the water available at a	NA-B stated R86's, "Family ey would like R86 to have Il times, but the staff were still			reside here; the facility feels that wi changes put in place for resident #8 other residents will benefit from the		
	"Period of time" wit	ers and R86 was going a, hout her pitcher each day. NA-B stated they had not			change. c. To assure the deficient practice v re-occur a check-off form will be	will not	
	forwarded the conc	erns of R86's family to ere aware of the request to			implemented with an area for staff t indicate if any concerns/grievances		

Facility ID: 00023

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			MB NO.	APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY PLETED	
		245269	B. WING _		05/	26/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA	N HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 166	keep a pitcher at R When interviewed of registered nurse (R pitchers were picker replaced on the ever procedure." RN-A dysphagia (trouble her food, but was u regarding the lack of RN-A stated NA state voiced concerns to addressed timely. A facility Resident of dated 7/11, identifies should be contacted If unresolved, the g passed to the social	-	F 16	 brought forward during their shift. form will be signed off by the NAF working on each shift and will be r by the LPN team leader. If there h a concern identified during the shi Team Leader and staff member w the Shift Happenings form already place for this process to assure th concern is acted upon by the Cas Manager. Staff responsible to the be trained regarding their respons 6/17/2016. d. To assure interventions are eff the facility will complete random a thru the IDP meeting utilizing the r check-off sheets and Shift Happer forms to assure proper follow thro information gathered at the IDP m The audits will be conducted weel the first 4 weeks post IDP review a bi-monthly for the next month and randomly thereafter. The results audits will be reviewed at the quar meeting. e. Continued compliance to this to responsibility of DON, ADON and team. Completion date 6/17/2016 	a staff eviewed as been ft the ill utilize v in at the e tag will ibility by ective, udits new nings ugh with eeting. dy for and then of these terly QA ag is the IDP		
F 282 SS=D	PERSONS/PER C		F 28	•		6/17/16	
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of					
	This REQUIREME	NT is not met as evidenced					

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				יחו			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245269	B. WING			05/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER	• •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH AUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	Continued From pa	ige 3	F 28	82			
	Based on observat review the facility fa provided as directe residents (R53 & R urinary incontinence Findings include: R53's quarterly Min 3/18/16, identified F impairment, and wa urine. R53's care plan dat incontinence of blac assist her to the ba incontinence at leas During continuous of 7:01 a.m. to 10:00 a minutes) R53 was of had any incontinence by her plan of care. During interview 5/2 assistant (NA)-C st	tion, interview and document ailed to ensure toileting was d by the care plan for 2 of 4 177) who were reviewed for e. imum Data Set (MDS) dated R53 had severe cognitive as frequently incontinent of ted 3/31/16, identified R53 had dder, and directed staff to throom and check for urinary st every two hours. observation 5/25/16, from a.m. (total of 2 hours and 59 not assisted to the toilet, nor ce care provided as directed 25/16, at 9:41 a.m. nursing ated she had given R53 a bath	Γ 20	DZ	Good Shepherd does assure that residents receive toileting as directed the plan of care. Regarding residents #177 and 53, tf facility recognizes that during the w survey that the comprehensive assessment was in place; however not being followed by direct care stat indicated in plan of care/task list. T assure that the toileting program in continues to be accurate a new comprehensive assessment has be completed and the care plan revise necessary. These two residents have been re- assessed and plan of care revised necessary as of 6/10/2016. Regarding all other residents who h potential to be affected by the same deficient practice, they will have the current assessments and care plan reviewed and revised as necessary 6/24/2016. To improve care delivery by the direct staff especially those who have not consistently compliant with resident	the eek of , was aff as o place place een ed as as nave e s r by ect care been t plan	
	toileting and inconti hours and 56 earlie NA-C stated R53 sl every two hours. During observation 10:00 a.m. licensed	she was last assisted with inence care at 6:45 a.m. (2 er) that morning. Further, hould be assisted with toileting and interview 5/25/16, at d practical nurse (LPN)-A e bathroom and checked her			of care, training was provided regare the importance of maintaining urina continence if possible and timely response to toileting needs to prome dignity and quality of life. All staff responsible for compliance tag will be trained regarding their responsibility to this tag. The training be completed by 6/17/2016. Rando	ote of this	
	been moderately in voided a moderate	ence. LPN-A stated R53 had continent of urine, and then amount into the toilet. R53, continence care from 6:45			audits will be completed to assure compliance to the tag's requiremen residents remain dry unless unavoir The audits will be conducted week	it that dable.	

Facility ID: 00023

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY	
	245269		IG	(X3) DATE SURVEY COMPLETED		
	245269	B. WING		05/3	26/2016	
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HEPHERD LUTHERA	N HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379				
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE	
until 10:00 a.m., 3 though the care pla every 2 hours. During interview 5/ nurse (RN)-B state toileted with in two plan. R177 quarterly MD had severe cognitive extensive assistant incontinent of blade R177's care plan d was incontinent of for toileting. Further to, "Offer assistant as needed." During observation nursing assistant (I using a mechanica incontinence produ commode being por NA-D then assisted or assisting R177 t	hours and 15 minutes, even an directed staff to toilet R53 25/16, at 1:34 p.m. registered d R53 should have been hours according to her care S dated 3/5/16, identified R177 ve impairment, required t with toileting, and was always der. ated 3/14/16, identified R177 bladder and used a commode er, the care plan directed staff se to toilet every two hours and on 5/24/16, at 6:53 p.m. NA)-D assisted R177 to stand il lift, and changed his soiled act at the bedside, despite a ositioned next to the bathroom. d R177 to bed without offering o use the commode as	F 28	the first 4 weeks and then bi-mou the next month and randomly the The results of these audits will be reviewed at the quarterly QA me Continued compliance to this tag responsibility of the DON, ADON	ereafter. e eting. is the and IDP		
stated staff should two hours accordin NA-D stated R177 past, but she was u	check and change R177 every og to his care plan. Further, had used the commode in the unsure why staff had stopped					
	Continued From pa until 10:00 a.m., 3 though the care pla every 2 hours. During interview 5/ nurse (RN)-B state toileted with in two plan. R177 quarterly MD had severe cognitive extensive assistant incontinent of blade R177's care plan d was incontinent of for toileting. Furthe to, "Offer assistant as needed." During observation nursing assistant (I using a mechanica incontinence productor commode being po NA-D then assisted or assisting R177 t directed by his card When interviewed stated staff should two hours accordin NA-D stated R177 past, but she was u using the commod During interview or	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	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 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.	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. R177's care plan dated 3/14/16, identified R177 was incontinent of bladder. R177's care plan dated 3/14/16, identified R177 was incontinent of bladder. 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 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.	Deficiency 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. F 282 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. F 282 R177 quarterly MDS dated 3/5/16, identified R177 had severe cognitive impairment, required extensive assistant with toileting, and was always incontinent of bladder. F 282 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." Continued compliance to this tag is the responsibility of the DON, ADON and IDP team. Completion date is 6/17/2016. 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 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. 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. When interviewed on 5/25/16, at 9:53 a.m. Luring interview on 5/25/16, at 9:53 a.m.	

Facility ID: 00023

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II TIE		IO. 0938-039		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
		245269	B. WING		05/26/2016		
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA	N HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 282	Continued From pa	ige 5	F 282	2			
	the commode every	nd staff should be, "Offering y time" they check and rected by his care plan.					
F 309 SS=D	none was provided	CARE/SERVICES FOR	F 309	9	6/24/16		
	provide the necess or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment					
	by: Based on observat review, the facility f support was provid	NT is not met as evidenced tion, interview, and document ailed to ensure proper leg ed while in a wheelchair for 1 7) reviewed for wheel chair		Good Shepherd does assure that all residents receive the necessary care ar services to attain or maintain the highes practicable physical, mental, and psychosocial well- being, in accordance with the comprehensive assessment an plan of care.	t d		
	4/21/16, identified impairment, and re- with activities of da During observation was seated in her v	on 5/25/16, at 7:35 a.m. R117 vheelchair in her room. n-supported in the wheelchair,		The facility recognizes that on the week 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 supporte while self-propelling their wheelchair. Although the resident's toes and front o their foot touched the floor the resident's heels did not. The facility also recognizes that althoug	e d f S		

Facility ID: 00023

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(X3) DATE	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED 05/26/2016	
		245269	B. WING _				
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME		111 SA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 309	floor, and her feet a edematous (fluid b subsequent observ R117 was seated in room for the noon be un-supported ca R117's toes touchin legs were edemato When interviewed nursing assistant (fl previously used wh her feet, and NA-F been discontinued. During interview or nurse (RN)-D state condition which ca R117 had been tria approximately a ye been comfortable implemented. Furt current wheelchair support her feet, w allowed R117 the a During subsequent a.m. RN-D stated t shorter wheelchair consulted to ensur- positioning for R11 ability to complete transferring and se varied throughout t	and lower legs were uild up in the tissue). During vation on 5/25/16, at 1:04 p.m. n her wheelchair in the dining meal. R117's feet continued to ausing them to dangle with only ng the floor, her feet and lower ous. on 5/25/16, at 2:02 p.m. NA)-F stated R117 had neelchair pedals to help support was unaware when they had of 5/25/16, 2:07 p.m. registered ed R117 had a medical used her feet to swell with fluid. Ided in a shorter wheelchair var ago, however R117 had not in the chair so it was not ther, RN-D stated R117's , without the use of pedals to as appropriate because it ability to self propel herself. t interview on 5/26/16, at 8:50 hey had trialed R117 in the one year prior which had been ing. Therapy was not e the best wheel chair 7. Further, RN-D stated R117's physical activities, including off propelling in her wheelchair,	F 3(09	the heels the resident remained at independently move about the hou as they wished to do so, the reside had no impairments related to lack support of the heels. Resident #117 medical record was reviewed and notes that OT had a the resident's wheel chair position ability to independently propel whe The assessment was completed a when resident was regularly weari shoes with an approximately 1 inc Since the assessment resident ha chosen to no longer wear those sh when propelling wheelchair. The fa recognizes that a re-assessment was shoes would have benefitted the resident's positioning and assured for impairment although there was impairment. a. Regarding resident #117, a vis assessment was completed on Ma per RN case manager and consult with therapy director. The chair he was changed at that time and low 2 inches. A follow up assessmen completed per RN case manager 6/1/2016, indicating that the reside the ability to rest feet flat on the flo seated in the wheelchair, the reside the ability to rest feet flat on the flo seated in the wheelchair, the reside the ability to rest feet flat on the flo seated in the wheelchair, the reside the ability to rest feet flat on the flo seated in the wheelchair, the reside the ability to rest feet flat on the flo seated in the wheelchair, the reside the ability to rest feet flat on the flo seated in the wheelchair, the reside the ability to rest feet flat on the flo seated in the wheelchair, the reside the ability to rest feet flat on the flo	usehold ent also c of ssessed ing and eelchair. tt a time ng h heel. s noes acility without no risk no ual ay 26th tation eight ered by t was on ent has por while lent wheel have a n ppel in	

Facility ID: 00023

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245269	B. WING		05/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
good s	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 309 F 312 SS=D	 wheelchair with her time. OT-A stated be lowered to allow the floor, so her fee make it easier for (wheelchair. During interview on stated she would he lowered as directed therapy evaluation needed. A facility policy on w requested, but none 483.25(a)(3) ADL C DEPENDENT RES A resident who is u daily living receives 	A observed R117 seated in her refet un-supported during this R117's wheelchair seat should ther feet and heels to contact et were supported and it would R117) to propel her 5/26/16, at 9:38 a.m. RN-D ave R117's wheelchair seat d by OT-A, and complete a if further intervention were wheelchair positioning was e was provided.	F 309	 proper wheelchair positioning. c. To assure the deficient practic reoccur the IDP team will review a significant wheelchair need chang new wheel chair needs at the daily meeting. All staff responsible for th will be trained by 6/17/2016. d. To assure interventions are eff the facility will complete random v audits regarding positioning with o collected from the IDP meeting to proper follow through with informa gathered at the meeting. The aud be conducted weekly for the first 4 post IDP review and then bi-month the next month and randomly ther The results of these audits will be reviewed at the quarterly QA meet e. Continued compliance to this to the responsibility of DON, ADON a team. Completion date 6/24/2016. 	ny es or / IDP his F tag fective sual ata assure tion its will weeks hly for eafter. ing. ag is and IDP	6/24/16
	by: Based on observa review, the facility f with shaving for 1 c	NT is not met as evidenced tion, interview and document ailed to provide assistance of 3 residents (R94) reviewed y living (ADLs) whom were for care.		Good Shepherd does assure that resident who is unable to carry ou activities of daily living receives th necessary services to maintain go nutrition, grooming, and personal	t e od	

Facility ID: 00023

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE		
F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETED		
	245269	B. WING			05/2	26/2016	
PROVIDER OR SUPPLIER							
HEPHERD LUTHERA	N HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE	
Continued From pa	age 8	F 3	812				
Findings include:	•						
5/4/16, identified Raimpairment and wa	94 had severe cognitive is totally dependent on staff for			upper lip and of the 3 residents that in the survey sample resident #94 v only one noted to have facial hair.	t were vas the		
was seated in her warea. R94 has visil	wheelchair in the commons ble black facial hair on her			was removed the same day that it v noted by the surveyor. The record was reviewed	vas 1 and		
millimeters (mm) in observations on 5/2 5/26/16, at 9:07 a.m	l length. During subsequent 25/16, at 8:45 a.m. and n. R94 continued to have the			Task List direct staff to monitor for a remove as needed any facial hair o 6/1/2016.	and		
R94's care plan da required, "Extensiv	ted 5/24/16, identified R94 e assistance" with grooming,			affected by this deficient practice had had their medical records reviewed revised as necessary to assure the of Care and Task List reflect the ne	and ir Plan ed for		
assistant (NA)-C st completed every m "Whiskers" are not	ated shaving should be orning, especially if, ed on a female resident. NA-C			needed by 6/24/2016. c. To assure the deficient practice re- occur a checkoff form will be implemented with a listing of basic.	will not AM		
observed R94 and facial hair and R94 Further, NA-C state the facility and staff registered nurse (F	stated she noticed the black , "Needs to be shaved." ed R94 did not have a razor at f should have notified the RN) so one could be obtained			removal of facial hair". This form w signed off by the person completing cares on the AM shift indicating tha listed tasks were completed. They reviewed by the Team Leader for the	rill be the t the will be at shift		
When interviewed of stated she was not R94 to have facial	on 5/26/16, at 9:33 a.m. RN-A aware of any preference of hair and it should of been			shift. All staff responsible for this F tag w trained by 6/17/2016. d. To assure interventions are effe	ill be ective		
	PROVIDER OR SUPPLIER HEPHERD LUTHERA SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa Findings include: R94's quarterly Mir 5/4/16, identified R impairment and wa personal hygiene c During observation was seated in her v area. R94 has visi upper lip which app millimeters (mm) ir observations on 5/2 5/26/16, at 9:07 a.r visible black facial R94's care plan da required, "Extensiv and should, "Look I During interview or assistant (NA)-C st completed every m "Whiskers" are not stated R94 was not observed R94 and facial hair and R94 Further, NA-C state the facility and staff registered nurse (F to ensure she gets When interviewed a stated she was not R94 to have facial	IDENTIFICATION NUMBER: 245269 PROVIDER OR SUPPLIER HEPHERD LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8	PF CORRECTION IDENTIFICATION NUMBER: A. BUILD 245269 B. WING PROVIDER OR SUPPLIER BEPHERD LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 8 F 3 Findings include: F 3 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	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245269 B. WING	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245269 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEPHERD LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION SHOULD CARDS REFERENCED TO THE APPROPH DEFICIENCY Continued From page 8 F 312 Findings include: F 312 Findings include: F 312 Findings include: F 312 During observation on 5/24/16, id 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 5/26/16, 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. Task List direct staff to monitor for remove as needed any facial hair o 6/1/2016. R94's care plan dated 5/24/16, identified R94 required, "Extensive assistance" with grooming, and should, "Look nice and be clean every day." The staff responsible for this F tag w signed off by the person completing cares on the AM shift incleant practice the re- occur a checkoff form will be implemented with a listing of basic. and PM cares highlighting 'checkin removal of facial hair on the veriweed by the person completing cares on the AM shift incleant gha listed tasks were completed. They revieweed by the person completing cares on the AM shift incl	F CORRECTION IDENTIFICATION NUMBER: 245269 A. BUILDING COMM PROVIDER OR SUPPLIER 3TREET ADDRESS, CITY, STATE, ZIP CODE 1116 4TH AVENUE NORTH 05/2 HEPHERD LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE 1116 4TH AVENUE NORTH SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLANG CORPECTION 05/2 ICAON DEFICIENCY MIST DE PRECEDED BY PRILL REGULATORY OR LSC IDENTIFINIG INFORMATION) IP PREFIX TAG PROVIDERS PLANG CORPECTION COMM Continued From page 8 F 312 PROVIDERS PLANG CORPECTIVE ACTIONS SHOULD BE CARONS REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX PROVIDERS PLANG CORPECTION PREFIX CARONS REFERENCED TO THE APPROPRIATE DEACH CORPECTIVE ACTIONS SHOULD BE CARONS REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 8 F 312 hygiene. The facility recognizes that on the week of the survey resident #94 was noted to have personal hygiene Cares. F 312 hygiene. During observation on 5/26/16, at 9:24/16, identified R94 required, "Extensive assistance" with grooming, and should, "Look nice and be clean every day." F 345 a.m. and 5/24/16, at 9:07 a.m. R94 continued to have the visible black facial hair on fer upper lip and 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 S94 wind stated she noticed the b	

Facility ID: 00023

		AND HUMAN SERVICES				FORM	06/28/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245269	B. WING	à		05/	26/2016
NAME OF I	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH AUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 9	F	312			
	A facility policy on g none was provided	grooming was requested, but			tracking form. The audits will be conducted weekly for the first 4 wee and then bi-monthly for the next mo and randomly thereafter. The resu these audits will be reviewed at the quarterly QA meeting. e. Continued compliance to this ta the responsibility of DON, ADON au team. Completion date 6/24/2016.	onth Its of ag is	
F 315 SS=D	483.25(d) NO CATI RESTORE BLADD	HETER, PREVENT UTI, ER	F	315			6/24/16
	assessment, the fa resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.					
	by: Based on observat review, the facility f assess, develop an promote urinary con (R135, R53, R177) incontinence. Findings include: R135's admission M dated 1/13/16, iden	NT is not met as evidenced tion, interview and document ailed to comprehensively id implement interventions to ntinence for 3 of 4 residents reviewed for urinary Minimum Data Set (MDS) tified R135 had severe nt, required supervision with			Good Shepherd does assure that residents receive comprehensive assessments to develop and consis implement interventions to promote urinary continence. Regarding resident #135 the facility recognizes that during the week of it was noted that the comprehensiv assessment did not accurately mee resident's need to promote contine after an increase in urinary incontin was noted. The facility also recogni	e survey e et the nce ience	

Facility ID: 00023

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						<u>/B NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245269	B. WING _			05/2	26/2016
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SI	HEPHERD LUTHERA	N HOME		11 S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 315	Continued From pa	ae 10	F 31	5			
		ccasionally (less than seven			that the comprehensive care plan di identify the incontinence or interven to promote bladder continence. Thi	tions	
		DS dated 4/6/16, identified limited assistance with			resident has had a full assessment completed to reflect accurate needs		
		requently (more than seven			plan of care has been revised as necessary. Regarding resident #177 the facility		
C	Catheter Care Area	ontinence and Indwelling Assessment (CAA) dated			recognizes that during the week of s that the comprehensive assessmen	survey It was	
		R135 to be, "Incontinent of ," but will, "Ask for assistance en needed."			in place however was not being follo by direct care staff as indicated in p care. To assure that the toileting pro- in place continues to be accurate a	in plan of ng program ate a new as been	
	1/28/16, identified F	nd) Bladder Assessment dated R135 had ability to, "Call for			comprehensive assessment has be completed and the care plan revised		
	incontinent of blade "Bladder Program S	he toilet" and was occasionally ler. Further, a section titled, Selection" was provided to			necessary. Regarding resident #53 the facility recognizes that during the week of s		
	along with a progra	f incontinence R135 had, m selection space to help e bladder function was			the comprehensive assessment did accurately meet the resident's need promote continence after an increas	to	
	•	, these areas were left blank. ord was reviewed. There was			urinary incontinence was noted. Th facility also recognizes that the plan	of	
	no comprehensive determine why R13	assessment identified to 5 had a change in continence,			care was not being followed by direct staff as it was indicated. To assure toileting program is accurate a new	the	
		nally incontinent on admission inent with in three months.			comprehensive assessment has be completed and plan of care revised necessary.		
	nursing assistant (on 5/25/16, at 6:58 a.m. NA)-C opened R135's ying a clear plastic bag with a			These three residents have been re-assessed and plan of care revise necessary as of 6/10/2016.	ed as	
	soiled incontinence	product visible inside the bag.			Regarding all other residents who h potential to be affected by the same)	
	stated R135 had be	on 5/25/16, at 7:00 a.m. NA-C een incontinent of urine just the staff help R135 to the			deficient practice will have their curr assessments and care plans review and revised as necessary by 6/24/2	/ed	

Facility ID: 00023

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		245269	B. WING			26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 315	Continued From pa	age 11	F 31	5		
	residents, but adde she needs to use th time." R135 was, " mornings but typica being assisted to th incontinent. R135's care plan d R135 had a problet there any intervent promote bladder co During interview or practical nurse (LP [R135]" with toiletin incontinent voiding able to verbalize th Further, LPN-A stat after being incontin staff. On 5/25/16, at 9:38 and RN-C were inter residents were con continence upon ac thereafter. If a resi continence, like R1 reassessed to, "Lo that." RN-A review was used to detern completed MDS er two episodes of inc admission assess however had 11 ep her quarterly asses Further, RN-A state comprehensively a	ated 4/22/16, did not identify m with incontinence, or were ions for staff to follow to		change in condition by the ca or noted recurrent urinary tra as monitored through infection tracking process will be revier daily IDP meetings to determ for a re-assessment of reside incontinence. All staff responsible for comp tag will be trained to the new expectations. The training wi completed by 6/17/2016. Ra will be completed to assure of the new process. The audits conducted weekly for the firs and then bi-monthly for the n and randomly thereafter. Th these audits will be reviewed quarterly QA meeting. Continued compliance to this responsibility of the DON, AE team. Completion date is 6/2	ct infections on control wed at the ine the need ent's bliance of this process Il be indom audits compliance to a will be t 4 weeks ext month e results of at the ctag is the DON and IDP	

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		AND HUMAN SERVICES				FORM	06/28/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245269	B. WING			05/	26/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD SI	HEPHERD LUTHERAI	N HOME			115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	Both RN-A and RN- been reassessed fo	ige 12 -C identified R135 should have or her bladder incontinence. inimum Data Set (MDS) dated	F	315			
	12/23/15, indicated urine. R53's quarter indicated she was n urine. R53's care an 12/28/15, indicated continent of bowel a risk for incontinence polypharmacy (seve use. Resident reco bowel movement; s needs assistance. brief; is able to man	she was always continent of erly MDS dated 3/18/16, now frequently incontinent of rea assessment (CAA) dated "Resident is currently and bladder. Resident is at e related to impaired mobility, eral medications), and diuretic ognizes urge to void/pass she alerts staff when she Resident wears pull-up style nage brief with supervision sist with peri-cares q (every)					
	continent and incon plan indicated staff check for incontiner change pad as nee nursing assistant) T kept in the residents	tted 3/31/16, indicated she was national of bladder. The care to assist to the bathroom, nce every two hours and ded. R53's CNA (certified Task List Assignment that was s room dated 3/29/16, d change every two hours and every two hours.					
		der Risk Assessment dated she was continent of bowel					
	7:01 a.m. to 10:00 a	observation 5/25/16, from a.m. (total of 2 hours and 59 not assisted to the toilet or nce care.					

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		AND HUMAN SERVICES				FORM	: 06/28/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245269	B. WING	i	·····	05/	26/2016
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	Continued From pa	ige 13	F:	315			
	assistant (NA)-C sta in the morning and toileting and inconti hours and 56 earlie	25/16, at 9:41 a.m. nursing ated she had given R53 a bath she was last assisted with inence care at 6:45 a.m. (2 er) that morning. Further, hould be assisted with toileting					
	10:00 a.m. licensec assisted R53 to the for urinary incontine been moderately in voided a moderate had not received in until 10:00 a.m., 3 h	and interview 5/25/16, at d practical nurse (LPN)-A e bathroom and checked her ence. LPN-A stated R53 had continent of urine, and then amount into the toilet. R53, continence care from 6:45 nours and 15 minutes, even in directed staff to toilet R53					
	nurse (RN)-B stated to the unit had rece the unit. RN-B state should be complete RN-B stated she ha was unable to find I assessment. RN-B progress note on 3/ was now frequently unable to find a void indicate if there was incontinence.	25/16, at 1:34 p.m. registered d the previous case manager ently left and she was covering ted the bladder assessment ed on admission and quarterly. ad checked the computer and R53's quarterly bladder 8 further stated she did find a /18/16, that indicated resident v incontinent of urine but was ding pattern assessment to s a specific pattern with her					
	from being continer urine there was no determine why ther	arterly MDS indicated a change int to frequently incontinent of assessment completed to re was a change. In addition ited/or checked and changed					

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		AND HUMAN SERVICES				FORM	06/28/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245269	B. WING			05/:	26/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH AUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	every two hours R5 minutes without bei changed. R177 quarterly Min 3/5/16, identified R impairment, require toileting, was not or program and was a R177's Urinary Inco Catheter Care Asse identified R177 was bladder. R177 was odor and infection r required assistance toileting needs and bathroom. R177 do had to use the bath R177's care plan up R177 was incontine staff to, "offer assis and as needed" and bathroom." During observation 5/24/16, at 6:53 p.n assisted the resider changed R177 inco visibly soiled with a assisted him to beo commode was posi the bathroom. NA-E assist R177 toileting.	ing toileted/or checked and imum Data Set (MDS) dated 177 had severe cognitive ed extensive assistant with n a scheduled toileting always incontinent of bladder. ontinence and Indwelling essment (CAA) dated 9/24/15, s frequently incontinent of at risk for skin breakdown, related to incontinence, e of two staff members for utilized the commode in his besn't always know when he	F 3	315			

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STATEMENT	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245269	B. WING _		05/	26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 315	every two hours ac stated that she was to be offered the co was unsure of the offered R177 the c During observation 5/25/16, at 7:28 a.r personal cares. R1 and NA-E assisted did not attempt or c During observation assisted R177 to la incontinent product amount of urine. N toileting assistance When interviewed stated R177 was c and should be offe hours as directed b "he [R177] can't al had fragile skin. During interview or registered nurse (F offered the common checked/change ac Further, RN-B state because of his den "offering the common and changed resid A facility policy title Assessment of blac completed upon ac	cording to his care plan. NA-D s aware that resident needed ommode every two hours, but last time she had actually ommode. of morning personal cares on m. NA-E assisted R177 with 77's incontinence pad was dry R177 to his wheelchair. NA-E offer toileting to R177. on 5/25/16, at 9:21 a.m. NA-E ay down after breakfast. R177's t was visibly soiled with a large A-E did not attempt to offer	F 3	15		

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED	
		245269	B. WING _		05/	26/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 315	Continued From pa	age 16	F 31	5			
		entation for assessment and gement. Care plan will be nence needs.					
F 441 SS=E	483.65 INFECTION	N CONTROL, PREVENT	F 44	1		6/17/16	
	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.						
	Program under whi (1) Investigates, co in the facility; (2) Decides what p should be applied t	stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d	tion Control Program esident needs isolation to of infection, the facility must It prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted					
	(c) Linens Personnel must ha	ndle, store, process and					

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		AND HUMAN SERVICES				FORM	06/28/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245269	B. WING			05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH AUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	infection.	ige 17 as to prevent the spread of NT is not met as evidenced	F 4	441			
	review the facility fa infection control sta soiled bed pans. T 13 of residents 157 R89, R88, R170, R and R8) in the facili Findings include: The facility provided bed pans in the fac R24,R148,R73,R11 R170,R15,R12,R12 bed pan. During an anonymo 5/25/16, at 1:00 p.m stated she does no her family members FM-A stated they h before to staff, and across the hall to th them. FM-A stated bed pans in the bat FM-A further stated that they are cleani where her family m During interview 5/2 stated if a resident	tion, interview and document ailed to implement appropriate andards related to cleaning his had the potential to affect 7 (R24, R148, R73, R113, 15, R12, R159, R262, R102 ity who utilize a bed pans. d a list of residents that utilized lity. The list indicated (3,R89, R88, 59,R262, R102 and R8 used a bus family interview on n. family member (FM)-A t like that the staff are cleaning s bed pan in the bathroom. ad complained about this felt staff should be going the utility room and cleaning the staff continued to clean throom for nearly a year now. I she just doesn't feel it is right ng the bed pans in a bathroom ember brushes their teeth. 25/16, at 1:09 p.m. NA-G who uses the bed pain we use and get water from the			Good Shepherd does have and ma an established infection control pro- designed to provide a safe, sanitary comfortable environment and to pro- the development and transmission disease and infection. The facility recognizes that during to survey it was identified that there we possibility that staff were not fully a carefully following the facility s pro- for the emptying and rinsing of bed Regarding the 13 residents identified consistently utilizing a bed pan, the has chosen to change the current practice. For all other residents wh a potential to be affected by this pra- the process change will be benefici- well. See process change below. Each resident utilizing a bed pan consistently will have a container (graduate) in the bathroom, solely for purpose of gathering water from the residents sink to be used for rinsing bed pan after use. The container we marked water only/bed pan rinse. will utilize the container to gather we from the residents sink which will b to rinse the bed pan over the toilet prevent any contamination of the si area. This process will also be implemented for any resident with the bed pan use.	gram y and event of he as a nd cess pans. ed as facility no have actice al as for the e y the yill be Staff ater e used to ink	

Facility ID: 00023

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	r		OMB NO.	APPROVE 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245269	B. WING _		05/	26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME		1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 441	bathroom sink and dump it. The facilit by the toilet like sor bed pan over the to During interview 5/2 if a resident used a wipes and get water rinse it out in the to During observation 1:19 p.m. a bed pa plastic bag on a rai bathroom sink was from the toilet. During observation Sunny Lake unit the the hall that had a H which can be used During interview 5/2 nurse (RN)-E state control program in cleaning the bed pa bed pan in the toile sink and dump that room. She further s uncleanable they th stated this process water from a sink w away and they do r bedpan to the resid During interview 5/2 stated if a resident the contents into th bowel movement s	then go over to the toilet and y does not have a spray nozel me facilities have to rinse the bilet. 25/16, at 1:16 p.m. NA-I stated bed pan we wipe it out with er from the bathroom sink to ilet. of R159's room on 5/25/16, at n was hanging in a clear I next to the toilet. The approximately two feet away 5/25/16, at 1:20 p.m. on ere was a soiled utility room in nopper with a sink that flushes for cleaning soiled bed pans. 25/16, at 2:52 p.m. registered d she does the infection the facility and the protocol for ans is to dump what's in the t, rinse with water from the into the toilet in the residents stated if the bed pan is prow it away. RN-E then was fine because the staff got which was only two to four feet not touch anything but carry the	F 44	All staff responsible for complia tag has been trained to the new expectations. This training will be completed with staff prior to the assigned shift over the next two Completion date will be 6/17/20 Random audits will be complete assure compliance to the new p The audits will be conducted we the first 4 weeks and then bi- methe next month and randomly th The results of these audits will reviewed at the quarterly QA m Continued compliance to this ta responsibility of the DON, ADO team. Completion date is 6/17/2	r process be ir next weeks. 16. do to process. eekly for ponthly for hereafter. be eeting. g is the N and IDP	

If continuation sheet Page 19 of 20

		AND HUMAN SERVICES				FORM	06/28/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245269	B. WING			05/:	26/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	HEPHERD LUTHERA	N HOME			115 4TH AVENUE NORTH AUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	for cleaning the floc the residents sinks. clean the resident sishe would use a we During interview 5/2 who stated it was h of cleaning a bed p protocol was old. Si soiled utility room to on each of the eigh stated housekeepin Monday thru Sunda p.m. The housekeepin musing staff would from the bed pan w the house keepers Review of the Good Giving and Removi 4/10, indicated "Dis Empty bedpan into bedpan with cool w without splashing. place (if bedpan is sunable to clean or w and replace a new fill	ean utility room for staff to use br, and housekeeping cleans . NA-J stated they do not sink, but could if it was dirty, et wash cloth. 26/16, at 8:37 a.m. with RN-E her understanding the protocol an was not a problem but the he further stated there are to clean soiled resident items thouseholds. RN-E then ng staff were in the facility ay and work from 7:30 -4:00 eping staff clean the d she was unsure of how clean the sinks if substance yould splash onto the sink after left for the day. d Shepherd Lutheran Home ng Bedpan protocol revised spose of contents of bedpan. toilet without splashing. Rinse rater end empty into toilet Replace bedpan to proper soiled, use peri wipe to clean if yery soiled, dispose of bedpan one in residents storage area.) n wastebasket wash hands	F 4	141			

Facility ID: 00023

If continuation sheet Page 20 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES F5269024 OMB NO. 0938-039								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - FALLOWSHIP HALL			(X3) DATE SURVEY COMPLETED		
245269			B. WING		05/24/2016			
	PROVIDER OR SUPPLIER	RAN HOME	1115 4T	RESS, CITY, S TH AVENUE RAPIDS, MI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(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 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.					a		
		apacity of 162 beds the time of the survey						
	The requirement at MET.	t 42 CFR, Subpart 4	33.70(a) is					
LABORATO	DRY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIG	SNATURE	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 SERVIO CENTERS FOR MEDICARE & MEDICAID SERVIO		F52	69024	FORM	05/27/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
245269		B. WING		05/24/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME	STREET ADDRE 1115 4TH SAUK RA		NORTH		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL R TAG OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION () (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 000 INITIAL COMMENTS		K 000			
FIRE SAFETY		0.1			
A Life Safety Code Survey was conducter Minnesota Department of Public Safety, Fire Marshal Division. At the time of this Good Shepherd Lutheran Home, Buildin 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 edition of National Fire Protection Assoc (NFPA) Standard 101, Life Safety Code Chapter 19 Existing Health Care.	State survey, g 01 was 2000 iation				
The facility was inspected as four separa buildings:	ate				
Good Shepherd Home, Building 01, is a building with a partial basement. The bu constructed at 5 different times: The original building was constructed in was determined to be of Type II (111) construction. In 1969, an addition was added to the ea was determined to be of Type II (111) construction. In 1980, an addition was added to the no that was determined to be Type V (111). In 1997, an addition was added to the w	ilding was 1963 and ast that orthwest				
was determined to be of Type V (111) construction. In 2002, an addition was added to the M Dining Room that was determined to be (111) construction.					
Due to the Type II (111) construction als complying to the requirements of Type V Building 01 is surveyed as one building.	/ (111),	ATURE	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 FOR MEDICARE & MEDICARE SERVICES OMB NO. 0938-0391								
CENTERS FOR MEDICARE & MEDICAID SERVICE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE		R/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
245269			B. WING		05/24/2016			
NAME OF PROVIDER OR SUPPLIER								
GOOD SHEPHERD LUTHE			TH AVENUE RAPIDS, MI					
PREFIX (EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCI F BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
K 000 Continued From p	K 000 Continued From page 1							
A two story addition determined to be of located on the sour A two story addition determined to be of located on the nort A one story addition determined to be of located north of the The building is fully sprinkler system is NFPA 13 the Stand Sprinkler Systems a manual fire alarm detection and smo the corridors. The automatic fire depa installed in accord National Fire Alarm The facility has a of census of 157 at the	 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 					n sheet Page 2 of 2		

	MENT OF HEALTH A			书5	269024	FORM	05/27/2016 APPROVED 0.0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			E CONSTRUCTION 02 - TWO-STORY ADDITION	(X3) DATE S COMPL	
		245269		B. WING		05/2	24/2016
	PROVIDER OR SUPPLIER	RAN HOME	1115 4T	RESS, CITY, ST TH AVENUE RAPIDS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
K 000	Minnesota Departm Fire Marshal Divisio Good Shepherd Lu found in substantia requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 18 New He Good Shepherd Lu 2-story addition with addition was constr determined to be T fully sprinkler prote The facility has a fin detection in the cor corridors that is mo department notifica	Survey was conduct nent of Public Safety on. At the time of this theran Home, Buildin I compliance with the articipation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code ealth Care. theran Home's Build h partial basement. T ructed in 2010 and w ype II (111). The add cted throughout. re alarm system with ridors and spaces of onitored for automatic	, State s survey, ng 02, was e 2000 ciation (LSC), ing 02 is a rhe vas lition is smoke ben to the c fire and had a	K 000			
	The requirement at MET.	t 42 CFR, Subpart 48	33.70(a) is				
LABORATO	DRY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRES	ENTATIVE'S SIG	INATURE	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 03 - NORTH EAST ADDITION (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME 245269 B. WING 05/24/2016 NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379 05/24/2016 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES OR LISC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION OR LISC IDENTIFYING INFORMATION) (X6) DEFICIENCY 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 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.	DEPARTMENT OF HEAL			Ŧ5:	269024	FORM	05/27/2016 APPROVED 0.0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SHEPHERD LUTHERAN HOME 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (PREFIX) CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CACH DEFICIENCY K 000 INITIAL COMMENTS 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				1 1			
GOOD SHEPHERD LUTHERAN HOME 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (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) COMMETTIC 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 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		245269		B. WING		05/2	4/2016
(A) ID PREFIX TAG Submeth of Deficiency Must Strement of Deficiency and the preceded by Full Regulatory OR LSC IDENTIFYING INFORMATION) PREFIX TAG CACH CORRECTURE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DEFICIENCY 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 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			1115 4T	H AVENUE	NORTH	10	
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	PREFIX (EACH DEFICIENCY N	IUST BE PRECEDED BY FULL	REGULATORY	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	COMPLETION
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 INITIAL COMM FIRE SAFETY A Life Safety Co Minnesota Depa Fire Marshal Dir Good Shephero found in substa requirements for Medicare/Medic 483.70(a), Life edition of Nation (NFPA) Standar Chapter 18 New Good Shephero two story addition determined to b located on the r The facility has detection in the corridors that is department not The facility has census of 157 a The requirement	ENTS de Survey was conduct artment of Public Safety vision. At the time of this Lutheran Home, Buildi ntial compliance with the r participation in raid at 42 CFR, Subpart Safety from Fire, and the hal Fire Protection Asso of 101, Life Safety Code v Health Care. I Lutheran Home's Buildon, building 03, that was e of Type II (111) constitu- northeast corner of the f a fire alarm system with corridors and spaces o monitored for automati fication. a capacity of 162 beds at the time of the survey	ted by the , State s survey, ng 03,was e e 2000 ciation e (LSC), ling 03 is a suction acility. n smoke pen to the c fire and had a				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	LABORATORY DIRECTOR'S OR	PROVIDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	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 <u>only a suggestion</u> 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.

Good Shepherd Lutheran Home June 9, 2016 Page 2

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 meeth

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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00023	B. WING		05/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		AVENUE NO PIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the	nether a violation has been				
	When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	he number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
Ainpoceto	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
	epartment of Health 7 DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

TATEMENT	Department of He OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI		
		00023	B. WING		— 05/26		
AME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
GOOD SHE	PHERD LUTHERA		I AVENUE NO APIDS, MN 5				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
2 000 C	Continued From pa	ge 1	2 000				
E y is e tt S c c M C E tt F c a A w u M tt ft a N a T li c tt tt s a a T F F " A T T	Department of Heal ou electronically. Is necessary for State inter the word "com- ext. You must then State licensure proof ompletion date, the orrected prior to ele Ainnesota Department's staff, ne following correct Please indicate in y orrection that you and identify the date to the time of the sur- vas investigated ar insubstantiated. Ainnesota Department's staff the time of the sur- vas investigated ar insubstantiated. Ainnesota Department's staff the state Licensing ederal software. Tate signed to Minness Jursing Homes. The ppears in the far le ag." The state state sted in the "Summ olumn and replace ne correction order ne findings which a tatute after the state s evidence by." For ite the Suggested Time period for Cor PLEASE DISREGA OURTH COLUMN PROVIDER'S PLA COURTH COLUMN PROVIDER'S PLA HERE IS NO REC	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 16, surveyors of this visited the above provider and tion orders are issued. rour electronic plan of have reviewed these orders, e when they will be completed urvey, complaint #H5269048 and found to be nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies' es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and		The assigned tag number far left column entitled "IE The state statute/rule num corresponding text of the out of compliance is listed "Summary Statement of E column and replaces the ' portion of the correction o column also includes the are in violation of the state statement, "This Rule is n evidenced by." Following findings are the Suggester Correction and the Time F Correction. PLEASE DISREGARD TH THE FOURTH COLUMN STATES, "PROVIDER'S F CORRECTION." THIS AP FEDERAL DEFICIENCIES WILL APPEAR ON EACH THERE IS NO REQUIRED SUBMIT A PLAN OF COF VIOLATIONS OF MINNE STATUTES/RULES.	D Prefix Tag." aber and the state statute/rule in the Deficiencies" 'To Comply" rder. This findings which e statute after the ot met as the surveyors d Method of Period For HE HEADING OF PHICH PLAN OF PLIES TO S ONLY. THIS PAGE. MENT TO RECTION FOR		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		00023	B. WING		05/26/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY,	STATE, ZIP CODE	
GOOD S	HEPHERD LUTHERA		H AVENUE NO APIDS, MN 3	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
2 000	Continued From pa	ige 2	2 000		
	MINNESOTA STAT	E STATUTES/RULES.			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		6/17/16
		omprehensive plan of care I personnel involved in the			
	by: Based on observati review the facility fa provided as directe	ent is not met as evidenced ion, interview and document ailed to ensure toileting was d by the care plan for 2 of 4 177) who were reviewed for e.		Good Shepherd does assure that residents receive toileting as directe the plan of care. Regarding residents #177 and 53, th facility recognizes that during the we survey that the comprehensive	ne
	Findings include:			assessment was in place; however, not being followed by direct care sta	ff as
	3/18/16, identified F	imum Data Set (MDS) dated R53 had severe cognitive as frequently incontinent of		indicated in plan of care/task list. To assure that the toileting program in p continues to be accurate a new comprehensive assessment has be completed and the care plan revised	blace en
	incontinence of blac	ted 3/31/16, identified R53 had dder, and directed staff to throom and check for urinary st every two hours.		necessary. These two residents have been re- assessed and plan of care revised a necessary as of 6/10/2016. Regarding all other residents who ha	S
	7:01 a.m. to 10:00 a minutes) R53 was r	observation 5/25/16, from a.m. (total of 2 hours and 59 not assisted to the toilet, nor ce care provided as directed		potential to be affected by the same deficient practice, they will have thei current assessments and care plans reviewed and revised as necessary 6/24/2016. To improve care delivery by the direct	r s by
	During interview 5/2	25/16, at 9:41 a.m. nursing		staff especially those who have not	

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If continuation sheet 3 of 23

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00023	B. WING	05/2	6/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME	AVENUE NO PIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ige 3	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.			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.		r.
	had severe cognitiv	S dated 3/5/16, identified R177 re impairment, required with toileting, and was always ler.				
	was incontinent of I for toileting. Furthe	ated 3/14/16, identified R177 bladder and used a commode er, the care plan directed staff e to toilet every two hours and				
	nursing assistant (Nusing a mechanical	on 5/24/16, at 6:53 p.m. NA)-D assisted R177 to stand I lift, and changed his soiled ct at the bedside, despite a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00023	B. WING	B. WING		26/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	NHOME	TH AVENUE NOF			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	NA-D then assisted	psitioned next to the bathroom d R177 to bed without offering o use the commode as e plan.				
	stated staff should two hours accordin NA-D stated R177 past, but she was u	on 5/25/16, at 9:26 a.m. NA-E check and change R177 eve g to his care plan. Further, had used the commode in the unsure why staff had stopped e as of late to toilet R177.	ry e			
	registered nurse (F forgetful at times a the commode ever	n 5/25/16, at 9:53 a.m. RN)-B stated R177 was nd staff should be, "Offering y time" they check and rected by his care plan.				
	A facility policy on a none was provided	care plans was requested, bu	t			
	The director of nursi inservice staff on for	THOD OF CORRECTION: sing (DON) or designee could blowing the individualized pla to ensure compliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-on	e			
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			6/24/16
	receive nursing car custodial care, and individual needs ar the comprehensive	general. A resident must re and treatment, personal an supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 ar	1			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/26/2016	
		00023	B. WING			
	ROVIDER OR SUPPLIER			STATE, ZIP CODE	05/20/20	10
		1115 41				
JOOD SI	IEPHERD LUTHERA	IN HOME SAUK F	RAPIDS, MN 5	56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE CO	(X5) MPLET DATE
2 830	Continued From pa	age 5	2 830			
	of bed as much as written order from t	ing home resident must be ou possible unless there is a the attending physician that th ain in bed or the resident n 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.			Good Shepherd does assure tha residents receive the necessary of services to attain or maintain the practicable physical, mental, and psychosocial well- being, in acco with the comprehensive assessm	care and highest rdance	
	4/21/16, identified impairment, and re with activities of da	inimum Data Set (MDS) dated R117 had severe cognitive quired extensive assistance ily living (ADLs).		plan of care. The facility recognizes that on the the survey; 1 resident out of the s residents in the surveyor's review noted to be in a wheel chair in wh resident did not have their feet su while self-propelling their wheelch Although the resident's toes and	e week of 55 v was nich the upported hair.	
	was seated in her v R117's feet were u causing them to da suspended approx floor, and her feet a	wheelchair in her room. n-supported in the wheelchair angle towards the floor being imately 3-4 inches from the and lower legs were uild up in the tissue). During		their foot touched the floor the re heels did not. The facility also recognizes that a resident #117 lacked the foot sup the heels the resident remained a independently move about the ho	sident's although oport at able to	
	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.		o ly	as they wished to do so, the resident had no impairments related to lace support of the heels. Resident #117 medical record wareviewed and notes that OT had the resident's wheel chair position	dent also ck of as assessed	
	-	on 5/25/16, at 2:02 p.m.		ability to independently propel wh The assessment was completed when resident was regularly wea	neelchair. at a time	

ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00023	B. WING		05/26	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
OOD S	HEPHERD LUTHERA		I AVENUE N APIDS, MN 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
2 830	previously used wh her feet, and NA-F been discontinued. During interview or nurse (RN)-D state condition which cau R117 had been tria approximately a ye been comfortable implemented. Furt current wheelchair, support her feet, w allowed R117 the a During subsequent a.m. RN-D stated t shorter wheelchair completed by nursi consulted to ensure positioning for R11 ability to complete transferring and se varied throughout t When interviewed occupational theray last been seen for time she could self up to 45 feet. OT-/ wheelchair with her time. OT-A stated be lowered to allow the floor, so her feet	eelchair pedals to help support was unaware when they had a 5/25/16, 2:07 p.m. registered d R117 had a medical used her feet to swell with fluid. led in a shorter wheelchair ar ago, however R117 had not in the chair so it was not her, RN-D stated R117's without the use of pedals to as appropriate because it ibility to self propel herself. interview on 5/26/16, at 8:50 hey had trialed R117 in the one year prior which had been ng. Therapy was not e the best wheel chair 7. Further, RN-D stated R117's physical activities, including If propelling in her wheelchair,		shoes with an approximately Since the assessment resider chosen to no longer wear thos when propelling wheelchair. T recognizes that a re-assessm shoes would have benefitted to positioning and assured no ris impairment although there wa impairment. a. Regarding resident #117 assessment was completed of per RN case manager and co with therapy director. The cha was changed at that time and 2 inches. A follow up assess completed per RN case mana 6/1/2016, indicating that the re the ability to rest feet flat on th seated in the wheelchair, the maintains the ability to self-pr chair independently and is ab slightly quicker momentum wh propelling. The care plan has revised as of 6/1/2016. b. All other residents who set their wheelchairs have had th records reviewed and revised necessary as of 6/24/2016 to proper wheelchair positioning c. To assure the deficient pr not reoccur the IDP team will significant wheelchair need cf new wheel chair needs at the meeting. All staff responsible will be trained by 6/17/2016.	nt has se shoes The facility ent without the resident's sk for as no , a visual on May 26th onsultation air height lowered by ment was ager on esident has ne floor while resident opel wheel le to have a hile s been elf-propel in eir medical as assure actice will review any nanges or daily IDP	
	stated she would h	n 5/26/16, at 9:38 a.m. RN-D ave R117's wheelchair seat d by OT-A, and complete a		 d. To assure interventions a the facility will complete rando audits regarding positioning w collected from the IDP meetin 	om visual vith data	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00023	B. WING		05/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		I AVENUE NO APIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 7	2 830			
	requested, but none SUGGESTED MET The director of nurs audit residents for p inservice staff on id and how to correct complete audits to e	HOD OF CORRECTION: ing (DON) or designee could proper positioning, and entifying positioning concerns them. The DON could then		gathered at the meeting. The be conducted weekly for the fit post IDP review and then bi-m the next month and randomly The results of these audits will reviewed at the quarterly QA n e. Continued compliance to t the responsibility of DON, ADO team. Completion date 6/24/20	ly for the first 4 weeks d then bi-monthly for randomly thereafter. e audits will be rterly QA meeting. pliance to this tag is DON, ADON and IDP	
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. 		2 910			6/24/16
	by:	ent is not met as evidenced on, interview and document		Good Shepherd does assure t	hat	

ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00023	B. WING		05/26/2016	
IAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD SHEPHERD LUTHERA	NHOME	AVENUE N PIDS, MN			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
2 910 Continued From pa	ge 8	2 910			
review, the facility fa assess, develop and promote urinary corr (R135, R53, R177) incontinence. Findings include: R135's admission M dated 1/13/16, ident cognitive impairment toileting, and was of episodes) incontine R135's quarterly MI R135 now required toileting, and was fr episodes) incontine R135's Urinary Inco Catheter Care Area 1/14/16, identified F urine several times, to the bathroom who R135's Bowel & (an 1/28/16, identified F assistance to use th incontinent of bladd "Bladder Program S identify what type of along with a program maintain or improve provided. However R135's medical reco	Alinimum Data Set (MDS) tified R135 had severe nt, required supervision with ccasionally (less than seven nt of bladder. DS dated 4/6/16, identified limited assistance with equently (more than seven nt of bladder. DS dated 1/6/16, identified limited assistance with equently (more than seven nt of bladder.		residents receive comprehensive assessments to develop and cons implement interventions to promo urinary continence. Regarding resident #135 the facili recognizes that during the week of it was noted that the comprehens assessment did not accurately me resident's need to promote contin- after an increase in urinary incont was noted. The facility also recog that the comprehensive care plan- identify the incontinence or interve promote bladder continence. This resident has had a full assessme completed to reflect accurate nee plan of care has been revised as necessary. Regarding resident #177 the facili recognizes that during the week of that the comprehensive assessme in place however was not being for by direct care staff as indicated in care. To assure that the toileting in place continues to be accurate completed and the care plan revis necessary. Regarding resident #53 the facility recognizes that during the week of the comprehensive assessment has a completed and the care plan revis necessary. Regarding resident #53 the facility recognizes that during the week of the comprehensive assessment of accurately meet the resident's new promote continence after an incre- urinary incontinence was noted. facility also recognizes that the pla- care was not being followed by di staff as it was indicated. To assur- toileting program is accurate a new	te ity of survey ive eet the ence inence nizes did not entions to s nt ds. The ity of survey ent was ollowed plan of program a new been sed as y of survey lid not ease in The an of rect care re the	

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If continuation sheet 9 of 23

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00023	B. WING		05/26	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		AVENUE N PIDS, MN 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 9	2 910			
	nursing assistant (f bedroom door carry soiled incontinence When interviewed of stated R135 had be prior. NA-C stated bathroom, "Every to residents, but adde she needs to use th time." R135 was, " mornings but typicat being assisted to the incontinent. R135's care plan da R135 had a problem there any interventing promote bladder con During interview on practical nurse (LP [R135]" with toileting incontinent voiding able to verbalize the Further, LPN-A stat after being inconting staff. On 5/25/16, at 9:38 and RN-C were inter residents were corr continence upon act thereafter. If a resi continence, like R1 reassessed to, "Loo that." RN-A review	on 5/25/16, at 6:58 a.m. NA)-C opened R135's ying a clear plastic bag with a product visible inside the bag. on 5/25/16, at 7:00 a.m. NA-C een incontinent of urine just the staff help R135 to the wo hours" like the other ed R135 will, "Tell you" when he bathroom, "Most of the 'Usually" incontinent in the ally will, "Void again" after he toilet, even after being ated 4/22/16, did not identify m with incontinence, or were ions for staff to follow to ontinence. n 5/25/16, at 9:16 a.m. licensed N)-A stated staff, "Helps her ig. R135 has continent and at times and is, "Sometimes" e need to use the restroom. ted R135 will still void even tent if helped to the toilet by 8 a.m. registered nurse (RN)-A erviewed. RN-C stated nprehensively assessed for dmission and annually dent has a change in 35 had, they should be ok into what might be causing ed the collected data which nine R135's continence for the		necessary. These three residents have been re-assessed and plan of care re- necessary as of 6/10/2016. Regarding all other residents we potential to be affected by the sideficient practice will have their assessments and care plans re- and revised as necessary by 6/ Each resident who has a noted change in condition by the case or noted recurrent urinary tract as monitored through infection tracking process will be reviewed daily IDP meetings to determin for a re-assessment of resident incontinence. All staff responsible for complia- tag will be trained to the new pre- expectations. The training will be completed by 6/17/2016. Rand will be completed to assure conducted weekly for the first 4 then bi-monthly for the next modified randomly thereafter. The result audits will be reviewed at the quite meeting. Continued compliance to this tato responsibility of the DON, ADO team. Completion date is 6/24/	evised as ho have same current eviewed 24/2016. significant e managers infections control ed at the e the need t's unce of this ocess be lom audits npliance to ill be weeks and onth and ts of these uarterly QA ag is the N and IDP	

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If continuation sheet 10 of 23

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 APPROPRIAT DEFICIENCY) 2 910 Continued From page 10 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 2 910	05/26/2016 (X5) COMPLET DATE
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 APPROPRIAT DEFICIENCY) 2 910 Continued From page 10 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. 2 910	(X5) COMPLET
GOOD SHEPHERD LUTHERAN HOME(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)2 910Continued From page 10 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 4/6/16.2 910	COMPLET
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)2 910Continued From page 10 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 4/6/16.2 910	COMPLET
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.	
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.	
 Funder, inter-vision transfer 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 wars 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	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00023	B. WING		05/	26/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	HEPHERD LUTHERA	NHOME	AVENUE NOF				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 910	Continued From pa	ge 11	2 910				
	and bladder.						
	7:01 a.m. to 10:00 a	bbservation 5/25/16, from a.m. (total of 2 hours and 59 not assisted to the toilet or nce care.					
	assistant (NA)-C sta in the morning and toileting and inconti hours and 56 earlie	25/16, at 9:41 a.m. nursing ated she had given R53 a bath she was last assisted with nence care at 6:45 a.m. (2 r) that morning. Further, nould be assisted with toileting					
	10:00 a.m. licensec assisted R53 to the for urinary incontine been moderately in voided a moderate had not received in until 10:00 a.m., 3 h	and interview 5/25/16, at I practical nurse (LPN)-A bathroom and checked her ence. LPN-A stated R53 had continent of urine, and then amount into the toilet. R53, continence care from 6:45 nours and 15 minutes, even n directed staff to toilet R53					
	nurse (RN)-B stated to the unit had rece the unit. RN-B states should be completed RN-B stated she haw was unable to find I assessment. RN-B progress note on 3/ was now frequently unable to find a void	25/16, at 1:34 p.m. registered d the previous case manager ntly left and she was covering ed the bladder assessment ed on admission and quarterly. ad checked the computer and R53's quarterly bladder further stated she did find a '18/16, that indicated resident incontinent of urine but was ding pattern assessment to s a specific pattern with her					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00023	B. WING		05/	05/26/2016	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	HEPHERD LUTHERA		I AVENUE NOF APIDS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 910	Continued From pa	age 12	2 910				
	from being contine urine there was no determine why then R53 was to be toile every two hours R5	arterly MDS indicated a change nt to frequently incontinent of assessment completed to re was a change. In addition eted/or checked and changed 53 but went 3 hours and 15 sing toileted/or checked and	•				
	3/5/16, identified R impairment, require toileting, was not o	nimum Data Set (MDS) dated 177 had severe cognitive ed extensive assistant with n a scheduled toileting always incontinent of bladder.					
	Catheter Care Asso identified R177 was bladder. R177 was odor and infection required assistance toileting needs and	ontinence and Indwelling essment (CAA) dated 9/24/15, s frequently incontinent of a trisk for skin breakdown, related to incontinence, e of two staff members for I utilized the commode in his besn't always know when he proom.					
	R177 was incontine staff to, "offer assis	pdated 3/14/16, identified ent of bladder, and directed stance to toilet every two hours Id "I use the commode in the					
	5/24/16, at 6:53 p.r assisted the reside changed R177 inco visibly soiled with a assisted him to beo	n of evening personal cares on m. Nursing assistant NA-D ent with evening cares. NA-D pontinent product which was a small amount of urine and d for the night. R177's sitioned in residents room near					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00023	B. WING		05/	05/26/2016	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
OOD S	HEPHERD LUTHERA		H AVENUE NOF APIDS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 13	2 910				
		D did not offer or attempt to g as directed by his care plan.					
	stated staff should every two hours ac stated that she was to be offered the co	on 5/25/16, at 9:26 a.m. NA-D check and change resident cording to his care plan. NA-D s aware that resident needed ommode every two hours, but last time she had actually ommode.					
	5/25/16, at 7:28 a.r personal cares. R1 and NA-E assisted	of morning personal cares on n. NA-E assisted R177 with 77's incontinence pad was dry R177 to his wheelchair. NA-E offer toileting to R177.	,				
	assisted R177 to la incontinent product	on 5/25/16, at 9:21 a.m. NA-E ay down after breakfast. R177's t was visibly soiled with a large A-E did not attempt to offer e to R177.	s				
	stated R177 was ca and should be offer hours as directed b	on 5/25/16, at 10:05 a.m. NA-I apable of using the commode red the commode every two by his care plan. NA-E stated ways remember to ask" and	Ξ				
	registered nurse (F offered the commo checked/change ac Further, RN-B state because of his den "offering the comm	n 5/25/16, at 9:53 a.m. RN)-B stated R177 should be de every two hours and ccording to his care plan. ed R177 was forgetful at times nentia and staff should be ode every time" they check ent according to his care plan.					
	A facility policy title	d, "Bowel and Bladder					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		00023	B. WING		05/2	26/2016
	PROVIDER OR SUPPLIER	N HOME 1115 4T	ADDRESS, CITY, S TH AVENUE NC RAPIDS, MN 50	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 910	Assessment Proce assessment of blac completed upon ac and with annual re- monitor the docum incontinence mana updated for inconti SUGGESTED MET The director of nur- inservice nursing s comprehensive ass elimination are com interventions are in basis. The DON c compliance.	edure" dated 10/2010, stated dder incontinence will be dmission, significant change view. RN case manager to entation for assessment and agement. Care plan will be				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintai and personal and o This MN Requirem by: Based on observat review, the facility f	b is unable to carry out ring receives the necessary n good nutrition, grooming, oral hygiene. ent is not met as evidenced ion, interview and document failed to provide assistance of 3 residents (R94) reviewed y living (ADLs) whom were	2 920	Good Shepherd does assure resident who is unable to carr activities of daily living receive necessary services to maintai nutrition, grooming, and perso hygiene.	y out es the in good	6/24/16

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
		00023	B. WING		05/26/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
GOOD SI	HEPHERD LUTHERA		AVENUE NO PIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) MPLEI DATE
2 920	Continued From pa	age 15	2 920			
	Findings include: R94's quarterly Mir 5/4/16, identified R impairment and wa personal hygiene c During observation was seated in her v area. R94 has visil upper lip which app millimeters (mm) in observations on 5/2 5/26/16, at 9:07 a.r visible black facial R94's care plan da required, "Extensiv and should, "Look f During interview on assistant (NA)-C st completed every m "Whiskers" are not stated R94 was not observed R94 and facial hair and R94 Further, NA-C state the facility and staff registered nurse (F to ensure she gets When interviewed of stated she was not R94 to have facial removed. Further,	himum Data Set (MDS) dated 94 had severe cognitive as totally dependent on staff for ares. on 5/24/16, at 12:10 p.m. R94 wheelchair in the commons ble black facial hair on her beared to be several a length. During subsequent 25/16, at 8:45 a.m. and n. R94 continued to have the hair present on her upper lip. ted 5/24/16, identified R94 e assistance" with grooming, nice and be clean every day." n 5/26/16, at 9:12 a.m. nursing rated shaving should be orning, especially if, ed on a female resident. NA-C t resistive with cares. NA-C stated she noticed the black , "Needs to be shaved." ed R94 did not have a razor at f should have notified the RN) so one could be obtained shaved. on 5/26/16, at 9:33 a.m. RN-A aware of any preference of hair and it should of been RN-A stated she was unaware razor, and would notify the		The facility recognizes that on the the survey resident #94 was note a small number of facial hairs on upper lip and of the 3 residents the in the survey sample resident #94 only one noted to have facial hair a. Regarding resident #94 her facility was removed the same day that is noted by the surveyor. The record was review revised to assure the Plan of Car Task List direct staff to monitor for remove as needed any facial hair 6/1/2016. b. All other residents who may be affected by this deficient practice their medical records reviewed at revised as necessary to assure the of Care and Task List reflect the remonitoring and removal of facial needed by 6/24/2016. c. To assure the deficient practing the form will implemented with a listing of basis PM cares highlighting "checking a removal of facial hair". This form signed off by the person completic cares on the AM shift indicating the listed tasks were completed. The reviewed by the Team Leader for prior to the staff member leaving shift. All staff responsible for this F tag trained by 6/17/2016. d. To assure interventions are end the facility will complete random values and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization of the new ADL complete random values regarding facial hair and the utilization the tage	d to have her hat were 4 was the cacial hair t was red and e and or and or and or and or and or and have had hd heir Plan heed for hair as ce will be fic AM and and will be ing the hat the ey will be that shift their g will be ffective <i>v</i> isual he proper	
	A facility policy on c	prooming was requested, but		tracking form. The audits will be conducted weekly for the first 4 w	veeks and	
nesota De	epartment of Health		μ			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00023	B. WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	NHOME	I AVENUE N APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 16	2 920			
	none was provided SUGGESTED MET The director of nurs inservice staff on c then audit to ensure	THOD OF CORRECTION: sing (DON) or designee could ompleting routine grooming,		 then bi-monthly for the next randomly thereafter. The re audits will be reviewed at th meeting. e. Continued compliance t the responsibility of DON, A team. Completion date 6/24 	esults of these e quarterly QA to this tag is DON and IDP	
21375	Program Subpart 1. Infection home must establis control program de sanitary environme This MN Requirem	0 Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection signed to provide a safe and nt. ent is not met as evidenced	21375			6/17/16
	review the facility fa infection control sta soiled bed pans. T 13 of residents 15 R89, R88, R170, R and R8) in the facil Findings include: The facility provide bed pans in the fac R24,R148,R73,R11 R170,R15,R12,R12 bed pan. During an anonymo	ion, interview and document ailed to implement appropriate andards related to cleaning 'his had the potential to affect 7 (R24, R148, R73, R113, 15, R12, R159, R262, R102 ity who utilize a bed pans. d a list of residents that utilized ility. The list indicated I3,R89, R88, 59,R262, R102 and R8 used a ous family interview on n. family member (FM)-A		Good Shepherd does have an established infection con designed to provide a safe, comfortable environment ar the development and transr disease and infection. The facility recognizes that survey it was identified that possibility that staff were no carefully following the facility for the emptying and rinsing Regarding the 13 residents consistently utilizing a bed p has chosen to change the co practice. For all other resid a potential to be affected by the process change will be to well. See process change b	atrol program sanitary and ad to prevent mission of during the there was a at fully and y s process of bedpans. identified as ban, the facility current ents who have this practice beneficial as	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
	00023	B. WING		05/2	6/2016
IAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD SHEPHERD LUTHER		AVENUE NO APIDS, MN 5			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375 Continued From p	age 17	21375			
 her family member FM-A stated they h before to staff, and across the hall to t them. FM-A stated bed pans in the bar FM-A further state that they are clean where her family n During interview 5/ stated if a resident wipes to wipe it out bathroom sink and dump it. The facilit by the toilet like so bed pan over the t During interview 5/ if a resident used a wipes and get water rinse it out in the to During observation 1:19 p.m. a bed pa plastic bag on a ra bathroom sink was from the toilet. During observation Sunny Lake unit th the hall that had a which can be used During interview 5/ nurse (RN)-E state control program in cleaning the bed p 	/25/16, at 1:16 p.m. NA-I stated a bed pan we wipe it out with er from the bathroom sink to		Each resident utilizing a k consistently will have a co (graduate) in the bathroo purpose of gathering wat residents sink to be used bed pan after use. The co marked water only/bed pa will utilize the container to from the residents sink w to rinse the bed pan over prevent any contaminatio area. This process will a implemented for any resid bed pan use. All staff responsible for co tag has been trained to th expectations. This trainin completed with staff prior assigned shift over the ne Completion date will be 6 Random audits will be co assure compliance to the The audits will be conduct the first 4 weeks and then the next month and rando The results of these audii reviewed at the quarterly Continued compliance to responsibility of the DON team. Completion date is	ontainer m, solely for the er from the for rinsing the container will be an rinse. Staff o gather water thich will be used the toilet to on of the sink lso be dent with new ompliance to this ne new process g will be to their next ext two weeks. 5/17/2016. mpleted to a new process. cted weekly for n bi-monthly for omly thereafter. ts will be QA meeting. this tag is the , ADON and IDP	

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00023	B. WING		05/	26/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	NHOME	H AVENUE NOI APIDS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 18	21375			
	room. She further s uncleanable they the stated this process water from a sink w away and they do r bedpan to the reside During interview 5/2 stated if a resident the contents into the bowel movement s utility room. NA-J f chemicals in the clea for cleaning the floo the residents sinks clean the resident s she would use a way During interview 5/2 who stated it was ho of cleaning a bed p protocol was old. S soiled utility room to on each of the eight	26/16, at 8:28 a.m. NA-J uses the bed pan we dump eir toilet and if they had a he would clean it in the soiled further stated there were ean utility room for staff to use or, and housekeeping cleans . NA-J stated they do not sink, but could if it was dirty, et wash cloth. 26/16, at 8:37 a.m. with RN-E her understanding the protocol an was not a problem but the he further stated there are o clean soiled resident items it households. RN-E then ng staff were in the facility	t			
	p.m. The houseke bathrooms daily an nursing staff would	ay and work from 7:30 -4:00 eping staff clean the d she was unsure of how clean the sinks if substance ould splash onto the sink afte left for the day.	r			
	Giving and Removi 4/10, indicated "Dis Empty bedpan into bedpan with cool w without splashing.	d Shepherd Lutheran Home ng Bedpan protocol revised spose of contents of bedpan. toilet without splashing. Rinse rater end empty into toilet Replace bedpan to proper soiled, use peri wipe to clean				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00023	B. WING		05/	26/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME	I AVENUE NOI APIDS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ige 19	21375			
	and replace a new	very soiled, dispose of bedpan one in residents storage area.) n wastebasket wash hands ted procedure."				
	The director of nurs inservice staff on th	THOD OF CORRECTION: sing (DON) or designee could ne proper cleaning of bed ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			6/17/16
	shall be encourage their stay in a facilit to understand and patients, residents, residents may voice changes in policies and others of their interference, coerci including threat of o grievance procedur well as addresses a Office of Health Fa nursing home omb	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area udsman pursuant to the Older tion 307(a)(12) shall be suous place.				
	residential program 253C.01, every nor facility employing m	e inpatient facility, every n as defined in section nacute care facility, and every nore than two people that mental health services shall				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00023	B. WING		05/2	05/26/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA		HAVENUE N RAPIDS, MN	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21880	Continued From pa	age 20	21880				
	at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pr an impartial decisio otherwise resolved residential program 253C.01 which are treatment program centers with sectio health maintenance 62D.11 is deemed	arnal grievance procedure that a forth the process to be time limits, including time sponse; provides for the patien a written response to written ovides for a timely decision by on maker if the grievance is no . Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the written internal grievance	nt v ot				
	by: Based on observat review, the facility of family grievance w residents (R86) wh not having water at Findings include: R86's quarterly Mir 3/16/16, identified received a mechan During interview or member (FM)-A sta risk" and was supp room at all times, "	ent is not met as evidenced ion, interview and document failed to ensure a voiced as acted upon timely for 1 of io's family complained about vailable at all times. himum Data Set (MDS) dated R86 had intact cognition and hically altered diet. n 5/23/16, at 2:38 p.m. family ated (R86) was a, "Swallow losed to have water in her In case something gets at. FM-A stated the staff		Good Shepherd does as residents receive prompt their grievances. The facility recognizes th survey a family member expressed a concern tha not respond to her reque resident have water avail That said, the facility was this request the family she told an NAR. Also, th is such that during the sh that water pitchers are pi exchanged for new pitch- water, the resident/family glass of water at any time exchange of pitchers. W	at on the week of of resident #86 t the facility did st that the able at all times. a never alerted to member stated the facility practice nort time period cked up and ers and fresh v can request a e during this		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
			A. BUILDING	i:		
		00023	B. WING		05/2	6/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		AVENUE NO PIDS, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETI DATE
21880	Continued From pa	ge 21	21880			
21880	remove the provide morning and do not mid-afternoon, caus without having wate stated they had tolo pitcher available for still was not being of soda and bringing in has something" to co observed during the was available, there soda on her bedsid they supplied. During a subsequen 1:42 p.m. R86 was television. R86 did her room. On 5/25/16, at 1:43 and NA-B were inter morning shift removil lunch, and the ever supplies new ones. has said before" the water available at a removing the pitche "Period of time" witt Further, NA-A and I	d water pitchers in the		to be picked up at the end of and exchanged for fresh wate pitchers at the beginning of th shift. The facility recognizes and is during the week the survey te this was the only concern bro attention from residents/famil the waters pitcher exchange The facility recognizes that al a process in place to assure grievances are brought forwar consistently; this request was forward for this resident/famil a. Regarding resident #86, th Manager for this resident cor daughter and discussed her of talked to the daughter about process to ensure that conce brought forward. b. As this deficient practice h potential to affect all the resid reside here; the facility feels the changes put in place for reside other residents will benefit from change. c. To assure the deficient pra- re-occur a check-off form will implemented with an area for indicate if any concerns/griev	er and clean he evening pleased that eam was here ught to their y regarding period. though it has that and timely and a not brought y concern. he Case tacted the concern and the facility s rns are has the lents who hat with the dent #86; all om the actice will not be staff to	
	keep a pitcher at Ri When interviewed o	on 5/25/16, at 1:51 p.m.		brought forward during their s form will be signed off by the working on each shift and wil by the LPN team leader. If the	NAR staff I be reviewed ere has been	
	pitchers were picke replaced on the eve procedure." RN-As	N)-A stated the resident water d up on the morning shift, and ening shift, "That is our stated R86 had a history of swallowing) and shoking an		a concern identified during th Team Leader and staff memb the Shift Happenings form all for this process to assure tha	per will utilize ready in place t the concern	
		swallowing) and choking on naware of any family concerns		is acted upon by the Case Ma responsible to the tag will be		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		00023			- 05/26/2016		
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
iOOD S	HEPHERD LUTHERA	N HOME	I AVENUE N APIDS, MN	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
21880	Continued From pa	age 22	21880				
	regarding the lack of RN-A stated NA state voiced concerns to addressed timely. A facility Resident of dated 7/11, identifies should be contacted If unresolved, the g passed to the social addressed at a high SUGGESTED MET The director of nurs inservice nursing stated review. The DON of compliance.	aff should be bringing any her so they could be Grievance Procedure policy ed the, "Staff supervisor" d to, "Discuss your concern." prievance would be further al services department to be her management level. THOD OF CORRECTION: sing (DON) or designee could taff on forwarding resident d concerns to mangement for could then audit to ensure R CORRECTION: Twenty-one		regarding their responsib d. To assure intervention the facility will complete ra thru the IDP meeting utiliz check-off sheets and Shif forms to assure proper for information gathered at th The audits will be conduct the first 4 weeks post IDF bi-monthly for the next main randomly thereafter. The audits will be reviewed at meeting. e. Continued compliance responsibility of DON, AD team. Completion date 6/	s are effective, andom audits zing the new it Happenings illow through with he IDP meeting. ted weekly for P review and then onth and results of these the quarterly QA to this tag is the PON and IDP		