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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZN8D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**

2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **7/10/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 07/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/13/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245393

July 13, 2016

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

Dear Mr. Lindh:

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 30, 2016 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 13, 2016

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

RE: Project Number S5393025

Dear Mr. Lindh:

On June 8, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 25, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 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 30, 2016 and therefore remedies outlined in our letter to you dated June 8, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245393 Y1	A. Building B. Wing Y2	7/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0279	Correction	ID Prefix F0329	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25(l)	Completed
LSC	06/09/2016	LSC	06/16/2016	LSC	06/22/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0520	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.75(o)(1)	Completed
LSC	06/22/2016	LSC	06/22/2016	LSC	06/16/2016
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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	7/13/2016	10160	7/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/26/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245393 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/5/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0014	Correction Completed 06/30/2016	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 06/30/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 06/30/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	7/13/2016	37008	7/5/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZN8D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**
2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. Name and Address of facility
(L3) GOOD SHEPHERD LUTHER HOME
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)
13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Justin Main, HFE NE II 6/17/20I6 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 8, 2016

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

RE: Project Number S5393025

Dear Mr. Lindh:

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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 5, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 26, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 26, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure survey results were easily accessible for resident viewing. This has the potential to effect all residents in the facility. Findings include:	F 167	Corrective Action: Good Shepherd Lutheran Home respects the residents' right to examine the results of the most recent survey of our facility conducted by the Federal or State surveyors and any plan of corrections in effect with respect to the facility. Colored	6/9/16

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

Electronically Signed | 06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 Upon entrance to the facility on 5/23/16 at 8:51 a.m.during the facility tour the results of the most recent survey findings (Centers for Medicare/Medicaid Services [CMS] 2567) was not located. At 9:15 a.m. the administrator was asked the location of the Statement of Deficiencies (HCFA-2567) and he said, "On the bulletin board here." The administrator walked surveyor over to the bulletin board located outside of his office. On a hook was a ring with several sheets in page protectors. The administrator identified the papers as the admission agreement. Under the admission agreement was the Statement of Deficiencies in page protectors on a ring. However, the Statement of Deficiencies was not visible or posted for resident access. On 5/26/16 at 12:40 p.m. nursing assistant (NA)-A stated, " The survey results from last year would be posted at the north nurses station." At 12:41 p.m. R87 stated, "No, I just got here at the first of the month." Admission Minimum Data Set (MDS) revealed R87 was cognitively intact. At 12:44 p.m. NA-B stated, "We usually go over that at a meeting. It's confidential. We don't usually let the family know because that is our job." At 12:47 p.m. R10 stated, "I don't know anything about that." Quarterly MDS dated 5/11/16 revealed R10 was cognitively intact. At 12:51 p.m. trained medication aid (TMA)-A stated, "I think they are on our website, but I'm not sure." At 12:52 p.m. licensed practical nurse (LPN)-C stated, "I think they are on the board near [administrator's] office." A facility policy was requested but not provided.	F 167	signage was added identifying location of the most recent survey results. Identification: All current and future residents residing in the facility will have the most recent survey results available to them. Measures: Current location of the posted survey results were discussed with the IDT. Decision was made to relocate them to the wall beside the facility directory which was felt to receive more resident/visitor traffic. All staff were educated on the location of the posting during the all staff PoC inservice. Social Service Director added information on location of results to the admission packet. DON will post final copy of most recent survey results when they are made available by the Minnesota Department of Health. Monitoring: Administrator will review and ensure placement of the most recent survey results on a monthly basis. Survey results will be reviewed during the next QA committee meeting. Responsible Person: Director of Nursing monitored by facility Administrator.	

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F 279	Continued From page 2	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive dialysis interventions to include at a minimum monitoring fistula for patency and emergency procedure in case the fistula were to bleed for 1 of 1 resident (R12) reviewed for dialysis. Findings include: R12's admission record, dated 10/3/2011, indicated that the resident had a diagnosis of end stage renal disease.	F 279	Corrective Action: R12's Care Plan was reviewed and updated to include emergency procedures and Access Cares which include monitoring her fistula for patency. Identification: All residents with chronic kidney disease that have a fistula were identified. Each Care Plan was reviewed for fistula cares and emergency procedures.	6/16/16

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F 279	Continued From page 3 R12's quarterly Minimum Data Set (MDS), dated 3/31/16, indicated that the resident was cognitively intact. R12's order summary report, dated 9/30/2015, indicated that the resident attended dialysis at Winona Health on Tuesdays, Thursdays and Saturdays of every week. R12's care plan, dated 10/10/2014, indicated that the resident needed dialysis related to end stage renal failure. The goal of care for R12 identified that the resident would have no signs and symptoms of complications from dialysis. The care plan advised the staff not to take a blood pressure reading in the same arm as her graft; it recommended monitoring for edema (swelling) in her arm; it advised to report to the physician any signs and symptoms of infection to the access site; it also advised the nursing staff to monitor for signs and symptoms of renal insufficiency such as changes in level of consciousness. When interviewed on 5/25/16 at 10:18 a.m., licensed practical nurse (LPN)-B stated that R12's fistula was located in her left arm. LPN-B stated that the nursing staff were to check R12's fistula every shift to make sure that it was not infiltrated. When asked what to do in case of an emergency regarding R12's fistula, LPN-B stated that the nursing staff would contact the clinic in Winona and they would transfer the nursing staff to the dialysis center. When interviewed on 5/25/16 at 11:23 a.m., licensed practical nurse (LPN)-A stated that if R12 suddenly started bleeding from her fistula site the nursing staff would automatically put	F 279	Measures: Current policy and procedure titled Nursing Care Plan was reviewed and found to be accurate. This policy was reviewed during the Nurse Management meeting by the Case Managers, Quality Improvement Coordinator, Staff Development Coordinator and Director of Nursing. EMR Care Plan intervention library was also updated to prompt Access Care and Emergency Procedures when dialysis or renal insufficiency focus is triggered. All Nursing department staff educated on Access Cares and Emergency procedures when caring for residents with fistulas during all staff PoC inservice. Monitoring: All new admissions with a diagnosis of chronic kidney disease will have their care plans reviewed for Access Cares and Emergency procedures if applicable within 21 days of admission or if a current resident has a fistula placed in anticipation of the need for dialysis, the care plan will be reviewed and updated within 1 week. Results will be reviewed during the quarterly QA-A meeting. Responsible Person: Clinical Case Manager monitored by Quality Improvement Coordinator and Director of Nursing.	

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F 279	Continued From page 4	F 279		

pressure at the fistula site and they would send R12 to the emergency room. LPN-A stated that the facility posted a number for the staff to call in case of emergencies. LPN-A stated that this information also had not been on the care plan which instructed the nursing staff in case the fistula site was bleeding. LPN-A stated that the care plan did not also instruct the nursing staff to check the fistula and bruit as well once a shift. LPN-A stated that the nursing staff should be checking the fistula site and bruit every shift. LPN-A stated that she did update the care plan to include this information after surveyor inquired about the information not being on the care plan. The order summary report, dated 5/25/16, was updated which instructed the nursing staff to check for bleeding from the fistula every shift. The staff were to apply pressure and send to the emergency department if R12 was bleeding from the fistula. The report also instructed the nursing staff to check the bruit every shift as well and to contact the physician if the bruit was not present.

When interviewed on 5/25/16 at 1:43 p.m., R12 stated that the nursing staff checked her fistula site once a day. She stated that they nursing staff would listen to her bruit with a stethoscope once a day. R12 stated that if her fistula suddenly started bleeding pressure would have to be applied to the fistula site. She explained that one time her fistula wouldn't stop bleeding and the nurses had to call an ambulance.

When interviewed on 5/26/15 at 9:48 a.m., licensed practical nurse (LPN)-C stated that the nursing staff should check R12's fistula and bruise every shift. LPN-C stated that it should be documented. LPN-C stated that if the fistula was bleeding the nursing staff would apply pressure to

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F 279	Continued From page 5 the fistula site and send R12 to the hospital. When interviewed on 5/26/15 at 12:32 p.m., the director of nursing (DON) stated that the coordination of care for emergency services should have been care planned. It should have contained information on what to do in case the fistula was bleeding. She stated that the staff should have checked the fistula site and bruit once a shift and this should have been included on the care plan. Review of the facility policy titled "Policy and Procedure for Residents Receiving Dialysis" (3/27/12), it stated that the purpose was to provide continuity of care for residents receiving dialysis provided on an outpatient basis by another facility. The nursing staff would coordinate daily care needs with the physician and other designated hemodialysis staff on a routine basis as ordered by the physician of the resident's choice. It identified the resident's physician orders and care plan as the source of individualized cares that were to be carried out by staff per provider orders. The fistula site was to be cared for every shift. The staff were to check the bruit every shift and report to the physician if not present. It also instructed in the event of uncontrolled bleeding from the access site the nursing staff would apply pressure and send by an ambulance to the emergency department. When interviewed on 5/26/15 at 12:32 p.m., the director of nursing (DON) stated that the staff should be checking the fistula site and checking for a bruit once a shift.	F 279		

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F 279	Continued From page 6 Review of the facility policy titled "Policy and Procedure for Residents Receiving Dialysis" (3/27/12), it stated that the fistula site was to be cared for every shift. The staff were to check the bruit every shift and report to the physician if not present.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 329	Corrective Action:	6/22/16

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F 329	Continued From page 7 facility failed to attempt medication tapering and to have justification for the continued use of psychoactive medications for 1 of 5 residents (R56); and failed to ensure nonpharmalocial interventions were attempted and documented prior to the administration of as needed (PRN) pain medications for 2 of 5 residents (R56, R1); in addition, the facility failed to ensure target behaviors/symptoms were monitored for a resident receiving an anti-depressant and as needed anti-anxiety medication for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings Include: LACK OF MEDICATION TAPERING AND/OR JUSTIFCATION FOR CONTINUED USE FOR PSYCHOTROPIC MEDICATIONS: R56's current physician orders dated 5/17/16 included orders for the following psychotropic medications: "Surmontil Capsule (Trimipramine Maleate) [antidepressant] Give 200 mg [milligrams] by mouth at bedtime related to depressive disorder not elsewhere classified" and "Trazodone HCl Tablet Give 25 mg by mouth at bedtime related to restless leg syndrome" R56's record review revealed there had been no attempt of a medication tapering for the Surmontiol or the Trazadone within the last calender year and there had been no documentation of clinical justification by the physcian for the continued use of these two medications.	F 329	The goal of Good Shepherd Lutheran Home staff is that each resident's drug regime will be free from unnecessary drugs. The resident's drug regime is reviewed by staff, physician/nurse practitioner (MD/NP), and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. R56's psychoactive medications were reviewed by the pharmacy consultant on 5/28/16 and by her Provider on 5/31/16. NP noted a dose reduction of her of her trazadone. Will reduce to 25mg every other day times 2 weeks, if stable may then d/c at that time based on response. Once completed then will trial a dose reduction of diazepam. After attempted GDR of these medications, will review use of Surmontil. R56 and R1's prn pain medications orders were updated in their EMR. Orders now contain indications for use and nonpharmacological interventions with codes that are required to be attempted/documented before the medication can be administered and saved in eMAR. R48's Behavior Monitoring sheet was updated to include target behaviors/symptoms to monitor for this resident. Identification:	

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F 329	Continued From page 8 On 5/25/2016, at 8:58 a.m. licensed practical nurse (LPN)-A stated there had been no tpering attempts made for trazodone or surmontil within the past year. LPN-A also stated there was no clinical justification by the physcian for the continued use of trazadone and surmontil in the medical record within the past year. LPN-A stated the medications were referenced in the physcian visit notes, but the clinical justification for ongoing use was not completed. On 5/25/2016, at 2:11 p.m. the director of nursing (DON) stated tapering had been attempted twice within the first year of starting a new medication and yearly thereafter. The DON stated if a tapering was not completed, the physcian was to document the clinical jsutification as to why the tapering was contraindicated at the time. The DON stated she talked to the case manager responsible for R56 and said they both looked in R56's chart and there were no tapering attempted or phyiscian clinicial justification for the continued use of trazodone or surmontil completed within the last year. Review of the Pharaceutical Services General Policies and Procedures undated included, "After the first year, a GDR [gradual dose reduction/taper] must be attempted annually unless clinically contradicted...The tapering may be considered clinically contradicted, if: the continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why the attmepted dose reduction would likely imapir the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or the resident's target symptoms returned or worsened after the most	F 329	All residents receiving psychotropic medications were reviewed for appropriate Gradual Dose Reductions as well as ensuring target behaviors are identified and relayed to staff for monitoring. All prn pain medication orders were reviewed and updated using the newly created PRN Pain Medication template in Point Click Care which auto populates nonpharmacological interventions which can then be updated with specific individualized interventions to attempt prior to administration of the medication. As noted above, the interventions are now a system requirement so the nurse cannot administer/save the medication in eMAR until nonpharmacological interventions are documented. Each nurse was individually trained on how to put prn pain medications into Point Click Care using the new template. Monitoring: Gradual dose reduction schedules will be reviewed quarterly at the QA/Medical Directors meeting. Administration records of prn pain medications will be reviewed on a weekly basis x 1 month then prn thereafter depending on results of previous audits to ensure proper documentation of nonpharmacological interventions. All prn pain medication orders will be reviewed on a monthly basis x 4 the every other month x 2 to ensure all nurses are putting any new orders of this type in using the newly created template that now requires	

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F 329	Continued From page 9 recent attempt at tapering the dose within the facility and the physician documented the clinical rationale for why any additional attempted dose reduction at that time would be lijkely to imapir the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychatric instability by exacerbating an underlying medical or psychiatric disorder. LACK OF NON-PHARMACOLOGICAL INTERVENTIONS ATTEMPTED TO RELIEVE PAIN: R56 was admitted to the facility on 10/23/2013 with diagnoses including: chronic interstitial cystitis without hematura and major depressive disorder per the face sheet. R56's current physician orders dated 5/17/16 included as needed (PRN) orders for the following pain medications: "Tylenol Tablet 325 MG [milligrams] (Acetaminophen) Give 650 mg orally every 6 hours as needed for Mild Pain related to PAIN, UNSPECIFIED, 2 tabs PO q [every] 6 hrs [hours]." Review of the May 2016 medication administration record showed the following: R56 received PRN Tylenol on 5/2/16 with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered. R56 received PRN Tylenol on 5/10/16 with no documentation of reason to give the medication and no documentation of non-pharmacological	F 329	nonpharmacological intervention documentation. Responsible Person: Licensed Nurse, Case Manager, Medical Director monitored by the Director of Nursing or designee.	

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F 329	Continued From page 10	F 329		

interventions attempted prior to the PRN acetaminophen being administered.

Review of the April 2016 medication administration record showed the following:

R56 received PRN Tylenol on 5/2/16 with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered.

R56 received PRN Tylenol on 5/13/16 with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered.

R56's care plan did not include non-medical interventions for pain control/relief to attempt before useing for PRN Tylenol.

On 5/26/2016, at 9:11 a.m. licensed practical nurse (LPN)-B stated non-pharmalogical interventions should be attempted prior to giving PRN pain medications and should be documented in a pain progress note. LPN-B stated the site of a residents pain and the reason the pain medication was given should also be documented in a pain progress note.

On 5/26/2016, at 9:29 a.m. LPN-A confirmed by review of the medication adminstration record of PRN Tylenol for April and May 2016 and nurse progress notes, there was no documentation of non-pharmacological interventions attempted prior to the admindtration of the PRN Tylenol all four times the Tylenol was used. LPN-A confirmed on 5/10/16, there was no documentation of reason to give the PRN Tyelnol or location of the pain documented. LPN-A stated

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F 329	Continued From page 11	F 329		

the current pain care plan did not include non-pharmalogical interventions to be used prior to the administration of PRN pain medications and stated she needed to add this to R56's care plan.

On 05/26/2016, at 9:43 a.m. the director of nusring stated she expected staff to attempt non-pahramolical inteventions prior to the administration of PRN pain medications and document in the medical record. The DON also stated the location of pain and the reason the PRN pain medication was being used should also be documented in the medical record. The DON stated specifc non-pharmalocial intevntions that work for a resident should be added to the care plan.

Review of the Pharaceutical Services General Policies and Procedures undated included, "When administering PRN medications, be sure to document administration and record all of the following information...a. date and time of medication Dose, route of administration and, if applicable, the injection site. b. Comaplints or symptoms for which the drug was given. c. Results achieved from giving the dose and time results were noted. d. Initial or signature..."
R1's admission record, dated 4/17/2015, indicated that the resident had diagnoses of: otorrhea, right ear (drainage from the ear which could include pain); acute mastoiditis (middle ear infection which can include pain); type two diabetes.

R1's order summary report, dated 2/29/16, indicated that the physician ordered: Tramadol (a pain medication) HCl (hydrochloride) tablet 50 mg (milligrams) give 1 tablet by mouth as needed for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12	F 329		

pain related to thoracic spine pain.

R1's care plan, reviewed from 5/23/16 through 5/26/16, indicated that the resident was to be observed for signs of pain. The nursing staff were to offer as needed (PRN) pain medications.

R1's medication administration record (MAR), reviewed from 4/1/16 through 5/26/16, indicated that the resident was given as-needed Tramadol a total of four times: 4/4/16, 4/6/16, 5/11/16 and 5/16/16.

R1's progress notes, reviewed from 4/1/16 through 5/26/16, indicated that R1 had not been provided non-pharmacological pain relief measures prior to the administration of as-needed Tramadol medication in all four instances when it had been provided.

When interviewed on 5/26/16 at 12:02 p.m., licensed practical nurse (LPN)-A stated that the process involved in administering as-needed pain medication first required the nurse to assess the resident for pain. LPN-A then stated that the nursing staff should have attempted to provide non-pharmacological pain relief measures prior to administering the as-needed Tramadol medication.

When interviewed on 5/26/16 at 12:32 p.m., the director of nursing (DON) stated that the nursing staff did implement non-pharmacological pain relief measures prior to administering pain relief medications it was just not documented. The DON stated that the facility recently upgraded the electronic medical record when documenting the administration of medications. The facility had been recording it by paper until April of 2016. The

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	245393	A. BUILDING _____ B. WING _____	05/26/2016

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GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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F 329	Continued From page 13 DON stated that previously the staff were documenting in the nurses' notes that they had provided non-pharmacological pain relief measures. She stated that now with the electronic charting, the staff will be required to document that they had provided non-pharmacological pain relief measures prior to the administration of a pain relieving medication. LACK OF MONITORING FOR EFFECTIVNESS OF ANTIANXIETY & ANTIDEPRESSANT MEDICATION: R48 was admitted to the facility on 1/12/16. Admission Record revealed diagnoses to include: unspecified dementia and anxiety disorder. R48's care plan, dated 2/2/16, identified target behaviors/symptoms to include: memory issues, confusion, repetitive questions, restless/anxious, and increased confusion in the evening. Review of R48's Medication Administration Record (MAR) revealed R48 received the antidepressant Celexa daily for anxiety and the anti-anxiety drug Xanax as needed for anxiety. R48's medical record revealed behavior progress notes from admission through 4/4/16. On 5/26/16 at 12:58 p.m. the director of nursing (DON) stated, "It's [target behavior/symptoms] care planned, more than likely it would fall back on the nurses to be charting their behavior notes." The DON verfied behavior charting had not been completed since the beginning of April 2016.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		6/22/16

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F 431	Continued From page 14 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were not used past the expiration date for 3 out of 3 medication carts. this had the potential to affect	F 431	Corrective Action: R87, R37, R23, R1, R56, R45 and R85's insulins were discarded and replaced with new. The new insulin pens were dated	

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F 431	Continued From page 15 several residents who utilized these medications. Findings include: On 5/23/16 during the initial tour of the facility, started at 8:51 a.m., the Norway, Evergreen, and ADD medication carts were observed. The Norway cart contained the following opened and undated medication: R87 Humalog insulin pen. R37 Lantus insulin pen. R28 Advair Diskus inhaler R51 Combivent inhaler, dated 8/5/15. Label on inhaler reads, discard after three months insertion into inhaler. Per medication administration record administered 10 times in March 2016 and three times in April 2016. Licensed Practical Nurse (LPN)-C stated, "I think we typically try to label [insulin]. I think we should for inhalers but haven't." The Evergreen cart contained the following opened and undated medication: R23 Humalog insulin pen. R1 Lantus insulin pen. R56 Novolin insulin vial with pharmacy label date 4/8/16 and Novolog insulin pen. R45 Lantus insulin pen. R85 Lantus insulin pen and Novolog insulin pen. Registered nurse (RN)-B stated, "They [insulin] are supposed to be dated when they are opened." The ADD cart contained the following opened and undated medication: R54 Advair inhaler. Pharmacy label dated 4/28/16 with 18 doses remaining. R18 Humulin insulin pen. R5 Novolog Flex pen and Lantus insulin pen. LPN-D stated, "We usually just date the eye	F 431	and all nurses were instructed on expirations dates. R28 and R54's Advair Diskus inhalers were discarded and replaced with new. R51's combivent inhaler was discarded and replaced with new. Each new inhaler was dated. Staff were instructed on Good Shepherd's policy to date all insulins and inhalers when they are opened and to discard them on or before each medications expiration date. Identification: All residents residing in the facility that receive insulin and/or inhalers had their supply inspected to ensure proper labeling and that the medication had not expired. Measures: Each medication cart has been inspected for properly labeled medications, specifically to ensure all insulin and inhalers are dated and are not expired. Nurses and Trained Medication Aides will be educated on what medications require their label to show the date it was opened at the mandatory plan of corrections inservice on 6/22/16. Staff will also be visually instructed on the location of the expiration dates on specific medications. Standard expiration dates of commonly used medications were also addressed during the inservice. Each resident has their own individual insulin container. A new sticker was added to the inside lid of each container instructing staff to date insulin and refer to manufactures guidelines for specific	

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F 431	Continued From page 16 drops since they are only good for 30 days." LPN-D was unaware of the beyond use date once insulin was opened; "I will have to look into that." On 5/24/16 at 3:15 p.m. the Norway, Evergreen, and ADD medication carts were again observed. The following remained in the ADD cart open and undated: R54 Advair inhaler. R18 Humulin insulin pen. R5 Novolog Flex pen and Lantus insulin pen. Trained medication aide (TMA)-A stated, "[Advair inhaler] there is a number on there that you how many are left. They expire one year from the pharmacy date received, 4/16/16." The following remained in the Evergreen cart open and undated: R1 Lantus insulin pen. R45 Lantus insulin pen. R85 Lantus insulin pen and Novolog insulin pen. LPN-E stated, "I don't know when to stop using them [insulin] because they are not dated. I will call and get them replaced for tomorrow." On 5/24/15 at 6:47 p.m. the director of nursing (DON) stated, "They [insulin & Advair] need to be dated when they are open. Training is completed at orientation. Every so often I have a standing email that I send out regarding all bottles need to be labeled and dated." The DON provided emails that were sent to staff for training. The emails did not contain education regarding the use of insulin or Advair inhalers. Good Shepherd Lutheran Services Insulin Policy reads, "...Date insulin bottle after opening, dispose of lantus after 28 days and others 30 days, and reorder new supply..."	F 431	expiration dates. Commonly used insulin preparations were listed along with each ones recommended expiration timeframe. Pharmacy was also contacted to apply a “Date Opened” sticker that the nurses will need to fill in on medications that require specific awareness in regards to their expiration date. Monitoring: Quality Improvement Coordinator will inspect each medication cart to ensure medications that are required to be dated are labeled correctly as well as ensuring each medication is not expired according to manufactures guidelines. QIC will conduct this audit on a monthly basis x 3 months then every other month x 2. Responsible Person: Clinical Nurses monitored by Quality Improvement Coordinator.	

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F 431	Continued From page 17 Manufacturer guidelines on storage and handling: Humalog pen should be stored at room temperature, below 86 degrees F and must be used within 28 days or be discarded, even if they still contain Humalog. Lantus pen 28 days room temperature only. Advair Diskus, Discard one month after opening the foil pouch or when the counter reads "0", whichever comes first. Combivent inhaler, after assembly the inhaler should be discarded at the latest three months after first use or when the locking mechanism is engaged, whichever comes first. Novolin vial throw away an opened vial after six weeks (42 days) of use, even if there is insulin left in the vial. Novolog pen, once punctured should be kept at temperatures below 86 degrees F for up to 28 days. Humulin pen if stored at room temperature, below 86 degrees F, the pen must discarded after 10 days.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		6/22/16

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F 441	Continued From page 18 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure damp linens were not left in washing machines overnight. This had the potential to effect all residents residing in the facility. In addition the facility failed to ensure ice packs were sanitized between resident use. This had the potential to effect all 16 residents residing on the evergreen unit. Findings include: On 5/26/16 at 1:30 p.m. a tour of the laundry was	F 441	Corrective Action: All linen found to be left in the washing machine overnight was rewashed immediately following the survey inspection. All ice packs as well as the infection control containers they are housed in between use have been washed with soap and water, dried and sanitized with a sani wipe to ensure each are clean/sanitized throughout the facility.	

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F 441	Continued From page 19 conducted. Upon entrance into the laundry room two washing machines were observed to have wet linens sitting in them. Maintenance worker-A stated "They [laundry staff] are all gone for the day, you missed them by 10 minutes." Environmental Services Director stated that linens were sorted and washed at the end of the day and dried the next day. State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities, revised 2/6/15 page 664 reads; "It is recommended that damp linen is not left in machines overnight. The CDC [centers for disease control] recommends leaving washing machines open to air when not in use to allow the machine to dry completely and to prevent growth of microorganisms in wet, potentially warm environments." Facility document Laundry Descriptions, undated reads: "At the end of the day fill one washer with towels and the other one with kitchen, beauty shop and personals leave. Leave for the following day." LACK OF SANITIZING ICE PACKS BETWEEN MULTIPLE RESIDENT USE: On 5/26/16 at 7:40 a.m. licensed practical nurse (LPN)-B was observed removing an ice pack wrapped in a towel from R12's room. LPN-B placed the towel in a dirty linen basket, walked to the unit's refrigerator, and placed the ice pack in the freezer. At 7:47 a.m. LPN-B was interviewed regarding infection control practices and the ice pack. "We usually just put them back in the freezer because they are wrapped in a towel. We could disinfect it with the wipes we use for the	F 441	Identification: All current and future residents choosing to use the facility laundry service have the potential to be effected. All residents that have a current or future need for cold therapy have the potential to be effective. Measures: Facility procedure of washing linen at the end of the day and drying them the following day was reviewed and revised. Linen will no longer be allowed to remain in the washing machines overnight. Environmental Services Director educated all laundry staff of the change. Labeling on the plastic infection control containers that house the ice packs in the freezers was applied reminding staff to sanitize each ice pack with a sani wipe after each use. Staff were educated on infection control policy in regards to the use of ice packs at the time of survey and re-educated during the mandatory plan of corrections inservice. Monitoring: After laundry staff leave for the day, all machines will be checked to ensure they are empty and doors are left open weekly x 1 month then monthly x 3 by the Quality Improvement Coordinator. Above infection control practices will be reviewed by the QA/Medical Director	

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F 441	Continued From page 20 lifts, that's a good idea." At 8:39 a.m. LPN-C stated, "We should be wiping it [ice pack] down with the red top wipes before placing it back in the freezer." At 12:53 p.m. registered nurse(RN)-A, a quality improvement coordinator, stated "It [ice pack] should be wiped off with our sani-wipes. There there is drainage they should be disposed." At 12:57 p.m. the director of nursing stated, "They [ice packs] get wiped down and put back in the frig in a Tupperware container. The sani-wipes is what I would use." Good Shepherd Lutheran home Infection Control Policy, reviewed 6/9/15, reads, "Linens, equipment, and food is properly handled, stored, processed, and transported to prevent the spread of infection...Contact Transmission: Touching certain germs can cause the spread of disease. There may be direct contract with the germ by touching an infected person. There may be indirect contact with the germ by touching objects the infected person has had contact with. Examples of diseases caused by contact germs are: pink-eye, scabies, wound infections, MRSA, VRE, Clostridium difficile."	F 441	meeting committee. Responsible Person: Laundry aide monitored by the Quality Improvement Coordinator and Environmental Service Director. Resident Aides and Nurses monitored by the Infection Control Coordinator and Director of Nursing.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		6/16/16

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F 520	Continued From page 21 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assurance and assessment committee implemented measures to improve upon previously cited deficiencies related to unnecessary medications. This could affect all residents who use psychoactive medications. Findings include: Refer to F329: This tag was issued on the last recertification survey exited July 2015. When interviewed on 5/26/16 at 12:32 p.m., the director of nursing (DON) stated that the Quality Assessment and Assurance (QA&A) committee reviewed certain topics at every meeting. Among	F 520	Corrective Action: QA-A committee meeting agenda and action plan updated to include review of progress and ongoing status of Health Department Survey results on a quarterly basis. Identification: QA-A committee reviews and identifies issues which impact the quality of care and quality of life of the current and future residents of Good Shepherd Lutheran Services. Measures: As noted above, the progress and ongoing status of Health Department	

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F 520	Continued From page 22 these were behaviors, falls, infections, standing orders policies and the antipsychotic medication use. The DON stated that when behaviors would be reviewed, she would pull all the documentation related to behaviors of residents to see what they are experiencing so the medical director would review this information. The DON stated that when an issue was identified that needed to be remedied, she stated that it was her responsibility to "take the reins" when addressing the problem, either by reviewing with the physician during doctors' rounds. The DON stated that they review with the physician to make sure the physician was on board with the process. Currently, the DON stated that the QA&A committee had been working on resident behaviors, vulnerable adult (VA) reporting, antipsychotic medication reviews and the implementation of the new electronic medical record system. The DON stated that the facility recently changed how the staff document the medication administration record (MAR) which changed from paper to electronic. She stated that the staff were implementing non-pharmacological pain relief measures prior to administering pain relief medication, it had just not been documented. The staff were supposed to document this in the nursing progress notes. She stated that the updated software would require the staff to document that they were providing non-pharmacological measures for pain relief. She stated that she knew it was an issue that needed to be corrected.	F 520	Survey results will be reviewed on a quarterly basis to assess need for further improvement intervention implementation. Monitoring/Responsible Persons: Quality Improvement Coordinator monitored by the Director of Nursing.	

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	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2016

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

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GOOD SHEPHERD LUTHERAN HOME	**800 HOME STREET, BOX 747** **RUSHFORD, MN 55971**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Shepherd Lutheran Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1982, an addition was constructed and was determined to be of Type II(111) construction, with a partial basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinklered. The facility has full corridor smoke detection, spaces open to the corridors and resident sleep rooms that is monitored for automatic fire department notification. Good Shepherd Lutheran Home has elected to use the following Categorical Waivers - Doors, Combustible decorations on walls, doors and ceilings, Extinguishing Requirements and Capacity of Means of Egress.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2016**

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K 000	Continued From page 2 The facility has a capacity of 75 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 014 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 This STANDARD is not met as evidenced by: Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 During the facility tour between the hours of 09:30 AM and 12:30 PM on 05/25/2016, observation revealed: That there is wood paneling in the kitchen net area for AD section and there was no documentation of flame spread rating was provided.	K 014	Good Shepherd has purchased a product to apply to the wood paneling in the ADD kitchen area that meets the requirements of flame spread rating. Duane Franzwa, Maintenance Supervisor will assure the work is completed. Product documentation available upon request.	6/30/16

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K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, On facility tour between 09:30 AM and 12:30 PM on 05/25/2016, observation and documentation reviewed revealed that the review of the fire alarm documentation for the past 12 months, a letter from Fire Protection Specialists dated 6-3-15 stated 3 devices needed replacement or repair. There is no documentation showing this work was ever completed.	K 052	Good Shepherd has hired Fire Protection Specialist to test the fire system including all devices to assure that each device is in working order. Duane Franzwa, Maintenance Supervisor will assure that any devices needing replacement or repair work will be done.	6/30/16
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 On facility tour between 09:30 AM and 12:30 PM	K 054	Good Shepherd has hired Fire Protection Specialist to conduct a sensitivity test of the fire alarm system. Duane Franzwa, Maintenance Supervisor will assure that the sensitivity test is completed.	6/30/16

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K 054	Continued From page 4 on 05/25/2016, observation and documentation reviewed revealed that for the past 12 months showed no sensitivity test was completed. Last test was from 2010.	K 054		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
June 8, 2016

Mr. Tom Lindh, Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5393025

Dear Mr. Lindh:

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. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00123	A. BUILDING: _____ B. WING _____	05/26/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 23, 24, 25, & 26, 2016, surveyors of this Department's staff visited the provider and the following correction orders are issued. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 1 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. 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.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive dialysis interventions to include at a minimum monitoring fistula for patency and emergency procedure in case the fistula were to bleed for 1 of 1 resident (R12) reviewed for dialysis. Findings include:	2 560	corrected	6/16/16

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2 560	Continued From page 2 R12's admission record, dated 10/3/2011, indicated that the resident had a diagnosis of end stage renal disease. R12's quarterly Minimum Data Set (MDS), dated 3/31/16, indicated that the resident was cognitively intact. R12's order summary report, dated 9/30/2015, indicated that the resident attended dialysis at Winona Health on Tuesdays, Thursdays and Saturdays of every week. R12's care plan, dated 10/10/2014, indicated that the resident needed dialysis related to end stage renal failure. The goal of care for R12 identified that the resident would have no signs and symptoms of complications from dialysis. The care plan advised the staff not to take a blood pressure reading in the same arm as her graft; it recommended monitoring for edema (swelling) in her arm; it advised to report to the physician any signs and symptoms of infection to the access site; it also advised the nursing staff to monitor for signs and symptoms of renal insufficiency such as changes in level of consciousness. When interviewed on 5/25/16 at 10:18 a.m., licensed practical nurse (LPN)-B stated that R12's fistula was located in her left arm. LPN-B stated that the nursing staff were to check R12's fistula every shift to make sure that it was not infiltrated. When asked what to do in case of an emergency regarding R12's fistula, LPN-B stated that the nursing staff would contact the clinic in Winona and they would transfer the nursing staff to the dialysis center. When interviewed on 5/25/16 at 11:23 a.m., licensed practical nurse (LPN)-A stated that if	2 560		

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2 560	Continued From page 3 R12 suddenly started bleeding from her fistula site the nursing staff would automatically put pressure at the fistula site and they would send R12 to the emergency room. LPN-A stated that the facility posted a number for the staff to call in case of emergencies. LPN-A stated that this information also had not been on the care plan which instructed the nursing staff in case the fistula site was bleeding. LPN-A stated that the care plan did not also instruct the nursing staff to check the fistula and bruit as well once a shift. LPN-A stated that the nursing staff should be checking the fistula site and bruit every shift. LPN-A stated that she did update the care plan to include this information after surveyor inquired about the information not being on the care plan. The order summary report, dated 5/25/16, was updated which instructed the nursing staff to check for bleeding from the fistula every shift. The staff were to apply pressure and send to the emergency department if R12 was bleeding from the fistula. The report also instructed the nursing staff to check the bruit every shift as well and to contact the physician if the bruit was not present. When interviewed on 5/25/16 at 1:43 p.m., R12 stated that the nursing staff checked her fistula site once a day. She stated that they nursing staff would listen to her bruit with a stethoscope once a day. R12 stated that if her fistula suddenly started bleeding pressure would have to be applied to the fistula site. She explained that one time her fistula wouldn't stop bleeding and the nurses had to call an ambulance. When interviewed on 5/26/15 at 9:48 a.m., licensed practical nurse (LPN)-C stated that the nursing staff should check R12's fistula and bruise every shift. LPN-C stated that it should be documented. LPN-C stated that if the fistula was	2 560		

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2 560	Continued From page 4 bleeding the nursing staff would apply pressure to the fistula site and send R12 to the hospital. When interviewed on 5/26/15 at 12:32 p.m., the director of nursing (DON) stated that the coordination of care for emergency services should have been care planned. It should have contained information on what to do in case the fistula was bleeding. She stated that the staff should have checked the fistula site and bruit once a shift and this should have been included on the care plan. Review of the facility policy titled "Policy and Procedure for Residents Receiving Dialysis" (3/27/12), it stated that the purpose was to provide continuity of care for residents receiving dialysis provided on an outpatient basis by another facility. The nursing staff would coordinate daily care needs with the physician and other designated hemodialysis staff on a routine basis as ordered by the physician of the resident's choice. It identified the resident's physician orders and care plan as the source of individualized cares that were to be carried out by staff per provider orders. The fistula site was to be cared for every shift. The staff were to check the bruit every shift and report to the physician if not present. It also instructed in the event of uncontrolled bleeding from the access site the nursing staff would apply pressure and send by an ambulance to the emergency department. When interviewed on 5/26/15 at 12:32 p.m., the director of nursing (DON) stated that the staff should be checking the fistula site and checking for a bruit once a shift. Review of the facility policy titled "Policy and	2 560		

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2 560	Continued From page 5 Procedure for Residents Receiving Dialysis" (3/27/12), it stated that the fistula site was to be cared for every shift. The staff were to check the bruit every shift and report to the physician if not present. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees responsible for developing the comprehensive care plan to include all areas of cares and services identified on the comprehensive assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;	21390		6/22/16

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21390	Continued From page 6 G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ice packs were sanitized between resident use. This had the potential to effect all 16 residents residing on the evergreen unit. Findings include: LACK OF SANITIZING ICE PACKS BETWEEN MULTIPLE RESIDENT USE: On 5/26/16 at 7:40 a.m. licensed practical nurse (LPN)-B was observed removing an ice pack wrapped in a towel from R12's room. LPN-B placed the towel in a dirty linen basket, walked to the unit's refrigerator, and placed the ice pack in the freezer. At 7:47 a.m. LPN-B was interviewed regarding infection control practices and the ice pack. "We usually just put them back in the freezer because they are wrapped in a towel. We could disinfect it with the wipes we use for the lifts, that's a good idea." At 8:39 a.m. LPN-C stated, "We should be wiping it [ice pack] down with the red top wipes before placing it back in the freezer." At 12:53 p.m. registered nurse(RN)-A, a quality improvement coordinator, stated "It [ice pack]	21390	corrected	

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21390	Continued From page 7 should be wiped off with our sani-wipes. There there is drainage they should be disposed." At 12:57 p.m. the director of nursing stated, "They [ice packs] get wiped down and put back in the frig in a Tupperware container. The sani-wipes is what I would use." Good Shepherd Lutheran home Infection Control Policy, reviewed 6/9/15, reads, "Linens, equipment, and food is properly handled, stored, processed, and transported to prevent the spread of infection...Contact Transmission: Touching certain germs can cause the spread of disease. There may be direct contract with the germ by touching an infected person. There may be indirect contact with the germ by touching objects the infected person has had contact with. Examples of diseases caused by contact germs are: pink-eye, scabies, wound infections, MRSA, VRE, Clostridium difficile." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be re-educated and an auditing system developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines	21426		6/22/16

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21426	Continued From page 8 issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview the facility failed to accurately document administration and evaluation of Tuberculin skin test (TST) results for 3 of 5 residents (R85, R62, and R87) reviewed and failed to read a TST according to CDC guidelines for R85. In addition the facility failed to follow CDC recommendations for documentation of TST testing results for EE-1, EE-2, and EE-3. The facility also failed to screen EE-2 for the presence of TB symptoms and failed to evaluate EE-2's TST results in the recommended time period. The facility failed to administer the second step TST for EE-3, and the facilty failed to have historical reactions to TST on file for EE-4 and failed to follow CDC recommendations for alternatives to TST skin tests. R85 admitted to the facility on 4/15/16. R86 received tuberculin skin test (TST) on 4/15/16 at	21426	corrected	

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	00123	A. BUILDING: _____ B. WING _____	05/26/2016

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21426	Continued From page 9 8:41 p.m. The medication administration record (MAR) indicated results were obtained prior to the 48 hours after administration of the test. The MAR also indicated a (-) as the result of the test. The documentation lacked millimeters of induration and indication of positive or negative results. The record indicated R85 received second step TST on 4/29/16 at 10:09 p.m., the record did not reflect results from 5/1/16. R62 admitted to the facility on 4/15/16. R62 received the first step TST on 4/15/16 at 8:38 p.m. The MAR indicated on 4/17/16 the results of the TST were (-). The documentation lacked millimeters of induration and indication of positive or negative results. R62 received the second step TST on 5/1/16, the record did not reflect the test was evaluated. R87 admitted to the facility on 5/18/16. R87 received first step TST on 5/18/16 at 9:35 p.m. The MAR reflected zero millimeters of induration on 5/21/16, at 8:58 p.m. however, did not indicate a positive or negative result. Employee (EE)-1 received tuberculin skin test (TST) on 5/2/16 at 10:00 a.m. The record failed to identify location of administration of test. The test read on 5/4/16 indicated "negative", however failed to identify millimeters of induration. EE-2 received TST on 1/28/16 at 10:35 a.m. in left forearm, was read negative on 1/31/16 at 12:00 p.m. The facility failed to read the test results prior to the 72 hour time frame. In addition, the test result reading failed to identify millimeters of induration. The facility also failed to perform a Tuberculosis symptom screener. EE-3 received TST on 12/28/15 at 2:00 p.m. The test read negative, zero millimeters of induration on 12/30/15. The facility failed to identify the time the skin test was evaluated. In addition, the facility failed to administer the second step TST. EE-4 had a hire date of 8/2/15, with first	21426		

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21426	Continued From page 10 scheduled day of work on 9/2/15. According to the employee record, EE-5 had a chest x-ray performed to rule out tuberculosis (TB). Registered nurse (RN)-A infection control coordinator indicated the employee had stated previous reaction to TST, however there was no supporting documentation in the employee medical record. During an interview on 5/24/16, at 4:45 p.m. RN-A stated EE-3 should have had a second step TST. RN-A stated for EE-4 nothing was on file that indicated what the reaction to a previous TST was. RN-A stated EE-4 verbally reported a reaction, so the facility sent the employee into the clinic to have a chest x-ray done. RN-A indicated an unawareness of the why the IGRA blood test was not completed instead of the chest x-ray. RN-A indicated the documentation for employees and residents was incomplete and should have been filled out appropriately by staff. Facility policy Tuberculosis Control Plan last updated 3/26/15 included: · V) Tuberculin skin testing is the standard method of identifying persons infected with M. Tuberculosis. The TB skin test is to be read 48-72 hours after the injection. -New employees and newly admitted residents with no documentation of previous TST results will have the "two-step testing procedure" with documentation other the Tuberculin skin testing form. For employees and in PCC [electronic health record program] for residents. The two step testing procedure is used to identify a boosted reaction or delayed hypersensitivity to tuberculin. The booster effect can be seen on the second test given as soon as a week and no later than 21 days after initial test is read. · I) Prior to assuming job responsibilities, all employees will have a two step skin test for TB unless documentation of previous positive	21426		

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21426	Continued From page 11 reaction and treatment can be provided. Participation in TB screening is considered a condition of employment. The first step must be completed before direct resident contact by the new employee and the second step must be completed within 30 days of the first step. -If the individual reports a previous positive reaction, an assessment of tuberculin status will be done and reviewed by the Quality Improvement Coordinator. · IV) Data on the employee skin test conversations will be monitored monthly by Staff Development Coordinator. Employee TB test results will be recorded on the appropriate form and filed in the employee's employment file. Employee TB tests results will be reviewed at least quarterly for evidence of trends. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service the person responsilbe for the TB porgram to follow the most current Center for Disease Control recomendations. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were not used past the expiration date for 3 out of	21620	corrected	6/22/16

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21620	Continued From page 12 3 medication carts. this had the potential to affect several residents who utilized these medications. Findings include: On 5/23/16 during the initial tour of the facility, started at 8:51 a.m., the Norway, Evergreen, and ADD medication carts were observed. The Norway cart contained the following opened and undated medication: R87 Humalog insulin pen. R37 Lantus insulin pen. R28 Advair Diskus inhaler R51 Combivent inhaler, dated 8/5/15. Label on inhaler reads, discard after three months insertion into inhaler. Per medication administration record administered 10 times in March 2016 and three times in April 2016. Licensed Practical Nurse (LPN)-C stated, "I think we typically try to label [insulin]. I think we should for inhalers but haven't." The Evergreen cart contained the following opened and undated medication: R23 Humalog insulin pen. R1 Lantus insulin pen. R56 Novolin insulin vial with pharmacy label date 4/8/16 and Novolog insulin pen. R45 Lantus insulin pen. R85 Lantus insulin pen and Novolog insulin pen. Registered nurse (RN)-B stated, "They [insulin] are supposed to be dated when they are opened." The ADD cart contained the following opened and undated medication: R54 Advair inhaler. Pharmacy label dated 4/28/16 with 18 doses remaining. R18 Humulin insulin pen. R5 Novolog Flex pen and Lantus insulin pen. LPN-D stated, "We usually just date the eye	21620		

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21620	Continued From page 13 drops since they are only good for 30 days." LPN-D was unaware of the beyond use date once insulin was opened; "I will have to look into that." On 5/24/16 at 3:15 p.m. the Norway, Evergreen, and ADD medication carts were again observed. The following remained in the ADD cart open and undated: R54 Advair inhaler. R18 Humulin insulin pen. R5 Novolog Flex pen and Lantus insulin pen. Trained medication aide (TMA)-A stated, "[Advair inhaler] there is a number on there that you how many are left. They expire one year from the pharmacy date received, 4/16/16." The following remained in the Evergreen cart open and undated: R1 Lantus insulin pen. R45 Lantus insulin pen. R85 Lantus insulin pen and Novolog insulin pen. LPN-E stated, "I don't know when to stop using them [insulin] because they are not dated. I will call and get them replaced for tomorrow." On 5/24/15 at 6:47 p.m. the director of nursing (DON) stated, "They [insulin & Advair] need to be dated when they are open. Training is completed at orientation. Every so often I have a standing email that I send out regarding all bottles need to be labeled and dated." The DON provided emails that were sent to staff for training. The emails did not contain education regarding the use of insulin or Advair inhalers. Good Shepherd Lutheran Services Insulin Policy reads, "...Date insulin bottle after opening, dispose of lantus after 28 days and others 30 days, and reorder new supply..."	21620		

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21620	Continued From page 14 Manufacturer guidelines on storage and handling: Humalog pen should be stored at room temperature, below 86 degrees F and must be used within 28 days or be discarded, even if they still contain Humalog. Lantus pen 28 days room temperature only. Advair Diskus, Discard one month after opening the foil pouch or when the counter reads "0", whichever comes first. Combivent inhaler, after assembly the inhaler should be discarded at the latest three months after first use or when the locking mechanism is engaged, whichever comes first. Novolin vial throw away an opened vial after six weeks (42 days) of use, even if there is insulin left in the vial. Novolog pen, once punctured should be kept at temperatures below 86 degrees F for up to 28 days. Humulin pen if stored at room temperature, below 86 degrees F, the pen must discarded after 10 days. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

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21675	Continued From page 15	21675		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure damp linens were not left in washing machines overnight. This had the potential to effect all residents residing in the facility. Findings include: On 5/26/16 at 1:30 p.m. a tour of the laundry was conducted. Upon entrance into the laundry room two washing machines were observed to have wet linens sitting in them. Maintenance worker-A stated "They [laundry staff] are all gone for the day, you missed them by 10 minutes." Environmental Services Director stated that linens were sorted and washed at the end of the day and dried the next day. State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities, revised 2/6/15 page 664 reads; "It is recommended that damp linen is not left in machines overnight. The CDC [centers for disease control] recommends leaving washing	21675	corrected	6/16/16

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21675	Continued From page 16 machines open to air when not in use to allow the machine to dry completely and to prevent growth of microorganisms in wet, potentially warm environments." Facility document Laundry Descriptions, undated reads: "At the end of the day fill one washer with towels and the other one with kitchen, beauty shop and personals leave. Leave for the following day." SUGGESTED METHOD OF CORRECTION: The director of environmental services could review and revise the policies and procedures related to linen handling. He/she or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675		