



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 2, 2022

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

RE: CCN: 245269
Cycle Start Date: October 17, 2022

Dear Administrator:

On October 17, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by January 17, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 17, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:

https://mdhprovidercontent.web.health.state.mn.us/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:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 2, 2022

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

Re: Event ID: D1CK11

Dear Administrator:

The above facility survey was completed on October 17, 2022 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 11/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2022
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/14/22 through 10/17/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52695118C (MN87536), with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684			11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2022

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

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

PRINTED: 11/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2022
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 1 Based on interview and document review, the facility failed to ensure necessary and immediate measures to control active bleeding were implemented and maintained to prevent complication until emergency medical service (EMS) arrived for 1 of 1 resident (R1) reviewed who developed acute bleeding from the hand and was prescribed anticoagulant(blood thinners) medication. Finding include: R1's admission minimum data set (MDS) dated 10/06/22, indicated R1 had right pubic fracture, anemia, atrial fibrillation and mild cognitive impairment with no rejection of care. The MDS further indicated R1 required total assist with activities of daily living (ADL's), had severe pain, skin tear and received anticoagulant medication and opioids for pain. R1's Care Plan dated 10/03/22, indicated R1 had a fall with a fracture prior to admission, can be verbally aggressive and should have two staff members in room at all times during provision of cares. R1's Medication Administration Record indicated R1 was receiving two anticoagulant medications up until 10/08/22, Plavix 75 milligrams (mg) daily and Eliquis 2.5 mg twice daily. A reported dated 10/08/22, at 3:48 p.m. indicated when paramedics arrived to R1's room, they noted patient to have a large pool of blood soaking the carpet around the patient with blood soaked dressing. The paramedics stated no nursing staff were holding pressure on the wound dressing. In addition the report indicated the	F 684	The facility does ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices. Regarding Resident one, the facility does recognize the resident was receiving blood thinning medication and did have an episode in which he required a higher level of care than the facility was able to manage and was sent to the local ED. Resident one's medical record was audited and noted no other incidents of bleeding that were not resolved effectively during residents stay at the facility. To assure no other residents have been affected by the deficient practice; medical records for all other facility residents have been audited for the last 3 months. Audits performed including residents who were and who were not receiving blood thinning medications. There were no other episodes noted in which a resident had bleeding that was not resolved timely and effectively in the facility. Nursing staff will be re-educated to the standards of practice and their responsibility to the regulation with enhanced focus on appropriate interventions to stop active bleeding. Date of completion 11/21/22. To assure continued compliance the facility QA team/designee will conduct routine audits of accidents in the facility daily for one week, weekly for two weeks, monthly for two months and periodically after that to assure ongoing compliance. To assure ongoing compliance, results from these audits will be reviewed at the		

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

PRINTED: 11/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2022
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 2 patient reported he had requested to come to the emergency room multiple times and the nursing home staff refused. During interview 10/13/22, at 3:00 p.m. emergency room registered nurse (ERRN) who treated R1 in emergency department on 10/08/22, stated when he arrived he had a cut on the back of his right hand with sutures from a previous fall and they could not stop the bleeding and she had to hold pressure to the wound for 20-40 minutes before it would slow down. In addition, ERRN stated when he arrived he had a significant amount of blood loss and he was later admitted to the hospital for observation. During interview 10/14/22, at 10:53 a.m. registered nurse (RN)-B who cared for R1 in the facility stated she was scheduled to work with R1 on 10/08/22, and R1's hand started to bleed at 10:00 a.m. RN-B stated she was able to apply pressure and cold compress to stop the bleeding and checked on him twice with no bleeding. RN-B stated she went on break at 10:45 a.m. and while on break the bleeding restarted. RN-B stated the receptionist called her stated R1's family called concerned that no one was doing anything about his bleeding. The nursing assistant on the floor called the charge nurse RN-C to the room and RN-B stated she tried to stop the bleeding with no luck and it was decided around 12 p.m. to call the on-call physician, and have R1 sent to the emergency department. During interview 10/17/22, at 10:18 a.m. with paramedic who arrived at the facility on 10/08/22, at 12:25 p.m. to transport R1 to the emergency department stated she was called for an uncontrolled bleed. The paramedic stated when	F 684	facility Quality Assurance meetings.		

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

PRINTED: 11/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2022
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 3 she arrived to R1's room no one was applying pressure to R1's hand wound except the resident and it was not working. The paramedic stated there was a good amount of blood loss and his dressing was completely saturated with blood along with the towel wrapped around his hand and blood on the pillow underneath his hand. The paramedic further stated the residents hand was cold to touch and he was on two different blood thinners. In addition the paramedic stated there were two nurses in the room and neither were applying pressure to the wound. During interview 10/17/22, at 11:30 a.m. RN-B stated she felt everything was done for R1 the day his hand was bleeding. RN-B stated she does not know why pressure was not being applied to R1's hand when the paramedics arrived but thought maybe she had to step out of the room to get paperwork for them. In addition RN-B stated when she went on break that day she thought the bleeding had stopped. During interview 10/17/22, at 12:53 p.m. the director of nursing (DON) stated she was not in the room to say exactly what happened that day but she did know the nurse did decide at the end they were not equipped to handle the bleeding and decided to send him in for further evaluation. The DON stated the did send him in by calling the non-emergent line. The DON further stated R1 has been having low hemoglobin levels since he admitted and had been ranging in the 8 levels. A ED to Hospital Admission (Discharge) dated 10/08/22, indicated R1 initially received a pressure dressing when he arrived that helped initially but then Surgifoam (dressing to control capillary, venous and arteriolar bleeding by	F 684			

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

PRINTED: 11/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2022
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	Continued From page 4 pressure) was applied. His hemoglobin was 8.1 on admission and decreased to 7.0 on 10/09/22, and was given 1 unit of packed red blood cells (PRBC) and transferred on a inpatient status to a medical bed. A facility policy was requested on emergency services and was not provided.	F 684			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2022
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
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 10/14/22 through 10/17/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

11/11/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2022
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H52695118C (MN87536), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			