DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 4, 2022

Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

RE: CCN: 245393
Cycle Start Date: June 21, 2022

Dear Administrator:

On July 6, 2022, we notified you a remedy was imposed. On August 1, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 1, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 21, 2022 be discontinued as of August 1, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 6, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 21, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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August 4, 2022

Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

Re: Reinspection Results
Event ID: S4LI12

Dear Administrator:

On August 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 21, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
July 6, 2022

Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

RE: CCN: 245393
Cycle Start Date: June 21, 2022

Dear Administrator:

On June 21, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 21, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 21, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 21, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 21, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Shepherd Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 21, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 December 21, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	C 06/21/2022

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 On 6/21/22, 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: H53932105C (MN84214), with a deficiency cited at F580 & F689. 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 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		7/28/22

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

Electronically Signed | 07/15/2022

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.

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 580	Corrective Action:	

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F 580	Continued From page 2 review the facility failed to notify the medical provider for guidance for 1 of 3 residents (R1) who sustained a head injury following a fall, who was on Coumadin (a blood thinner) and was complaining of a headache reviewed for falls. The facility's failure to contact the physician timely resulted in actual harm for R1 who required hospitalization and was diagnosed with C1-C2 fractures. The findings include: R1's quarterly Minimum Data Set (MDS) dated 6/3/22, indicated R1 was severely cognitively impaired and had diagnoses which included abnormalities of gait and mobility, anxiety disorder, age-related physical debility, cognitive communication deficit, history of falling, long term use of anticoagulants (blood thinner), mild cognitive impairment, age-related osteoporosis with current pathological fracture, peripheral vascular disease and macular degeneration. The MDS also indicated R1 required extensive physical assistance of one staff with all activities of daily living except eating, had no pain, and for moving from seated to standing position and on and off the toilet R1 was not steady and only stabilized with human assistance. A report dated 6/12/22, indicated on 6/4/22, early morning, R1 had fallen off the commode after nursing assistant (NA)-A had thought something was wrong with R1 and had left R1 unattended despite the change in condition and gone to the door looking for help. The report indicated R1 had fallen fell forward off the commode, hitting her forehead on the floor and had sustained a goose egg injury and had a headache. The report also indicated after the incident licensed practical	F 580	R1 was transferred to the hospital for physician evaluation. Resident has since passed away from a condition unrelated to the fall. Facility began utilizing an updated version of the Resident/Visitor Incident Report form on 6/24/22. Updated form which the licensed nurse fills out at the time of a resident fall now includes a question regarding use of anticoagulants and instruction for the nurse to “Notify Dr. ____, (phone number), if on an anticoagulant with active bleeding/bruising/head injury or internal injury suspected r/t unstable vital signs, abnormal neuro exam or if the resident sustains other significant injury resulting in new or worsening c/o pain”. Identification: Report was generated from facility EMR to identify all residents currently taking an anticoagulant/blood thinner. Care plans of those residents identified were updated to include notification and interventions along with updating the Resident/Visitor Incident Report form to reduce the likelihood of untimely physician notification in the future. Resident Care Profile Special Instructions in Point Click Care have also been updated to quickly alert staff regarding the use of an anticoagulant/blood thinner. Measures: Current Resident/Visitor Incident Report form has been updated to include a question regarding use of anticoagulants and instruction for the nurse to “Notify Dr. ____, (phone number), if on an	

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F 580	Continued From page 3 nurse (LPN)-A continued taking R1's vitals and never notified the physician but at around 5:25 p.m. in-coming PM shift registered nurse (RN)-B thought R1 needed to go by ambulance to hospital. The report further indicated at the hospital a brain scan was completed and showed there was hematoma on the outside of the brain and R1 had sustained fractures on C1 and C2 which were caused by trauma from the fall. In addition, a neurologist consult indicated R1 was not eligible for surgery due to age and taking Coumadin thus R1 was hospitalized from 6/4/22, through 6/8/22. Review of R1's Progress Notes revealed the following information: -6/4/22, at 3:51 p.m. note indicated R1 had a fall from the commode which was in middle of room at 8:20 a.m. after staff removed a mechanical stand away from resident to provide cares and get R1 dressed. The note indicated R1 was unable to state what happened, or what's wrong. R1 initially stated no pain when ask, then complained of back pain, then headache only and as needed Tylenol 1000 milligram (mg) was administered. The note also indicated R1 had sustained a purple/blue bruise with swelling to mid to left forearm measuring Width 8.0 centimeter (cm) by 9.0 cm, a purple/blue bruise to left side of nose measuring 3.0 cm by 3.0 cm and a small skin tear to left outer elbow. The note indicated following the incident neurological checks were within normal limits, the plan was staff was to monitor for additional bruising, pain, headaches, the responsible party was notified at 9:00 a.m. but the physician was notified until 4:05 p.m. which was 7 hours later after the incident and was notified via fax.	F 580	anticoagulant with active bleeding/bruising/head injury or internal injury suspected r/t unstable vital signs, abnormal neuro exam or if the resident sustains other significant injury resulting in new or worsening c/o pain." Fall Risk Assessment and Procedure for Falls policy have been updated to aid in preventing future recurrence. All nursing home staff will be educated on fall prevention policies and procedures during the Plan of Correction inservice scheduled for 7/26/22. Monitoring: Each fall will be reviewed by the IDT consisting of RN Case Manager(s), Quality Improvement Coordinator, and Director of Nursing to monitor for timely physician notification and care plan update implementation x 3 months with results being brought to the Quality Assurance Committee. Further monitoring as needed based on results.	

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F 580	Continued From page 4 -6/4/22, at 11:59 p.m. note indicated R1's neuro check were done and no changes from the baseline but R1 was complaining of pain on her head and on her neck with grimacing facial expression when R1 was helped to remove her coat for blood pressure reading. The writer indicated R1 was leaning more on her right side, head was stiff and complaints of pain when being moved and R1 had been sent to the hospital for medical evaluation. -6/8/22, note indicated resident was re-admitted to the facility and had neck injury, bruising noted on face, under eyes, nose, and cheeks. There is a bump on the right side of the forehead sustained from the fall. -Facility Resident/Visitor Incident Report dated 6/4/22, at 8:20 a.m. indicated R1 had a fall out of the commode when staff had moved the mechanical lift away from R1 to get R1 washed and dressed. The incident report indicated staff had peeked their head out of the room yelling for nurse and in that time frame R1 "started dropping to the left and fell right out of the commode." The report indicated R1 was not sure what had happened, and the case manager review of the risk factors indicated R1 had history of vasovagal episode on the toilet/commode, intermittent confusion and comments/interventions "Resident sent to ER for evaluation [eval]." The incident report further indicated "assessed cause/contributing factors: Resident Action." On 6/21/22, at 8:58 a.m. R1 was observed lying in bed with blue/purple bruises on the face, a large goose egg bump was observed in the middle of the forehead and R1 was wearing a neck collar. R1 was asleep at the time.	F 580		

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F 580	Continued From page 5 R1's care plan 6/15/22, identified R1 was at risk for falls related to history of falls related to left hip fracture and mild cognitive impairment. The care plan indicated R1 had intermittent confusion and directed staff to ensure the bed was in the lowest position when occupied and my walker and/or wheelchair is out of hand reach. R1's falls Care Area Assessment (CAA) dated 8/31/21, identified R1 had the potential for falls related to decreased mobility and decreased cognition, age related muscle degeneration, and cognitive impairment. During interview on 6/21/22, at 3:06 p.m. family member (FM)-A stated following the incident LPN-A had notified her of the fall and had indicated R1 was being monitored. FM-A stated she had called a few other times during the day to check and was told R1 was okay. FM-A stated she had gotten a call from the evening nurse RN-A who informed her R1 was not doing okay and that she had to send her to the hospital due to pain. FM-A stated while at the hospital with R1 the attending physician had stated because R1 had a fall with a head injury and was on Coumadin she should have been brought in immediately. FM-A stated due to the fall R1 had a forehead that was swollen, she sustained fractures and one of the front teeth was knocked out. FM-A also stated following the fall, R1 was using the neck collar to immobilize the neck, had a total change of self and was having trouble with eating. During interview on 6/21/22, at 2:22 p.m. LPN-A stated after the incident they had pushed the emergency call system and multiple staff had	F 580		

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

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F 580	Continued From page 6 come to the room and with the Hoyer (mechanical lift) they assisted R1 into bed. LPN-A stated R1 was complaining of her head hurting when asked about pain but later when in the bed, indicated she had a headache, and she gave Tylenol as needed. LPN-A then stated after the incident she had made some calls to the responsible party and RN-B case manager then later in the afternoon she sent a fax to the primary physician regarding the fall. LPN-A acknowledged she did not notify the physician and was relying for guidance from RN-B case manager stating, "I should have called the physician hide sight. I figured the neuros were normal, I was monitoring the headache and if there were major changes, I would contact the physician." LPN-A also stated she did not remember if R1 had complained of pain but being cold when NA-A had called her to the room to assist getting R1 ready for the day as NA-A had indicated R1 was complaining of pain on her back and head when being rolled which NA-A felt was unsafe. LPN-A stated during the shift R1 was complaining of her head/headache and she assumed it was from the bruising in her forehead with swelling which later during the day spread to the side of the nose. During review of the neuro flow sheet with LPN-A at 9:40 a.m. (one hour after the fall) R1's neuros were at baseline but R1 was lethargic which she stated to her meant R1 was tired from the fall. LPN-A stated it was a normal practice to fax the physician following the fall unless it was an emergency when residents had to sent out. During interview on 6/21/22, at 2:48 p.m. NA-A stated the morning of the incident she had gone to R1's room to get her ready for the day and in the care plan they were allowed to take the E-Z stand from R1 to do the cares.	F 580		

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F 580	Continued From page 7 NA-A then stated after she took it off, she had noticed R1 leaning to the left side and she felt the nurse needed to check on R1. NA-A stated after the incident they had transferred R1 to the bed then when she rolled R1 she started to complain of her head, back and when she was washing under the arms, she was in pain lifting the arms up to clean and was crying. NA-A then stated she had gone to get LPN-A and had reported to her the concerns and LPN-A had assisted her to get R1 ready for the day. NA-A stated during the cares, R1 was complaining of the back and headache, and she had received Tylenol and she had relief but still had the headache. During interview on 6/21/22, at 12:08 p.m. RN-C stated staff would notify the physician if something was significant via a call following a fall but if something was not significant, they would send a fax to the physician which the physician would be able to review the next day. RN-C further stated if there was an increase in pain, head injury or significant other injury then she would then say the nurses needed to call the physician right away. During interview on 6/21/22, at 4:36 p.m. RN-B case manager stated he was notified of the fall and initially the details were not clear as LPN-A was shaken. RN-B stated LPN-A had asked him if they should send R1 to the hospital for evaluation, and he had told her to call the responsible party to decide if they wanted R1 to be sent out. RN-B then stated afterwards LPN-A had called the responsible party, then reported to him the responsible party wanted R1 to remain at the facility since she was stable and monitor.	F 580		

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F 580	Continued From page 8 RN-B then stated he had asked LPN-A to complete the necessary documentation which LPN-A indicated she had filled the appropriate paperwork including faxing the physician. RN-B then stated later that day in the evening he had received a call from RN-A who reported R1 was complaining of neck pain, and he said it was good to send R1 in to be evaluated. RN-B then stated after R1 was sent in he had received a call from FM-A who informed him R1 had the fractures in the neck. RN-B then stated hide sight he should have asked for more details at the time of the fall as he was at home while communicating with LPN-A about the fall. RN-B stated R1 was bruised after the fall because R1 was on Coumadin and from going through the fall and interviewing the staff it appeared R1 was experiencing a vasovagal episode as R1 had a history of it when having a bowel movement. During interview on 6/21/22, at 11:13 the director of nursing (DON) acknowledged LPN-A should have notified the physician via call following the incident as resident was on Coumadin, had a head injury and was complaining of a headache. The DON stated she had not realized until surveyor brought it up that LPN-A had not called the physician. The DON stated there was no training that had been provided to the nurses about notification of change either. During interview on 6/21/22, at 4:13 p.m. R1's physician (MD) stated anytime a resident had a fall with head injury, was on a blood thinner and had pain he expected the nurses to call right away for the resident to be evaluated. The MD also stated because R1 had sustained a big hematoma, had complained of pain and a headache right away this was a trauma case and	F 580		

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F 580	Continued From page 9 he or the on-call should have immediately been notified or the ambulance should have been called to put a C-Collar on immediately. The MD further stated he expected the nurses to call emergency medical services (EMS) or someone with expertise when incidents such as these if not a physician. The facility Resident Status Change and Notification of Attending Physician Policy and Procedure revised 3/30/22, directed the following: "Procedure: 1. The attending physician should be notified immediately when there is: a. An accident involving the resident that results in injury and has the potential for requiring physician intervention. b. A significant change in the resident's physical, mental or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). c. A need to alter treatment significantly (i.e., a need to discontinue or change an existing form of treatment, Blood glucose readings greater than 400) d. A need to improve pain/symptom relief and control. e. Decision to transfer or discharge the resident from the facility. 2. Unless an extreme emergency, only an LPN or RN should notify a physician. 3. When in doubt if physician should be notified, notify physician. 4. Red Flags: fever (think respiratory and begin fluid intake encouragement/monitoring), pain, anxiety/confusion/lethargy, behavioral disturbance or change in mentation, nausea/vomiting/diarrhea, low O2 sats or SOB	F 580		

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F 580	Continued From page 10 (start O2), chest pain (start O2), blood (emesis, stool), critical labs, glucose (high or low-sign something else going on), weight loss/poor po intake, edema (unilateral or bilateral, new/increased)..."	F 580		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to supervise and implement interventions to prevent a fall for 1 of 3 residents (R1) who had unknown history of Vasovagal syncope (fainting spell) reviewed for falls. This resulted in actual harm for R1 who sustained a head injury, was hospitalized, and was diagnosed with C1-C2 fractures. The findings include: R1's quarterly Minimum Data Set (MDS) dated 6/3/22, indicated R1 was severely cognitively impaired and had diagnoses which included abnormalities of gait and mobility, anxiety disorder, age-related physical debility, cognitive communication deficit, history of falling, long term use of anticoagulants (blood thinner), mild cognitive impairment, age-related osteoporosis with current pathological fracture, peripheral	F 689	Corrective Action: R1's care plan was updated to include 2-3 staff assist during all transfers and personal cares, direction for staff not to leave her alone on the commode and that they are to stay within close physical contact while on the commode r/t history of unresponsive episodes. Identification: Reviewed all current resident's fall risk assessments and residents with more than one fall in the past 6 months for patterns. IDT reviewed fall prevention interventions using newly created Post Fall Huddle Review form to assess medications, current and previously attempted interventions, review of previous fall circumstances including time, location, and reasons to identify root	7/28/22

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F 689	Continued From page 11 vascular disease and macular degeneration. The MDS also indicated R1 required extensive physical assistance of one staff with all activities of daily living except eating, had no pain, and for moving from seated to standing position and on and off the toilet R1 was not steady and only stabilized with human assistance. A report dated 6/12/22, indicated on 6/4/22, early morning, R1 had fallen off the commode after nursing assistant (NA)-A had thought something was wrong with R1 and had left R1 unattended despite the change in condition and gone to the door looking for help. The report indicated R1 had fell forward off the commode, hitting her forehead on the floor and had sustained a goose egg injury and had a headache. The report also indicated after the incident licensed practical nurse (LPN)-A continued taking R1's vitals and never notified the physician but at around 5:25 p.m. in-coming PM shift registered nurse (RN)-B thought R1 needed to go by ambulance to hospital. The report further indicated at the hospital a brain scan was completed and showed there was hematoma on the outside of the brain and R1 had sustained fractures on C1 and C2 which were caused by trauma from the fall. In addition, a neurologist consult indicated R1 was not eligible for surgery due to age and taking Coumadin thus R1 was hospitalized from 6/4/22, through 6/8/22. Review of R1's Progress Notes revealed the following information: -6/4/22, at 3:51 p.m. note indicated R1 had a fall from the commode which was in middle of room at 8:20 a.m. after staff removed a mechanical stand away from resident to provide cares and get R1 dressed. The note indicated R1 was unable to stated what happened, or	F 689	causes. Measures: Good Shepherd Lutheran Home Procedure for Falls has been updated to include assessment for head or neck injury and new requirement for staff to do a Post Fall Huddle review to determine root cause. All nursing home staff will be educated on updated fall prevention policies and procedures during Plan of Correction inservice scheduled for 7/26/22. Monitoring: Each fall will be reviewed by the IDT consisting of RN Case Manager(s), Quality Improvement Coordinator, and Director of Nursing to monitor for timely physician notification and care plan update implementation x 3 months with results being brought to the Quality Assurance Committee. Further monitoring as needed based on results.	

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F 689	Continued From page 12 what's wrong. R1 initially stated no pain when ask, then complained of back pain, then headache only and as needed Tylenol 1000 milligram (mg) was administered. The note also indicated R1 had sustained a purple/blue bruise with swelling to mid to left forearm measuring Width 8.0 centimeter (cm) by 9.0 cm, a purple/blue bruise to left side of nose measuring 3.0 cm by 3.0 cm and a small skin tear to left outer elbow. The note indicated following the incident neurological checks were within normal limits, the plan was staff was to monitor for additional bruising, pain, headaches, the responsible party was notified at 9:00 a.m. but the physician was notified until 4:05 p.m. which was 7 hours later after the incident and via fax. -6/4/22, at 11:59 p.m. note indicated R1's neuro check were done and no changes from the baseline but R1 was complaining of pain on her head and on her neck with grimacing facial expression when R1 was helped to remove her coat for blood pressure reading. The writer indicated R1 was leaning more on her right side, head was stiffed and complaints of pain when being moved and R1 had been sent to the hospital for medical evaluation. -6/8/22, note indicated resident was re-admitted to the facility and had neck injury, Bruising noted on face, under eyes, nose, and cheeks. There is a bump on the right side of the forehead sustained from the fall. -Facility Resident/Visitor Incident Report dated 6/4/22, at 8:20 a.m. indicated R1 had a fall out of the commode when staff had moved the mechanical lift away from R1 to get R1 washed	F 689		

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F 689	Continued From page 13 and dressed. The incident report indicated staff had peeked their head out of the room yelling for nurse and in that time frame R1 "started dropping to the left and fell right out of the commode." The report indicated R1 was not sure what had happened, and the case manager review of the risk factors indicated R1 had history of vasovagal episode on the toilet/commode, intermittent confusion and comments/interventions "Resident sent to ER for evaluation [eval]." The incident report further indicated "assessed cause/contributing factors: Resident Action." During further review of the medical record, it was revealed, on 1/20/22, resident had been sent to the hospital to be evaluated related to syncope and was sent back to the facility. The medical record lacked documentation of the facility implementing interventions for R1 to reduce the likelihood of another incident occurring. Additionally the facility was unable to provide evidence of training they provided staff to reduce re-occurrence. On 6/21/22, at 8:58 a.m. R1 was observed lying in bed with blue/purple bruises on the face, a large goose egg bump was observed in the middle of the forehead and R1 was wearing a neck collar. R1 was asleep at the time. R1's care plan 6/15/22, identified R1 was at risk for falls related to history of falls related to left hip fracture and mild cognitive impairment. The care plan indicated R1 had intermittent confusion and directed staff to ensure the bed was in the lowest position when occupied and my walker and/or wheelchair is out of hand reach. The care plan lacked documentation of what staff was supposed to do when R1 experience a vasovagal	F 689		

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F 689	Continued From page 14 episode or how to ensure safeguards were in place in the event she experienced a similar incident. R1's falls Care Area Assessment (CAA) dated 8/31/21, identified R1 had the potential for falls related to decreased mobility and decreased cognition, age related muscle degeneration, and cognitive impairment. During interview on 6/21/22, at 9:52 a.m. NA-B stated R1 had sustained the goose bump on her forehead from a fall about two weeks ago and according to what she heard R1 had leaned forward when seated on the commode and had fallen. NA-B stated R1 was not supposed to be left alone as she was a fall risk even prior to this fall. NA-B stated since the incident happened the only training, they had received was using the Hoyer to transfer R1 as she was "a E-Z Stand" at the time of the fall and no other training had been provided regarding using the call light system to call for assistance when a resident had a change of condition instead of leaving them unsupervised. During interview on 6/21/22, at 4:23 p.m. NA-C stated because of R1's history of falls, leaning to the side and not being able to support herself she had never left R1 alone. NA-C stated she had seen R1 hematoma on the face and was shocked someone had left her unattended as R1 was at risk for falls. During interview on 6/21/22, at 3:06 p.m. family member (FM)-A stated R1 was at risk of falls and R1 could not be left unsupervised and that was the reason the staff did not get R1 up on the toilet because R1 could not hold herself. FM-A stated	F 689		

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F 689	Continued From page 15 R1 had dementia and her answers are not reliable. FM-A stated the staff told resident to use the call buttons but in this incident the staff did not use it to avoid leaving R1 alone who subsequently fell and had injuries from the fall. FM-A stated the facility had started to use the mechanical lift because R1 was not able to hold herself and was not strong. FM-A stated due to the fall R1 had a forehead that was swollen, she sustained fractures and one of the front teeth was knocked out. FM-A also stated following the fall, R1 was using the neck collar to immobilize the neck, had a total change of self and was having trouble with eating. During interview on 6/21/22, at 2:48 p.m. NA-A stated that morning of the incident she had gone to R1's room to get her ready for the day and in the care plan they were allowed to take the E-Z stand from R1 to do the cares. NA-A then stated after she took it off, she had noticed R1 leaning to the left side, and she felt the nurse needed to check on R1. When asked why she had walked away from R1 if she felt the nurse needed to see resident, NA-A stated, "I did not feel it was an emergency, I knew the nurse was out there and she was okay. She was alert, talking to me and I knew she had history of blackouts but in this case, she was her normal self even though she was slouching. I felt it was safe for me to walk away. I made sure the resident was okay before I walked away from her to call the nurse outside the room. If the nurse was not outside the room, I would have put the emergency call light. There was nothing wrong she has had a spell before not in the commode. She blacks out when having a bowel movement [BM] but she was talking in this incident." NA-A	F 689		

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F 689	Continued From page 16 stated after the incident they had transferred R1 to the bed then when she rolled R1 she started to complain of her head, back and when she was washing under the arms, she was in pain lifting the arms up to clean and was crying. During interview on 6/21/22, at 4:36 p.m. RN-B case manager stated he was notified of the fall the morning of 6/4/22 and after R1 was sent in during the evening shift, he had received a call from FM-A who informed him R1 had the fractures in the neck. RN-B stated R1 had bruised after the fall because R1 was on Coumadin and from going through the fall and interviewing the staff, it appeared R1 was experiencing a vasovagal episode as R1 had a history of it when having a bowel movement. RN-B stated NA-A had gone to the door to get LPN-A to evaluate and wether R1 passed out or not, it was fast session of events. RN-B acknowledged the distance between the commode where R1 sat was technically five to six feet from the doorway, and NA-A was not within arm's reach of R1 and probably putting the call light would have been more appropriate to alert the nurse. RN-B acknowledged although the staff was aware R1 had a history of vasovagal for R1, the medical record lacked a care plan to direct staff what they were supposed to do in case of another episode. RN-B further stated hind sight it took a tragedy to bring light to certain things and he acknowledged before when R1 was ambulatory the care plan directed R1 was not to be left alone. RN-B also stated since R1 stopped ambulating she had never tried or attempted to self-transfer so, "I may have taken it out." During interview on 6/21/22, at 11:13 the director of nursing (DON) stated staff used the "E-Z	F 689		

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F 689	Continued From page 17 Stand" (mechanical lift) to transfer R1 to the commode and on the day of the incident after NA-A had transferred R1, NA-A had moved it out of the way to assist with care, which was normal. The DON then stated after removing the E-Z Stand NA-A had noticed R1 was starting to lean over to the side and that was when NA-A left R1 alone and had gone to the door to call LPN-A to come assess R1. The DON stated as NA-A turned back she observed R1 falling forward hitting the floor head first and NA-A was not close enough to stop the fall. The DON also stated following the fall, LPN-A came right away and assessed R1 and at that time R1 was starting to have bruising on her head, was complaining of a headache and no other injuries were apparent at the time. DON stated from what she knew R1 had never been impulsive wanting to self-transfer out of the commode when staff did the cares and because of that staff did not need to stand and be with her. The DON acknowledged following the incident she had not asked NA-A other than leaning over to the side what other symptoms R1 had that prompted NA-A to feel the need to get LPN-A into the room to assess R1. The DON stated when she interviewed NA-A, NA-A had indicated after R1 was starting to lean to the side, NA-A felt she needed to get LPN-A in the room as she knew she was right outside the room in the hallway. The DON stated NA-A had thought she was getting the LPN-A as soon as possible and did not expect R1 to tip off the commode. The DON stated there had not been any education completed for NA-A and other staff following the incident on not leaving residents alone if they had concerns with a change in condition. The DON stated the facility team thought the plan of care was being followed as resident was not usually supposed to be supervised.	F 689		

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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 689	Continued From page 18 The facility NURSING CARE PLAN policy revised 2/26/20, directed the following: "3. Interventions should be written to help meet the goal. The interventions should be individualized to the patient and person-centered. A discipline or department which will be responsible for the intervention will be listed. This may be more than one discipline. 4. The care plan is to be changed and updated as the care requirements for the resident change. The care plan will be reviewed throughout the patient's length of stay and as required for MDS assessments..." The facility PROCEDURE FOR FALLS revised 3/30/22, directed the following: "Fall resulting in injury requiring further medical evaluation/treatment by a Provider 4. If a fracture of leg, hip, or pelvis is suspected through examination, or the resident complains of much pain, Do not move the victim. The ambulance Attendants will transfer directly onto a stretcher..."	F 689		

Electronically delivered
July 6, 2022

Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

Re: State Nursing Home Licensing Orders
Event ID: S4LI11

Dear Administrator:

The above facility was surveyed on June 21, 2022 through June 21, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	C 06/21/2022

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

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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 6/21/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health. Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53932105C (MN84214) with a licensing order issued 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 830	Continued From page 2	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to supervise and implement interventions to prevent a fall for 1 of 3 residents (R1) who had unknown history of Vasovagal syncope (fainting spell) reviewed for falls. This resulted in actual harm for R1 who sustained a head injury, was hospitalized, and was diagnosed with C1-C2 fractures. The findings include: R1's quarterly Minimum Data Set (MDS) dated 6/3/22, indicated R1 was severely cognitively impaired and had diagnoses which included abnormalities of gait and mobility, anxiety disorder, age-related physical debility, cognitive communication deficit, history of falling, long term use of anticoagulants (blood thinner), mild cognitive impairment, age-related osteoporosis	2 830	Corrected	7/28/22

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2 830	Continued From page 3 with current pathological fracture, peripheral vascular disease and macular degeneration. The MDS also indicated R1 required extensive physical assistance of one staff with all activities of daily living except eating, had no pain, and for moving from seated to standing position and on and off the toilet R1 was not steady and only stabilized with human assistance. A report dated 6/12/22, indicated on 6/4/22, early morning, R1 had fallen off the commode after nursing assistant (NA)-A had thought something was wrong with R1 and had left R1 unattended despite the change in condition and gone to the door looking for help. The report indicated R1 had fell forward off the commode, hitting her forehead on the floor and had sustained a goose egg injury and had a headache. The report also indicated after the incident licensed practical nurse (LPN)-A continued taking R1's vitals and never notified the physician but at around 5:25 p.m. in-coming PM shift registered nurse (RN)-B thought R1 needed to go by ambulance to hospital. The report further indicated at the hospital a brain scan was completed and showed there was hematoma on the outside of the brain and R1 had sustained fractures on C1 and C2 which were caused by trauma from the fall. In addition, a neurologist consult indicated R1 was not eligible for surgery due to age and taking Coumadin thus R1 was hospitalized from 6/4/22, through 6/8/22. Review of R1's Progress Notes revealed the following information: -6/4/22, at 3:51 p.m. note indicated R1 had a fall from the commode which was in middle of room at 8:20 a.m. after staff removed a mechanical stand away from resident to provide cares and get R1 dressed. The note indicated R1 was unable to stated what happened, or	2 830		

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2 830	Continued From page 4 what's wrong. R1 initially stated no pain when ask, then complained of back pain, then headache only and as needed Tylenol 1000 milligram (mg) was administered. The note also indicated R1 had sustained a purple/blue bruise with swelling to mid to left forearm measuring Width 8.0 centimeter (cm) by 9.0 cm, a purple/blue bruise to left side of nose measuring 3.0 cm by 3.0 cm and a small skin tear to left outer elbow. The note indicated following the incident neurological checks were within normal limits, the plan was staff was to monitor for additional bruising, pain, headaches, the responsible party was notified at 9:00 a.m. but the physician was notified until 4:05 p.m. which was 7 hours later after the incident and via fax. -6/4/22, at 11:59 p.m. note indicated R1's neuro check were done and no changes from the baseline but R1 was complaining of pain on her head and on her neck with grimacing facial expression when R1 was helped to remove her coat for blood pressure reading. The writer indicated R1 was leaning more on her right side, head was stiffed and complaints of pain when being moved and R1 had been sent to the hospital for medical evaluation. -6/8/22, note indicated resident was re-admitted to the facility and had neck injury, Bruising noted on face, under eyes, nose, and cheeks. There is a bump on the right side of the forehead sustained from the fall. -Facility Resident/Visitor Incident Report dated 6/4/22, at 8:20 a.m. indicated R1 had a fall out of the commode when staff had moved the mechanical lift away from R1 to get R1 washed and dressed. The incident report indicated staff	2 830		

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2 830	Continued From page 5 had peeked their head out of the room yelling for nurse and in that time frame R1 "started dropping to the left and fell right out of the commode." The report indicated R1 was not sure what had happened, and the case manager review of the risk factors indicated R1 had history of vasovagal episode on the toilet/commode, intermittent confusion and comments/interventions "Resident sent to ER for evaluation [eval]." The incident report further indicated "assessed cause/contributing factors: Resident Action." During further review of the medical record, it was revealed, on 6/20/22, resident had been sent to the hospital to be evaluated related to syncope and was sent back to the facility. The medical record lacked documentation of the facility implementing interventions for R1 to reduce the likelihood of another incident occurring. Additionally the facility was unable to provide evidence of training they provided staff to reduce re-occurrence. On 6/21/22, at 8:58 a.m. R1 was observed lying in bed with blue/purple bruises on the face, a large goose egg bump was observed in the middle of the forehead and R1 was wearing a neck collar. R1 was asleep at the time. R1's care plan 6/15/22, identified R1 was at risk for falls related to history of falls related to left hip fracture and mild cognitive impairment. The care plan indicated R1 had intermittent confusion and directed staff to ensure the bed was in the lowest position when occupied and my walker and/or wheelchair is out of hand reach. The care plan lacked documentation of what staff was supposed to do when R1 experience a vasovagal episode or how to ensure safeguards were in place in the event she experienced a similar	2 830		

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2 830	Continued From page 6 incident. R1's falls Care Area Assessment (CAA) dated 8/31/21, identified R1 had the potential for falls related to decreased mobility and decreased cognition, age related muscle degeneration, and cognitive impairment. During interview on 6/21/22, at 9:52 a.m. NA-B stated R1 had sustained the goose bump on her forehead from a fall about two weeks ago and according to what she heard R1 had leaned forward when seated on the commode and had fallen. NA-B stated R1 was not supposed to be left alone as she was a fall risk even prior to this fall. NA-B stated since the incident happened the only training, they had received was using the Hoyer to transfer R1 as she was "a E-Z Stand" at the time of the fall and no other training had been provided regarding using the call light system to call for assistance when a resident had a change of condition instead of leaving them unsupervised. During interview on 6/21/22, at 4:23 p.m. NA-C stated because of R1's history of falls, leaning to the side and not being able to support herself she had never left R1 alone. NA-C stated she had seen R1 hematoma on the face and was shocked someone had left her unattended as R1 was at risk for falls. During interview on 6/21/22, at 3:06 p.m. family member (FM)-A stated R1 was at risk of falls and R1 could not be left unsupervised and that was the reason the staff did not get R1 up on the toilet because R1 could not hold herself. FM-A stated R1 had dementia and her answers are not reliable. FM-A stated the staff told resident to use the call buttons but in this incident the staff did	2 830		

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2 830	Continued From page 7 not use it to avoid leaving R1 alone who subsequently fell and had injuries from the fall. FM-A stated the facility had started to use the mechanical lift because R1 was not able to hold herself and was not strong. FM-A stated due to the fall R1 had a forehead that was swollen, she sustained fractures and one of the front teeth was knocked out. FM-A also stated following the fall, R1 was using the neck collar to immobilize the neck, had a total change of self and was having trouble with eating. During interview on 6/21/22, at 2:48 p.m. NA-A stated that morning of the incident she had gone to R1's room to get her ready for the day and in the care plan they were allowed to take the E-Z stand from R1 to do the cares. NA-A then stated after she took it off, she had noticed R1 leaning to the left side, and she felt the nurse needed to check on R1. When asked why she had walked away from R1 if she felt the nurse needed to see resident, NA-A stated, "I did not feel it was an emergency, I knew the nurse was out there and she was okay. She was alert, talking to me and I knew she had history of blackouts but in this case, she was her normal self even though she was slouching. I felt it was safe for me to walk away. I made sure the resident was okay before I walked away from her to call the nurse outside the room. If the nurse was not outside the room, I would have put the emergency call light. There was nothing wrong she has had a spell before not in the commode. She blacks out when having a bowel movement [BM] but she was talking in this incident." NA-A stated after the incident they had transferred R1 to the bed then when she rolled R1 she started to complain of her head, back and when she was washing under the arms, she was in pain lifting	2 830		

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2 830	Continued From page 8 the arms up to clean and was crying. During interview on 6/21/22, at 4:36 p.m. RN-B case manager stated he was notified of the fall the morning of 6/4/22 and after R1 was sent in during the evening shift, he had received a call from FM-A who informed him R1 had the fractures in the neck. RN-B stated R1 had bruised after the fall because R1 was on Coumadin and from going through the fall and interviewing the staff, it appeared R1 was experiencing a vasovagal episode as R1 had a history of it when having a bowel movement. RN-B stated NA-A had gone to the door to get LPN-A to evaluate and wether R1 passed out or not, it was fast session of events. RN-B acknowledged the distance between the commode where R1 sat was technically five to six feet from the doorway, and NA-A was not within arm's reach of R1 and probably putting the call light would have been more appropriate to alert the nurse. RN-B acknowledged although the staff was aware R1 had a history of vasovagal for R1, the medical record lacked a care plan to direct staff what they were supposed to do in case of another episode. RN-B further stated hind sight it took a tragedy to bring light to certain things and he acknowledged before when R1 was ambulatory the care plan directed R1 was not to be left alone. RN-B also stated since R1 stopped ambulating she had never tried or attempted to self-transfer so, "I may have taken it out." During interview on 6/21/22, at 11:13 the director of nursing (DON) stated staff used the "E-Z Stand" (mechanical lift) to transfer R1 to the commode and on the day of the incident after NA-A had transferred R1, NA-A had moved it out of the way to assist with care, which was normal. The DON then stated after removing the E-Z	2 830		

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2 830	Continued From page 9 Stand NA-A had noticed R1 was starting to lean over to the side and that was when NA-A left R1 alone and had gone to the door to call LPN-A to come assess R1. The DON stated as NA-A turned back she observed R1 falling forward hitting the floor head first and NA-A was not close enough to stop the fall. The DON also stated following the fall, LPN-A came right away and assessed R1 and at that time R1 was starting to have bruising on her head, was complaining of a headache and no other injuries were apparent at the time. DON stated from what she knew R1 had never been impulsive wanting to self-transfer out of the commode when staff did the cares and because of that staff did not need to stand and be with her. The DON acknowledged following the incident she had not asked NA-A other than leaning over to the side what other symptoms R1 had that prompted NA-A to feel the need to get LPN-A into the room to assess R1. The DON stated when she interviewed NA-A, NA-A had indicated after R1 was starting to lean to the side, NA-A felt she needed to get LPN-A in the room as she knew she was right outside the room in the hallway. The DON stated NA-A had thought she was getting the LPN-A as soon as possible and did not expect R1 to tip off the commode. The DON stated there had not been any education completed for NA-A and other staff following the incident on not leaving residents alone if they had concerns with a change in condition. The DON stated the facility team thought the plan of care was being followed as resident was not usually supposed to be supervised. The facility NURSING CARE PLAN policy revised 2/26/20, directed the following: "3. Interventions should be written to help meet the goal. The interventions should be individualized to the patient and person-centered.	2 830		

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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) COMPLETE DATE
2 830	Continued From page 10 A discipline or department which will be responsible for the intervention will be listed. This may be more than one discipline. 4. The care plan is to be changed and updated as the care requirements for the resident change. The care plan will be reviewed throughout the patient's length of stay and as required for MDS assessments..." The facility PROCEDURE FOR FALLS revised 3/30/22, directed the following: "Fall resulting in injury requiring further medical evaluation/treatment by a Provider 4. If a fracture of leg, hip, or pelvis is suspected through examination, or the resident complains of much pain, Do not move the victim. The ambulance Attendants will transfer directly onto a stretcher..." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		