DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2020

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

RE: CCN: 245269
Survey Start Date: February 18, 2020

Dear Administrator:

On August 24, 2020 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 July 10, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 12, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245269
Cycle Start Date: February 18, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 29, 2020, the Minnesota Department of Health completed a complaint investigation at Good Shepherd Lutheran Home to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

REMOVAL OF IMMEDIATE JEOPARDY

On May 28, 2020, the situation of immediate jeopardy to potential health and safety cited at F 678 was removed. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 29, 2020 survey. Good Shepherd Lutheran Home may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Kathleen Lucas, Unit Supervisor
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 29, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Kathleen Lucas, Unit Supervisor
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting

immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Good Shepherd Lutheran Home may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	C 05/29/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/28/20, to 5/29/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F678 began on 5/24/20, when resident (R1) had died. The facility failed to ensure timely cardiopulmonary resuscitation (CPR) was delivered upon identifying R1 had absent pulse and respirations. On 5/29/29, at 1:23 p.m. the administrator, director of nursing (DON) and assistant director of nursing (ADON) were notified of the IJ situation. The facility corrected the IJ on 5/28/20 prior to surveyors entering, and F678 is being issued at past non-compliance. Complaint H5269065C was substantiated at F678, at past non-compliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained. As a result of identifying substandard quality of care, an extended survey was conducted on 5/29/20. Although a plan of correction is not required for a finding of past non-compliance at F678, it is required the facility acknowledge receipt of the electronic documents. Upon receipt of an acceptable electronic POC at F609, an on-site revisit of your facility may be conducted to validate that substantial compliance	F 000		

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

Electronically Signed | 06/19/2020

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 000	Continued From page 1 with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an incident of potential neglect related to failure to provide cardio	F 609	The facility does have a process in place to ensure that all alleged violations involving abuse, neglect, exploitation or	7/10/20

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F 609	Continued From page 2 pulmonary resuscitation (CPR) was reported to the State Agency (SA) immediately, but not later than 2 hours after the allegation if it involved abuse or resulted in serious bodily injury, for 1 of 3 residents (R1) reviewed for neglect. Findings include: R1's admission record identified R1 was admitted to the facility on 5/19/20, with a diagnosis of Alzheimer's Disease, heart failure and chronic kidney disease. Review of R1's Healthcare Directive Decision Form signed on 5/19/20, identified R1 was a full code in which CPR would be started and the ambulance would be called for transport to the hospital. Review of R1's standing physician orders undated, revealed R1 was a full code. Review of R1's progress notes dated 5/19/20, to 5/24/20, revealed the following: -5/24/20, 3:05 a.m. staff walked by room at 2:40 a.m. and noticed R1 was not breathing. Nurse listened for a heartbeat, checked for pulse and did a sternal rub (applying a painful stimulus to the center of the chest with knuckles to someone who is not responding) and determined the time of death to be 2:43 a.m. The nurse made phone calls to three different family members, contacted the nurse practitioner (NP), the case manager (CM) and the assistant director of nursing (ADON). The note indicated the nurse was waiting for one of the family to return the call. -5/24/20, 3:49 a.m. the nurse went to get the	F 609	mistreatment are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not involve serious bodily injury to the facility administrator and to other officials. Regarding resident one, the facility recognizes there was a delay in reporting the incident where CPR was not provided timely for a resident who was a full code to the State Agency. This delay occurred due to inaccurate information given from the employee to the initial reporter. When further information was received by the initial reporter a report was made immediately, the facility administrator was updated, the employee was placed on suspension and an internal investigation was completed. Regarding all other residents in the facility, all applicable policies and procedures have been reviewed and revised as needed. Nursing staff will be re-trained regarding their responsibility to the regulation with enhanced focus on the timeliness of reporting. To assure the deficient practice has not affected any other residents residing in the facility an audit will be conducted of VA reports made for the prior three months to assure timely reporting was completed. To assure continued compliance the facility QA team/designee will conduct routine audits of reports of abuse, neglect, exploitation or mistreatment daily for one week, weekly for two weeks, monthly for	

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F 609	Continued From page 3 chart after speaking with the ADON and noticed R1 was a full code on her healthcare directive form, ran to R1's room, began CPR on R1 and directed nursing assistant (NA) to call 911. The note identified CPR was administered by the nurse until police and paramedics arrived on the scene and took over administering CPR. The notes lacked documentation of reporting the incident to the SA. On 5/28/20, at 2:32 p.m. LPN-B stated she had been working the night shift on 5/24/20, from 10:00 p.m. to 6:30 a.m. LPN-B stated she had checked R1's blood pressure, pulse, respirations and oxygen levels at 12:30 a.m. and the results were within R1's normal limits. LPN-B stated sometime after that R1 called out for a bus a few times and then fell asleep. At around 2:43 a.m. NA-A called for LPN-B to assess R1 and R1 had no pulse or respirations and her skin was yellow and cold. LPN-B performed a sternal rub which elicited no response from R1 and determined R1 had expired. LPN-B confirmed CPR had not been initiated at that time. LPN-B stated she had experienced one other resident death in the facility who was a DNR and she began the death notification process based on that experience. LPN-B stated she had assumed R1 had been a DNR status due to her advanced age. LPN-B stated she had made telephone calls to the NP to release the body to the funeral home, family, case manager (CM) on call and the ADON to answer questions she had. LPN-B stated she had started to review R1's MR when she noted R1's healthcare directive indicated she was a full code status. LPN-B stated she was not certain of the amount of time that had lapsed since R1 was noted to have expired however estimated around	F 609	two months and periodically after that to assure ongoing compliance. To assure ongoing compliance results from these audits will be reviewed at the facility Quality Assurance meetings.	

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F 609	Continued From page 4 17 minutes had elapsed from the time R1 had been found with no pulse and respirations and the discovery of her full code status. LPN-B stated she dropped R1's MR, ran to her room and began administering CPR. LPN-B stated she asked NA-A to call 911. LPN-B stated she thought seven minutes or so had gone by when PO arrived at the scene and took over administering CPR. LPN-B stated the EMS staff arrived a few minutes after the PO. LPN-B stated R1 was pronounced dead after PO and EMS staff administered CPR unsuccessfully. On 5/28/20, at 3:43 p.m. ADON stated she received a telephone call from LPN-B on 5/24/20, at 2:50 a.m. and notified her of a resident death. LPN-B stated the resident who had expired was in her 90's and did not inform ADON the name of the resident. ADON answered LPN-B's questions and the call ended. Around a half an hour later, ADON stated she received another telephone call from LPN-B who stated PO and EMS had arrived and were performing CPR on R1. LPN-B stated after she had called ADON she made other phone calls and noted in R1's MR she was a full code. LPN-B stated she dropped the MR, ran to R1's room, began CPR and asked NA-A to call 911. LPN-B stated it had been six to seven minutes before CPR was started on R1 after she had been found with no pulse and respirations and ADON confirmed it was closer to 25 minutes after reviewing the documentation and timing of the phone calls to herself and EMS. ADON confirmed CPR had not been administered timely to R1 and stated it was expected CPR be administered immediately when a resident who was a full code was found without a pulse or respirations.	F 609		

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F 609	Continued From page 5 On 5/28/20, at 4:08 p.m. director of nursing (DON) stated she had received a telephone call from ADON on 5/24/20, in the early morning sometime. ADON informed DON she had received two telephone calls during the night from LPN-B and stated R1 had been found without a pulse or respirations by NA-A. LPN-B started CPR once she had determined R1 was a full code. ADON informed her at the time five minutes had lapsed between the time R1 had been found unresponsive and CPR had been administered. DON stated the PO contacted her on 5/26/20, to inform her CPR had not been administered for a longer period of time and EMS had not been called for close to 30 minutes. After that conversation, DON and ADON reviewed the timing of the phone calls, documentation and determined it had been closer to 25 minutes before CPR was initiated on R1 after being found without a pulse or respirations. DON confirmed CPR had not been initiated on R1 for 25 minutes after being found expired. DON stated it was expected staff begin CPR immediately after being found without a pulse or respirations and determining their code status. DON confirmed a report to the SA was completed on 5/26/20, two days after the incident occurred. DON confirmed the report should have been made to the SA immediately or within two hours after the incident occurred. Review of facility policy titled Good Shepherd Community's Abuse Prevention Plan revised 10/19, defined neglect as the failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. The policy instructed staff to report all allegations of maltreatment including neglect immediately and no later than two hours after the incident	F 609		

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F 609	Continued From page 6 occurred.	F 609		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide basic life support, including cardiopulmonary resuscitation (CPR) to a resident (R1) who required such emergency care, in accordance with resident wishes and physician orders for full code status of CPR. This deficient practice resulted in an immediate jeopardy (IJ) situation when R1 was found not breathing and had no pulse. Timely CPR was not initiated, and R1 died. The immediate jeopardy began on 5/24/20, at 2:43 a.m. when R1 was noted to have no respirations or a pulse and CPR was not initiated to R1 for 25 minutes. However, once the facility identified the lack of providing immediate CPR, they implemented a corrective action to prevent recurrence by reviewing policies and procedures, re-educating the staff involved and other licensed staff to ensure they understood the proper procedure for identifying a resident's code status, where the emergency equipment was located and how to call a code blue (a procedure for notifying other staff a resident required CPR). On 5/29/29, at 1:23 p.m. the administrator, director of nursing (DON) and assistant director of nursing (ADON)	F 678	Past noncompliance: no plan of correction required.	6/19/20

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F 678	Continued From page 7	F 678		

were notified of the IJ situation. The facility implemented corrective action prior to the onsite investigation, therefore the IJ was removed on 5/28/20, when the majority of the staff had been re-educated. In addition, the facility completed audits of staff knowledge of the CPR status of residents. The deficiency is being issued at past noncompliance.

Findings include:

R1's admission record identified R1 was admitted to the facility on 5/19/20, with a diagnosis of Alzheimer's disease, heart failure and chronic kidney disease.

R1's care plan initiated on 5/19/20, indicated R1 required assistance of one to two with most activities of daily living (ADL's) which included bed mobility, transfers, toileting, bathing, grooming and dressing. The care plan lacked advance directives or R1's code status.

Review of R1's Healthcare Directive Decision Form signed on 5/19/20, identified R1 was a full code in which CPR would be started and the ambulance would be called for transport to the hospital.

Review of R1's standing physician orders undated, revealed R1 was a full code.

Review of R1's progress notes dated 5/19/20, to 5/24/20, revealed the following:

-5/24/20, 3:05 a.m. staff walked by room at 2:40 a.m. and noticed R1 was not breathing. Nurse listened for a heartbeat, checked for pulse and did a sternal rub (applying a painful stimulus to

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F 678	Continued From page 8	F 678		

the center of the chest with knuckles to someone who is not responding) and determined the time of death to be 2:43 a.m. The nurse made phone calls to three different family members, contacted the nurse practitioner (NP), the case manager (CM) and the ADON. The note indicated the nurse was waiting for one of the family to return the call.

-5/24/20, 3:49 a.m. the nurse went to get the chart after speaking with the ADON and noticed R1 was a full code on her healthcare directive form, ran to R1's room, began CPR on R1 and directed nursing assistant (NA) to call 911. The note identified CPR was administered by the nurse until police and paramedics arrived on the scene and took over administering CPR.

- 5/24/20, 4:15 a.m. paramedics were unable to revive R1.

On 5/27/20, at 2:52 p.m. during a telephone interview police officer (PO) who responded to the scene on 5/24/20, stated the facility waited almost 30 minutes to call 911 for assistance after R1 had no pulse or respirations. PO indicated he had a concern with the timely notification to EMS for proper administration of CPR. PO stated he had informed the facility administration of his concerns and had filed a report.

During interview on 5/28/20, at 2:07 p.m. licensed practical nurse (LPN)-A stated she was working on 5/24/20, day shift from 6:00 a.m. to 2:30 p.m. and indicated LPN-B was working the night shift on 5/24/20. LPN-A stated LPN-B informed her R1 had been found unresponsive at quarter to three in the morning on 5/24/20, and stated she did not know R1 was a full code. LPN-B informed LPN-A

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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
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she had thought R1 was a do not resuscitate (DNR) status due to R1's age and did not realize until she looked in R1's medical record (MR) that she was a full code. LPN-A stated the code status of all residents was located in the front of their MR and staff were expected to look there if a resident had been found unresponsive to determine what their wishes were. LPN-A stated if a resident was a full code, staff were expected to administer CPR immediately, bring the equipment needed, call 911 and announce a code blue overhead so other nurses can respond and assist as needed.

On 5/28/20, at 2:32 p.m. LPN-B stated she had been working the night shift on 5/24/20, from 10:00 p.m. to 6:30 a.m. LPN-B stated she had checked R1's blood pressure, pulse, respirations and oxygen levels at 12:30 a.m. and the results were within R1's normal limits. LPN-B stated sometime after that R1 called out for a bus a few times and then fell asleep. At around 2:43 a.m. NA-A called for LPN-B to assess R1 and R1 had no pulse or respirations and her skin was yellow and cold. LPN-B performed a sternal rub which elicited no response from R1 and determined R1 had expired. LPN-B confirmed CPR had not been initiated at that time. LPN-B stated she had experienced one other resident death in the facility who was a DNR and she began the death notification process based on that experience. LPN-B stated she had assumed R1 had been a DNR status due to her advanced age. LPN-B stated she had made telephone calls to the NP to release the body to the funeral home, family, case manager (CM) on call and the ADON to answer questions she had. LPN-B stated she had started to review R1's MR when she noted that R1's healthcare directive indicated R1 was a full

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	245269	A. BUILDING _____ B. WING _____	C 05/29/2020

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code status. LPN-B stated she was not certain of the amount of time that had lapsed since R1 was noted to have expired, however, estimated around 17 minutes had elapsed from the time R1 had been found with no pulse and respirations and the discovery of her full code status. LPN-B stated she dropped R1's MR, ran to her room and began administering CPR. LPN-B stated she asked NA-A to call 911. LPN-B stated she thought seven minutes or so had gone by when PO arrived at the scene and took over administering CPR. LPN-B stated the EMS staff arrived a few minutes after the PO. LPN-B stated R1 was pronounced dead after PO and EMS staff administered CPR unsuccessfully. LPN-B stated she had not received training on the code blue status, where to find the healthcare directives of residents or where emergency equipment was located during her new employee orientation. LPN-B stated she could not remember the education identified on her orientation checklist that she had signed on 3/25/20, which indicated she had received training in the code blue process, where to find emergency equipment and where to find the code status. LPN-B stated she was aware CPR should begin immediately upon finding a resident who was a full code with no pulse and respirations and confirmed CPR was not administered immediately for R1 after finding her unresponsive. LPN-B stated she had current certification in providing CPR.

During interview on 5/28/20, at 2:59 p.m. registered nurse case manager (CM)-A stated she was responsible for providing education to new employees on her unit regarding the code blue process, the place to find the resident's healthcare directive and where to find the emergency equipment. CM-A stated all licensed

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staff received the education. CM-A stated she went over paperwork with all new residents admitted and went over the advance directives with each resident. CM-A stated the forms were then placed in the front of the MR for staff to refer to. CM-A stated R1's healthcare directive was completed and signed by R1 on 5/19/20, which indicated R1 was a full code and placed in the front of her MR . CM-A stated staff were expected to look in the front of the MR if a resident was found unresponsive to determine what their healthcare directive was. CM-A stated if the resident was a full code, staff were expected to administer CPR immediately, call 911, bring emergency equipment and announce a code blue overhead. CM-A stated licensed staff were certified in CPR and were expected to be the staff to perform CPR, however, could delegate other tasks to the NA such as calling 911 and retrieving the emergency equipment. CM-A stated she had been aware of the 5/24/20, death of R1 and lack of providing timely CPR. CM-A stated the documentation showed LPN-B contacted the coroner and ADON and later realized R1 was a full code and then started administering CPR. CM-A stated on 5/26/20, the facility began to audit staff knowledge of code blue status, healthcare directive location and where emergency equipment was located and provided education to staff as a result of the 5/24/20, incident.

During interview on 5/28/20, at 3:21 p.m. NA-A stated she had worked the night shift on 5/24/20, from 10:00 p.m. to 6:15 a.m.. NA-A stated around 1:30 a.m. R1 had called out for the bus a couple of times and then appeared to fall asleep. NA-A stated around 2:30 a.m. or so she checked on R1 and noticed her chest was not rising. NA-A entered R1's room, turned the overhead light on,

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noted her skin was yellow and she was not breathing. NA-A notified LPN-B. LPN-B entered R1's room, performed a sternal rub three or four times, took R1's hand, checked for a pulse, opened R1's eyelids and informed NA-A R1 had expired. NA-A confirmed CPR had not been started on R1 at the time. NA-A stated LPN-B left R1's room and made several phone calls. NA-A stated LPN-B provided NA-A with the portable phone to answer in case R1's family called back as LPN-B expected to be tied up with other phone calls and returned to the nurses office. NA-A stated she was not aware how much time had elapsed from the time they found R1 unresponsive to the time LPN-B came running out of the nurses office and stated R1 was a full code. NA-A stated LPN-B ran to R1's room, began CPR and instructed NA-A to call 911. NA-A called 911 and returned to R1's room where LPN-B continued to administer CPR. PO arrived at the scene and took over administering CPR. NA-A stated it was two or three minutes later when EMS staff arrived and assisted with providing CPR. NA-A stated healthcare directives were located in the front of the MR and verified she did not know what R1's healthcare wishes were at the time.

On 5/28/20, at 3:43 p.m. ADON stated she received a telephone call from LPN-B on 5/24/20, at 2:50 a.m. and notified her of a resident death. LPN-B stated the resident who had expired was in her 90's and did not inform ADON the name of the resident. ADON answered LPN-B's questions and the call ended. Around a half an hour later, ADON stated she received another telephone call from LPN-B who stated PO and EMS had arrived and were performing CPR on R1. LPN-B stated after she had called ADON she made other

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phone calls and noted in R1's MR she was a full code. LPN-B stated she dropped the MR, ran to R1's room, began CPR and asked NA-A to call 911. LPN-B stated it had been six to seven minutes before CPR was started on R1 after she had been found with no pulse and respirations and ADON confirmed it was closer to 25 minutes after reviewing the documentation and timing of the phone calls to herself and EMS. ADON confirmed CPR had not been administered timely to R1 and stated it was expected CPR be administered immediately when a resident who was a full code was found without a pulse or respirations. ADON stated the facility process was to keep all residents' healthcare directives in the front of their MR's and stated staff were expected to refer to the MR when a resident was found without a pulse or respirations to determine if a resident was a full code or not. ADON stated staff were trained in new employee orientation regarding CPR status, how to call a code blue and where emergency equipment was located by the CM's of each unit. ADON stated all licensed staff were certified in CPR. ADON stated the facility had initiated staff training on where to find the healthcare directives, where the emergency equipment was located and how to call a code blue beginning on 5/26/20 as a result of the 5/24/20, incident.

On 5/28/20, at 4:08 p.m. DON stated she had received a telephone call from ADON on 5/24/20, in the early morning sometime. ADON informed DON she had received two telephone calls during the night from LPN-B and stated R1 had been found without a pulse or respirations by NA-A. LPN-B started CPR once she had determined R1 was a full code. ADON informed her at the time five minutes had lapsed between the time R1 had

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been found unresponsive and CPR had been administered. DON stated the PO contacted her on 5/26/20, to inform her CPR had not been administered for a longer period of time and EMS had not been called for close to 30 minutes. After that conversation, DON and ADON reviewed the timing of the phone calls, documentation and determined it had been closer to 25 minutes before CPR was initiated on R1 after being found without a pulse or respirations. DON confirmed CPR had not been initiated on R1 for 25 minutes after being found expired. DON stated it was expected staff begin CPR immediately after being found without a pulse or respirations and determining their code status. DON stated a report to the State Agency (SA) was completed on 5/26/20, and a full investigation into the incident began. The DON, ADON and CM's began educating staff regarding the location of residents' healthcare directives in the MR, the location of emergency equipment and the process for calling a code blue. DON stated they had not encountered a nurse who was not aware of the code blue process, where the healthcare directives were located and where the emergency equipment was located.

On 5/29/20, at 8:05 a.m. medical doctor (MD) stated R1 had only been in the facility for a few days and he had not seen or examined R1 prior to her death on 5/24/20. MD stated he would have expected facility staff would have administered CPR on R1 immediately after she had been found without a pulse or respirations.

The American Heart Association current guidelines dated 2015, identified: "The healthcare provider should take no more than 10 seconds to check for a pulse and if the rescuer does not

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definitely feel a pulse within that time period, the rescuer should start CPR beginning with chest compressions. Ideally, the healthcare provider performs a pulse check at the same time as the check for no breathing or only gasping to minimize delay in detection of cardiac arrest and initiation of CPR. Begin chest compression as quickly as possible after recognition of cardiac arrest."

Review of the facility policy titled Code Blue-Cardiac Arrest undated identified if staff found a resident in cardiac arrest, staff would find their code status in the front page of their MR. The policy identified if a resident with a full code status was found in cardiac arrest, staff were to initiate CPR, call code blue over the phone system and call 911. The policy indicated Ambu bags (a device used for mouth to mouth ventilation) and cardiac boards (used to lay residents on when performing CPR) were located at the nurses stations of each unit.

The past noncompliance immediate jeopardy began on 5/24/20. The immediate jeopardy was removed 5/28/20, when the majority of the staff had been re-educated on CPR practices.

In addition, the facility implemented a systemic plan which included the following actions:

-the staff involved were placed on leave pending the investigation results.

- re-educated licensed staff on where to find the resident's healthcare directives, the code blue process, and where emergency equipment used during CPR was stored. The education was provided during one to one sessions prior to the

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F 678	Continued From page 16 employee's next shift by the CM's, ADON and DON. -re-educated non-licensed staff on where to find the resident's healthcare directive and where the emergency equipment used during CPR was stored. The education was provided during one to one sessions prior to the employee's next shift by the CM's, ADON and DON. - completed audits of staff knowledge of where to find the residents' health care directive, the code blue process, and where emergency equipment used during CPR was stored.	F 678		

Electronically delivered
June 12, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: LJXR11

Dear Administrator:

The above facility was surveyed on May 28, 2020 through May 29, 2020 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:

Kathleen Lucas, Unit Supervisor
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	00023	A. BUILDING: _____ B. WING _____	05/29/2020

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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 5/28/20, to 5/29/20, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure. The following correction orders are issued.	2 000		

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2 000	Continued From page 1 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		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an incident of potential neglect related to failure to provide cardio pulmonary resuscitation (CPR) was reported to the State Agency (SA) immediately, but not later than 2 hours after the allegation if it involved abuse or resulted in serious bodily injury, for 1 of 3 residents (R1) reviewed for neglect.	21990	Corrected	7/10/20

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21990	Continued From page 2 Findings include: R1's admission record identified R1 was admitted to the facility on 5/19/20, with a diagnosis of Alzheimer's Disease, heart failure and chronic kidney disease. Review of R1's Healthcare Directive Decision Form signed on 5/19/20, identified R1 was a full code in which CPR would be started and the ambulance would be called for transport to the hospital. Review of R1's standing physician orders undated, revealed R1 was a full code. Review of R1's progress notes dated 5/19/20, to 5/24/20, revealed the following: -5/24/20, 3:05 a.m. staff walked by room at 2:40 a.m. and noticed R1 was not breathing. Nurse listened for a heartbeat, checked for pulse and did a sternal rub (applying a painful stimulus to the center of the chest with knuckles to someone who is not responding) and determined the time of death to be 2:43 a.m. The nurse made phone calls to three different family members, contacted the nurse practitioner (NP), the case manager (CM) and the assistant director of nursing (ADON). The note indicated the nurse was waiting for one of the family to return the call. -5/24/20, 3:49 a.m. the nurse went to get the chart after speaking with the ADON and noticed R1 was a full code on her healthcare directive form, ran to R1's room, began CPR on R1 and directed nursing assistant (NA) to call 911. The note identified CPR was administered by the nurse until police and paramedics arrived on the	21990		

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21990	Continued From page 3 scene and took over administering CPR. The notes lacked documentation of reporting the incident to the SA. On 5/28/20, at 2:32 p.m. LPN-B stated she had been working the night shift on 5/24/20, from 10:00 p.m. to 6:30 a.m. LPN-B stated she had checked R1's blood pressure, pulse, respirations and oxygen levels at 12:30 a.m. and the results were within R1's normal limits. LPN-B stated sometime after that R1 called out for a bus a few times and then fell asleep. At around 2:43 a.m. NA-A called for LPN-B to assess R1 and R1 had no pulse or respirations and her skin was yellow and cold. LPN-B performed a sternal rub which elicited no response from R1 and determined R1 had expired. LPN-B confirmed CPR had not been initiated at that time. LPN-B stated she had experienced one other resident death in the facility who was a DNR and she began the death notification process based on that experience. LPN-B stated she had assumed R1 had been a DNR status due to her advanced age. LPN-B stated she had made telephone calls to the NP to release the body to the funeral home, family, case manager (CM) on call and the ADON to answer questions she had. LPN-B stated she had started to review R1's MR when she noted R1's healthcare directive indicated she was a full code status. LPN-B stated she was not certain of the amount of time that had lapsed since R1 was noted to have expired however estimated around 17 minutes had elapsed from the time R1 had been found with no pulse and respirations and the discovery of her full code status. LPN-B stated she dropped R1's MR, ran to her room and began administering CPR. LPN-B stated she asked NA-A to call 911. LPN-B stated she thought seven minutes or so had gone by when PO	21990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00023	A. BUILDING: _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21990	Continued From page 4	21990		

arrived at the scene and took over administering CPR. LPN-B stated the EMS staff arrived a few minutes after the PO. LPN-B stated R1 was pronounced dead after PO and EMS staff administered CPR unsuccessfully.

On 5/28/20, at 3:43 p.m. ADON stated she received a telephone call from LPN-B on 5/24/20, at 2:50 a.m. and notified her of a resident death. LPN-B stated the resident who had expired was in her 90's and did not inform ADON the name of the resident. ADON answered LPN-B's questions and the call ended. Around a half an hour later, ADON stated she received another telephone call from LPN-B who stated PO and EMS had arrived and were performing CPR on R1. LPN-B stated after she had called ADON she made other phone calls and noted in R1's MR she was a full code. LPN-B stated she dropped the MR, ran to R1's room, began CPR and asked NA-A to call 911. LPN-B stated it had been six to seven minutes before CPR was started on R1 after she had been found with no pulse and respirations and ADON confirmed it was closer to 25 minutes after reviewing the documentation and timing of the phone calls to herself and EMS. ADON confirmed CPR had not been administered timely to R1 and stated it was expected CPR be administered immediately when a resident who was a full code was found without a pulse or respirations.

On 5/28/20, at 4:08 p.m. director of nursing (DON) stated she had received a telephone call from ADON on 5/24/20, in the early morning sometime. ADON informed DON she had received two telephone calls during the night from LPN-B and stated R1 had been found without a pulse or respirations by NA-A. LPN-B started CPR once she had determined R1 was a full

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	00023	A. BUILDING: _____ B. WING _____	05/29/2020

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21990	Continued From page 5 code. ADON informed her at the time five minutes had lapsed between the time R1 had been found unresponsive and CPR had been administered. DON stated the PO contacted her on 5/26/20, to inform her CPR had not been administered for a longer period of time and EMS had not been called for close to 30 minutes. After that conversation, DON and ADON reviewed the timing of the phone calls, documentation and determined it had been closer to 25 minutes before CPR was initiated on R1 after being found without a pulse or respirations. DON confirmed CPR had not been initiated on R1 for 25 minutes after being found expired. DON stated it was expected staff begin CPR immediately after being found without a pulse or respirations and determining their code status. DON confirmed a report to the SA was completed on 5/26/20, two days after the incident occurred. DON confirmed the report should have been made to the SA immediately or within two hours after the incident occurred. Review of facility policy titled Good Shepherd Community's Abuse Prevention Plan revised 10/19, defined neglect as the failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. The policy instructed staff to report all allegations of maltreatment including neglect immediately and no later than two hours after the incident occurred. SUGGESTED METHOD OF CORRECTION: The adminstrator and/or designee could review the facility polices in regards to reporting of allegations of abuse to the State Agency. The administrator and/or designee could educate staff	21990		

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21990	Continued From page 6 on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21990		