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	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Lutheran Home	1115 4th Avenue North Sauk Rapids, MN 56379

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46941 Based on interview and document review the facility failed to maintain records of a thorough investigation for 4 of 4 residents (R29, R318, R319, R50) related to facility reported events. Findings include: On 8/30/23 at 11:42 a.m., the facility submitted an incident report to Minnesota Department of Health (MDH) regarding possible allegations of financial exploitation for R29. R29 had reported her tablet had been missing, and after searching felt someone had taken it. Report indicated that Sauk Rapids police department (PD) had been notified, and no alleged perpetrator (AP) had been identified. On 9/6/23 at 4:32 a.m., the facility submitted a five day incident report to MDH with an overall summary of the event and their investigation summary. The investigation summary noted R29 history of losing tablet in the past, but not being able to find this time, resulting in a report filing. Tablet remains missing with no identified AP's at this time. Facility will continue to investigate. Report indicated R29 most recent BIMS of 15, interviewing of staff, and resident conducted. On 5/2/24 all documents were requested for R29 incident reported on 8/30/23. On section C of the provided documents titled, VA investigative format, labeled Interviews of staff on current shift, indicated see attached information. However, evidence of interviews conducted was not provided. On 5/9/23 at 10:03 p.m., the facility submitted an incident report to Minnesota Department of Health (MDH) regarding possible allegations of Neglect of R318. R318 had been found on the floor, call light had not been activated and skin tear noted. Immediate intervention of 15-minute checks, toileting, and anticipating of needs. X-Ray obtained following R318 increased right hip pain. On 5/15/23 at 5:04 p.m., the facility submitted a five day incident report to Minnesota Department of Health (MDH) regarding possible neglect of R318. R318 had fallen on 5/9/23 with skin tear noted and no other complaints of pain. MD ordered X-ray later revealed right hip fracture resulting in hospitalization , report to MDH and internal investigation conducted finding through interviews care plan had been followed and no evidence of neglect or abuse had been found. On 5/2/24 all documents were requested for R318's incidents reported on 5/22/23. On section C of the provided documents titled, VA investigative format, labeled Interviews of staff on current shift, indicated see attached information. However, evidence of interviews conducted was not provided. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/22/23 at 10:11 a.m., the facility submitted an incident report to the Minnesota Department of Health (MDH) regarding possible injury of unknown origin. R319 was found to have a dislocated right shoulder after reporting complaints of pain and having an x-ray on 3/21/23. On 3/28/23 at 4:21 p.m., the facility submitted a five-day incident report to MDH with an overall summary of the event and investigation summary. The investigation summary noted R319's had a fall documented on 3/18/23 with no injuries noted at the time. Resident was noted to have had a previous right shoulder dislocation on 2/23/23 and significant degeneration to the area. According to the report, R319 denied anyone harming her. The five-day incident report indicated 4 staff interviews had been conducted. On 4/30/24 the internal investigation regarding R319's incident was requested. Facility provided a VA Investigative Format Initial Determining Investigation packet dated 3/22/23. Which included a short summary of the event and a copy of the initial MDH report and the five-day report and a copy of the x-ray results. On section C of this document labeled Interviews of staff on current shift, indicated see attached information. However, evidence of the interviews conducted was not provided. On 5/22/23 at 11:19 a.m., the facility submitted an incident report to the Minnesota Department of Health (MDH) regarding possible allegations of neglect. R50 was found outside the facility, had fallen and obtained a head laceration (cut) and was sent to the emergency department (ED) for care. On 5/26/23 at 3:06 p.m., the facility submitted a five day incident report to MDH with an overall summary of the event and investigation summary. The investigation summary noted R50's mobility and cognition status and interventions in place prior the event on 5/22/23. At approximately 5 a.m. on 5/22/23, staff saw R50 through the window, R50 had fallen in the parking lot and was on the ground. Staff noted injuries to R50's knees, elbows, and a laceration over right eye. R50 was sent to the hospital. Upon return to the facility on [DATE], R50 was moved to the locked unit and had sustained additional injuries of a rib fracture, small subdural hematoma (bleeding in the brain), and wrist fracture. The five day incident report also discussed 10 staff interview had been conducted. On 4/30/24 internal investigation regarding R50's incident on 5/22/23 was requested. Facility provided a VA Investigative Format Initial Determining Investigation packet dated 5/22/23. Which included a short summary of the event, names of staff contacted with in the facility, and a copy of the initial MDH report and the five day report. On section C of this document labeled Interviews of staff on current shift, indicated see attached information. However, evidence of the interviews conducted was not provided. On 5/1/24 at 08:41 a.m., the assistant director of nursing (O)-D and the director of nursing (DON) stated they typically do not keep the information other than what was provided and will use the information gathered during their investigation to write up a summary which was then included in the 5 day report to MDH. On 5/2/24 at 11:52 a.m., the assistant director of nursing (O)-D and the DON stated after conducting an investigation they entered the information gathered into the vulnerable adult reporting website, then place the summarized information into their binder of investigations. However, it was not their practice to keep the evidence of the investigation and/or interviews conducted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Good [NAME] Community's Abuse Prevention Plan last revised 7/22, indicated incidents are to be reported, documented and investigated internally using the Good [NAME] Incident reporting policy and procedure. 49035 49657

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645 Based on interview and document review, the facility failed to notify the Ombudsman for Long Term Care (LTC) of resident transfers to the hospital for 2 of 5 residents (R42, R49), reviewed for hospitalization . This had the potential to affect all residents transferred to hospital. Findings include: R42's significant change minimum data set (MDS) dated [DATE], indicated intact cognition. Diagnoses included heart and renal failure. R42's progress notes indicated hospitalization from [DATE] through 2/19/24. R42's Ombudsman Notification of Discharge form, dated 2/14/24, indicated R42 would be transferred to the hospital on 2/14/24 due to R42's emergent medical need. The bottom section of the form indicated a copy of this notice has been sent to the office of ombudsman for LTC with a fax number. However, the areas for date and staff signature were left blank. R49's significant change MDS dated [DATE], indicated severe cognitive impairment. Diagnoses included heart failure and quadriplegia. R49's progress notes indicated hospitalization from [DATE] through 11/6/23, and 12/31/23 through 1/8/24. R49's Verification of Receipt of Notice of Bed Hold, dated 11/2/23, held a sticky note that indicated unable to locate ombudsman form for 11/2/23 hospitalization . R49's Ombudsman Notification of Discharge form, dated 12/31/23, indicated R49 would be transferred to the hospital on 12/31/23 due to R49's emergent medical need. The bottom section of the form indicated a copy of this notice has been sent to the office of ombudsman for LTC with a fax number. However, the areas for date and staff signature were left blank. On 5/2/24 at 1:39 p.m., the nurse case manager (RNCC) stated the facility's Ombudsman Notification of Discharge form was used by the facility to notify the resident/resident representative in writing of the reason for the transfer/discharge to the hospital and a copy of the notice was sent to the ombudsman. The nurse that received the order to send the resident to the hospital was responsible for faxing the signed notification to the ombudsman. The form should have been faxed to the ombudsman before it was filed in the resident's chart. The RNCC expected staff to make a notation on the form to indicate the form was sent to the ombudsman, and if the form lacked a notation it probably was not faxed to the ombudsman. RNCC stated the staff have a binder to reference that provided step-by-step guidance for when a resident was sent to the hospital emergency room (ER). The facility's Sending a Resident to the ER form, undated, indicated staff were expected to chart they discussed with family ombudsman notification of discharge and fax form to ombudsman and give to medical records. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy regarding required ombudsman notification for transfers/discharges was requested but not provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan that addressed resident dialysis care for 2 of 2 residents (R48, R108) reviewed for dialysis. Findings include: R48's admission record dated 5/2/24, included diagnosis of end stage renal disease (ESDR), chronic kidney disease [NAME] 4 (severe), fluid overload, type 2 diabetes, and dependance on renal dialysis. R48's undated care plan printed 4/30/24, included enhanced barrier precautions due to Hemodialysis catheter. R48's care plan included the need for dialysis related to renal failure. Approaches included to not take blood pressure or blood draws from arm with graft (a type of access for dialysis). Care plan included to encourage resident to go to scheduled dialysis appointments on Monday, Wednesday and Friday. Care plan included to monitor/document/report signs of infection at the access site PRN (as needed), signs and symptoms of renal insufficiency PRN, and to monitor for signs and symptoms of bleeding PRN. R48's care plan failed to include which arm had the dialysis graft and needed to be avoided. the location R48 received dialysis and contact information for the dialysis center, and scheduled, routine monitoring of the resident post dialysis. R108's admission record dated 5/2/24, included diagnosis of ESRD, type 2 diabetes, and dependance on renal dialysis. R108's undated care plan printed 4/20/24, included a problem of needing dialysis related to chronic kidney disease. Approaches included to not take blood pressure or draw labs on the arm with a graft. However, R108 did not have a graft for dialysis. Staff were to encourage resident to attend scheduled dialysis appointments. Staff were to monitor/document/report signs and symptoms of infection to the access site as needed and to monitor/document/report signs and symptoms of renal insufficiency as needed. The care plan failed to include scheduled monitoring post dialysis and did not specify the dates of treatment, location or contact information of the dialysis center. During interview on 5/1/24 at 8:45 a.m., registered nurse case manager (RN)-B stated the staff needed to look at the calendar in their electronic charting system to see when residents had appointments, such as dialysis. It was not listed on the care plan. RN-B stated she was unsure if unlicensed staff had access to the calendar. RN-B confirmed the care plan did not specify a specific time frame for dressing removal or for monitoring the dressing on the dialysis access site. During interview on 5/1/24 at 10:27 a.m., director of nursing (DON) stated a resident's care plan should have included if they received dialysis. DON confirmed the location and contact information for dialysis would not be on the residents' care plans. DON stated she would have expected staff to look it up if they needed the number for the dialysis center. Facility policy for care plans requested and not provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49035 Based on observation, interview and document review, the facility failed to provided bathing for 1 of 2 residents (R34) reviewed for dependent cares. Findings include: Quarterly minimum data set (MDS) submitted 3/5/24 reported R34 required partial to moderate assistance for shower/bathing. This response indicated R34 required assistance from a helper to complete the task. R34's Admission record printed 5/2/24, included diagnoses of chronic pain syndrome, major depressive disorder (depression), and generalized anxiety disorder (anxiety). R34's bathing task report for 30 days included one response of resident refused on 4/3/24. No other responses documented. R34's progress notes failed to include notes regarding offering of bathing assistance or refusal of bathing assistance. During interview on 4/29/24 at 12:26 p.m., R34 stated she it had been a month since she had received a bath. R34 stated she often would not feel well when staff would come to give her a bath and would request a bath at a later time. R34 stated staff would not be available to give her a bath at the time she requested. R34 was not noted to have a strong body odor at time of interview. During interview on 05/01/24 9:10 a.m., nursing assistant (NA)-C stated if a resident refused a bath, she would have given other options to complete the bath, such as a different time. NA-C would have updated the nurse on duty if the resident continued to refuse after having been reapproached. During interview on 5/1/24 at 1:34 p.m., registered nurse (RN)-A stated residents had the right to refuse a bath. RN-A stated she would have expected staff to have documented either in tasks or in a progress note when the resident had refused and which interventions were attempted. RN-A stated she would have expected the staff to offer alternative times or days to complete the bathing or to have provided a bed bath. Further, any attempts or completion of a bed bath was to be documented in the resident's chart. RN-A stated based on the documentation, it had not appeared R34 was offered nor received a bath during the previous 30 days. During interview on 5/1/24 at 2:05 p.m., director of nursing (DON) stated she would have expected a bath to be offered and completed on the scheduled bath days. The DON would have expected alternatives to be offered and documentation regarding the reason for refusal if the resident refused. The DON confirmed there was only one day documented as a refusal of a bath in the past 30 days. The DON stated it was important to complete all activities of daily living (ADLs) or to document refusals because they want to ensure resident's were being cared for properly. Facility policy for bathing and ADLs requested and not provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review, the facility failed to ensure post-dialysis assessment and monitoring was completed for 2 of 2 residents (R48, R108) reviewed for dialysis. Findings include: During observation on 04/29/24 at 2:20 p.m., R48 was in bed with long sleeve sweater covering both arms. R48 was able to adjust sweater sleeve with assistance from family member to show clean, dry and intact dressing she received at dialysis center earlier that day. R48 stated the staff would remove the dressing but was unsure a what time they typically removed the dressing. R48's admission record dated 5/2/24, included diagnosis of end stage renal disease (ESDR), chronic kidney disease [NAME] 4 (severe), fluid overload, type 2 diabetes, and dependence on renal dialysis. R48's order summary report dated 5/2/24, included an order for a 1500 milliliter (mL) fluid restriction, dialyvite oral tablet one time a day for ESDR, and lidocaine-prilocaine external cream 2.5-2.5% to affected area topically one time a day every Monday, Wednesday and Friday before dialysis. R48's orders failed to include daily monitoring of dialysis graft, removal of dressing after dialysis appointments and post-dialysis assessment requirements. R48's undated care plan printed 4/30/24, included enhanced barrier precautions due to Hemodialysis catheter. R48's care plan included the need for dialysis related to renal failure. Approaches included to not take blood pressure or blood draws from the arm with graft (a type of access for dialysis). Care plan included to encourage R48 to go to scheduled dialysis appointments on Monday, Wednesday and Friday. Care plan included to monitor/document/report signs of infection at the access site PRN (as needed), signs and symptoms of renal insufficiency PRN, and to monitor for signs and symptoms of bleeding PRN. R48's care plan failed to include scheduled monitoring of the resident post dialysis, where R48 received dialysis, and which arm had the graft. R108's admission record dated 5/2/24, included diagnosis of ESRD, type 2 diabetes, and dependence on renal dialysis. R108's order summary report dated 5/2/24, included 1500 mL fluid restriction and full set of vitals every evening shift. Order summary report failed to include orders for monitoring pre or post dialysis. R108's undated care plan printed 4/20/24, included a problem of needing dialysis related to chronic kidney disease. Approaches included to not take blood pressure or draw labs on the arm with a graft. However, R108 did not have a graft for dialysis. Staff were to have encouraged resident to attend scheduled dialysis appointments. Staff were to monitor/document/report signs and symptoms of infection to the access site as needed and to monitor/document/report signs and symptoms of renal insufficiency as needed. The care plan failed to include scheduled monitoring post dialysis the dates, location and contact information of the dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/1/24 at 9:10 a.m., unlicensed staff (NA)-C stated she had not received any training specifically on how to care for a resident who received dialysis. During interview on 5/1/24 at 7:29 a.m., licensed practical nurse (LPN)-B stated she would look at a resident's orders to see if anything specific needed to be done, such as monitoring or assessments. LPN-B stated there was not anything specific she did for her dialysis residents when they returned. During interview on 5/1/24 at 8:45 a.m., registered nurse case manager (RN)-B stated the staff would have had to look at the calendar in the electronic charting system to see when residents had appointments, such as dialysis. RN-B stated she was unsure if unlicensed staff had access to the calendar. RN-B stated staff did not typically document on the dialysis graft or do an assessment when they returned from dialysis. RN-B stated there was no specific time frame or orders for monitoring the dressing on the dialysis access site or orders of when it could be removed. RN-B stated the staff should have used nursing judgement to determine when the dressing could have been removed. RN-B confirmed there was not a current orders for R48 for monitoring of her dialysis graft. During interview on 5/1/24 at 11:05 a.m., dialysis center RN stated there are not standard orders the dialysis center sends for monitoring of a resident who received dialysis for return to the facility. Dialysis center RN stated the bandage on the access site needed to remain in place for a minimum of 4 hours after dialysis. She stated it was best practice to monitor the dialysis graft site for a thrill (a specific feeling over the dialysis graft) and a bruit (a whooshing sound heard with a stethoscope over the dialysis graft site) daily. During interview on 5/1/24 at 10:27 a.m., director of nursing (DON) stated a resident's care plan should have indicated if they received dialysis. She stated the staff should look at the calendar for details on where and when dialysis appointments are scheduled. DON confirmed the location and contact information for dialysis would not included on the a resident's care plans. DON stated she would have expected staff to look it up if they needed the number for the dialysis center. DON stated there was not a specific length of time to keep a dialysis bandage on after the resident returned from dialysis. She stated the staff would monitor for bleeding and if there was no active bleeding, the dressing could have been removed. She stated if any monitoring had been done on a resident, she would have expected the medical record to reflect it in an assessment or progress note. The DON stated there was not any specific standard monitoring when a resident returned from dialysis unless ordered by the provider. DON stated if any specific training was needed, the facility would have provided it to staff. Undated facility policy titled Good [NAME] Lutheran Home Dialysis procedure, failed to include monitoring of residents, training to be provided to staff caring for residents receiving dialysis, or instructions on care plan requirements. Current facility contract with dialysis center requested and not provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49035 Based on observation and interview, the facility failed to maintain safe storage of medications when medication carts were left unlocked and unattended in 2 of 6 facility medication carts. Findings include: On 4/29/24 at 4:43 p.m., medication cart on 100s wing of facility was observed unlocked. Facility staff was observed walking past medication cart to the dining room to fill a pitcher of water. She then walked past the unlocked medication cart again and continued down the hallway to a resident's room. Facility staff returned to the medication cart at 4:55 p.m. and locked the cart. During the observed time, the medication cart was out of direct eye site of the staff member. On 4/30/24 at 3:35 p.m., medication cart on 300s wing of facility was observed to be unlocked and unattended until 3:40 p.m. On 5/1/24 at 7:22 a.m., medication cart on 100s wing of facility was observed to be unlocked and unattended. Medication cart was observed being unlocked for approximately one minute before facility staff approached the medication cart to lock it. At 11:51 a.m. on 5/2/24, registered nurse (RN)-A stated medication carts should have been locked any time they are unattended or out of direct eye site, no matter how brief. At 11:57 a.m. on 5/2/24, director of nursing (DON) stated she expected medication carts to be locked any time staff left the area. This was important for security of medications, to avoid possible diversion of medication and for resident safety. Facility policy for medication storage requested and not provided.