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	07/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident [NAME] of Rights (RBOR) was displayed for residents, visitors, and staff to review. This had the potential to affect all residents currently residing in the facility, as well as all staff and visitors. Findings include: On 7/8/26 at 8:47 a.m., it was observed that RBOR poster was displayed in a locked glass case in a small common area near the entrance and was dated 1/16. On 7/8/26 at 12:02 p.m., director of Social Services confirmed the poster was outdated and a new one needed to be ordered. A facility policy was requested but none provided.

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.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 2 of 2 residents (R2, R69) reviewed for medication administration.Findings include:R69's comprehensive MDS assessment dated [DATE] indicated R69 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and renal insufficiency.R69's self-administration of medication inquiry form signed by R69 on 4/15/26 indicated R69 did not want to self-administer medications either independently or after set-up by facility staff.During observation and interview on 7/6/26 at 11:04 a.m., a bottle of Nystatin powder with a pharmacy label containing R69's name was observed on the dresser.R69's orders reviewed on 7/8/26 lacked an order for self-administration of medication.R2's quarterly minimum data set (MDS) assessment dated [DATE], indicated R2 was cognitively intact and had the following diagnoses: heart failure, high blood pressure, end stage renal disease (ESRD) and diabetes.R2's self-administration of medication inquiry form signed by R2 on 8/28/25 indicated R2 did not want to self-administer medications either independently or after set-up by facility staff.During observation and interview on 7/6/26 at 3:32 p.m., a bottle of antifungal powder with a pharmacy label containing R2's name was observed on the bedside table in R2's room.R2's orders reviewed 7/8/26 lacked an order for self-administration of medication.During interview on 07/09/2026 at 7:28 a.m., licensed practical nurse (LPN-A) stated medications could be left at the bedside only if they have the doctors order to leave them and they have been assessed as safe to self-administer.During interview on 7/9/26 at 4:51 p.m., Director of Nursing (DON) confirmed R69 and R2 did not have a SAM assessment and stated her expectation for SAM was residents were assessed and had a physician's order before a SAM was put in place or medications be left at bedside. DON went on to state it was important for residents to be assessed to ensure the 5 rights of medication administration were being followed, important for staff to know what medications the resident is taking and to prevent another resident gaining access to medications.A policy for self-administration of medications was requested but not provided.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation and interview, the facility failed to promote independence for 1 of 1 resident (R 72) reviewed for self determination.Findings include: R72's face sheet printed 7/9/26, indicated admission date of 4/10/25, and had diagnoses of Cerebral Infarction affecting left side, type 2 Diabetes, and difficulty in walking. R72's care plan printed 7/9/26, indicated at risk for falls, resident needs a safe environment with even floors free from clutter, when in bed place blue mats on each side of the bed.During observation and interview on 7/7/26 at 5:02 p.m. R72 was sitting in wheelchair with a blue mattress on the floor opposite side of the bed and blocking access to the refrigerator. R72 stated he was not able to access his pop or yogurt that was in the refrigerator. During observation on 7/8/26 at 4:48 p.m. R72 was sitting in his wheelchair. There were 2 blue mats on the floor opposite side of bed and blocking access to the refrigerator. on 7/9/26 at 8:09 a.m. nursing assistant (NA)-A stated resident needed assistance with activities of daily living (ADLs) and keeping his room picked up and organized. NA-A stated R72 required mats when in bed and staff were expected to move them when he was out of bed. NA-A stated R72 would not be able to safely access the refrigerator when the mats were left on the floor. The mats should be placed out of the way. On 7/9/26 at 8:15 a.m. LPN-C stated R72 was able to self-propel himself enough to retrieve items from the refrigerator. The mats should not be left on the floor when R72 was out of bed. On 7/9/26 at 8:41 a.m. ADON stated she expected mats to be removed from the floor and placed out of way when residents were not in their beds. It was an issue if a resident was not able to access their refrigerator when capable of doing so. Policy was requested but none provided.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 2 of 6 resident reviewed for bedrails. Findings include: R55's comprehensive minimum data set (MDS) dated [DATE] indicated R55 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and arthritis. Section P of the MDS which covers restraints and alarms indicated R55 did not use bedrails. During observation and interview on 7/6/26 at 10:24 a.m., R55's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R55 stated they had been there since her admission. R55's medical record was reviewed and did not indicate the use of bedrails. R16's quarterly MDS assessment dated [DATE] indicated R16 was cognitively intact and had the following diagnoses: coronary artery disease, heart failure, and high blood pressure. Section P of the MDS which covers restraints and alarms indicated R16 did not use bedrails. During observation and interview on 7/6/26 at 2:13 p.m., R16's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R15 stated he did not use them for positioning. R16's medical record was reviewed and did not indicate the use of bedrails. During interview on 7/9/26 at 4:51 p.m., director of nursing (DON) stated she expected the MDS assessment to be accurately completed and to include all necessary information pertaining to the resident's current health conditions. DON stated it was important to have the assessments be accurate as it drives the resident plan of care and ensures the resident received appropriate care. DON went on to state the MDS assessments also drive reimbursement and if incorrect the facility would not receive proper reimbursement. A policy was requested but not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to update the provider of a weight change per physician order for 1 of 5 residents (R8) reviewed for unnecessary medications.Findings include:R8's annual Minimum Data Set (MDS) dated [DATE], indicated R8 was mildly cognitively impaired, was admitted on [DATE], and had the following diagnoses: coronary artery disease, heart failure (HF) (hearts failure to pump blood efficiently and can cause weight fluctuation), hypertension (HTN) (high blood pressure), and dementia.R8's clinical physician orders dated 7-9-26, indicated the following order:daily weight- every day shift (REPORT CHANGE OF 3LBS OVERNIGHT). Start date 4-9-26R8's weights and vitals dated 7-9-26, indicated the following weight fluctuations:On 5-29-26 weight-153.5lbsOn 5-30-26 weight-149.5lbs, which showed a change of 4lbs.On 6-3-26 weight-148.5lbsOn 6-4-26 weight-153.5, which showed a change of 5lbs.R8's medical record lacked any evidence that the provider was ever updated per the provider order.On 7-9-26 at 12:08p.m. via email, the director of nursing confirmed the provider was never updated of the weight changes.On 7-9-26 at 4:51p.m., the director of nursing stated their expectation was the provider should have been updated on these weight changes per the physician order and stated the importance of preventing decline in regards to the residents HF, and in order start treatment as soon as possible if ordered by the provider.A policy for provider notification was requested and none was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure resident receive adequate supervision and assistance for 1 of 1 resident (R5) when transferred with and EZ stand lift.Findings include: R5's admission Minimum Data Set (MDS) dated [DATE], indicated cognitive deficit and dependent for toileting, Diagnoses included: Alzheimer's disease, dementia, fracture, and repeated falls. R5's care plan printed 7/8/26, indicated moderate risk for falls related to weakness. Toileting: EZ stand w/2A [with 2 assist]. Does not ambulate at this time. During observation on 7/6/26 at 1:49 p.m., nursing assistant (NA)-D entered R5's room with EZ stand. NA-D placed harness, safety belt and loops appropriately. NA-D asked R5 if she was awake and proceeded to raise the arms. R5 stood at approximately 135 degrees, never coming to a full stand. NA-D grabbed the back of R5's pants during transfer to toilet. R5 was allowed some privacy, but remaining by door of bathroom. Staff re-entered bathroom to assist resident with cares. Safety belts were placed, R5 was raised using the lift, however, never came to a full stand. Staff transferred R5 to bed. During observation on 7/8/26 at 10:47 a.m. NA-B and NA-C entered R5's room with the EZ stand, sanitized hands and donned gloves. Staff placed harness, safety straps and loops appropriately. Placed R5's hands appropriately to hang on. NA-C encouraged R5 to stand and to feel the pressure on [R5's] feet. R5 stood at approximately 135 degrees, never coming to a full stand. R5 was allowed privacy, but staff remained by the bathroom door. Staff re-entered, raised R5 and encouraged her to stand. However, R5 never came to a full stand, raising to approximately 135 degrees. R5 was placed in wheelchair. During interview on 7/8/26 at 10:59 a.m., NA-B stated the resident's Kardex hung in the closet for reference on how to care for each resident. NA-B stated R5 did not stand up straight. She felt it was a safe transfer because there were 2 staff assisting with the transfer. During interview on 7/8/26 at 11:05 a.m. RN Case Manager (RN)-A stated she expected a resident stood straight up when transferred with the EZ stand. The staff encouraged resident to stand-up. Staff were expected to sit residents back down and try again if they did not. Further, she expected staff to notify her when a resident was no longer doing so. RN-A was unaware of any concerns related to R5 transferring safely when using the EZ stand. Facility policy was requested but none provided.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and attempt alternatives prior to use of bed rails for 2 of 6 residents (R55, R16) reviewed for bed rails. Findings include:R55's comprehensive minimum data set (MDS) dated [DATE] indicated R55 was cognitively intact and had the following diagnoses: atrial fibrillation, high blood pressure and arthritis. Section P of the MDS which covers restraints and alarms indicated R55 did not use bedrails. During observation and interview on 7/6/26 at 10:24 a.m., R55's bed was noted to have half-length bed rails attached to the top portion of the right and left side of the bed. R55 stated they had been there since her admission, and she did not routinely use them. R55's medical record was reviewed and lacked an assessment, or consent and education for the use of bedrails. R16's quarterly MDS assessment dated [DATE] indicated R16 was cognitively intact and had the following diagnoses: coronary artery disease, heart failure, and high blood pressure. Section P of the MDS which covers restraints and alarms indicated R16 did not use bedrails. During observation and interview on 7/6/26 at 2:13 p.m., R16's bed was noted to have quarter bed rails attached to the top portion of the right and left side of the bed. R15 stated he did not use them and could not recall how long they had been on his bed.R16's medical record was reviewed and lacked an assessment, consent and education for the use of bedrails.During interview on 07/09/2026 at 4:51 p.m., Director of Nursing (DON) stated a resident who used bedrails required an assessment for appropriateness, a physician's order, consent and education provided to the resident or their representative. Further, bedrails needed to be compatible with the bed and installed by maintenance staff. DON confirmed R55 and R16 had not had a bedrail assessment prior to the installation of bedrails. DON stated she expected nursing staff to complete a bedrail assessment prior to initiating bedrails. It was important to ensure the bedrails did not restrain the residents in any way, and to ensure residents safety.A policy titled Side-Rail Use with a last review date of 2/2026 indicated the purpose of bedrails was to promote resident independence at the highest possible level for turning, repositioning and mobility in bed while ensuring resident safety and compliance with regulatory standards. The policy stated bedrails were only used when clinically indicated to support resident mobility, positioning and comfort and never as a restraint, and are based on individual assessments.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to transcribe orders according to standards of practice for medication management for 1 of 5 (R150) residents reviewed for unnecessary medications.Findings include:R150's undated faceheet indicated they were admitted on [DATE], and had the following diagnoses: restlessness and agitation, pain, palliative care, and a frontotemporal neurocognitive disorder. R150's clinical physician orders dated 7-9-26, indicated the following order: Ativan 0.5mg solutabs- Give 0.25mg by mouth every 4 hrs as needed for restlessnessR150's corresponding narcotic book page associated with the Ativan order, showed the following: Ativan 5mg three times a day (TID) q4hr PRNR150's bubble pack card for Ativan listed the following: Lorazepam (Ativan) 0.25mg solutab-dissolve 1 tablet (0.25mg) by mouth three times a day AND dissolve 1 tablet by mouth every 4 hours as needed. The pharmacy card did not include a sticker or any other connotation which would have indicated the different tablet strength which was listed in the EMAR and not on the card.The undated index page for the above listed narcotic book listed the following: R150-Lorazepam 0.25mg- entered on 7-1-26.On 7/9/26 at 1:40p.m. during an observation of medication storage in a medication cart, the narcotic drawer contained a card for R150's Ativan 0.25milligrams (MG) by mouth (PO). Page 111 of the corresponding narcotic book listed Ativan 5mg every (q) 4 hours (HR) as needed (PRN). The electronic medication administration record (EMAR) listed 0.5MG solutabs-give 0.25mg PO q4hr PRN. The licensed practical nurse (LPN)-B confirmed all the transcribed locations for the same order did not match and should have. On 7/9/26 at 1:50p.m., LPN-B stated the facility process for receiving and transcribing new narcotics was for the nurse or trained medical aide (TMA) to receive them and verify they have the correct medication, enter it in the narcotic book and verify with two nurses. Furthermore, when they completed a narcotic count, one staff would have the narcotic book, and one staff would have the medication cards. LPN-B stated they go by the index, the staff with the book would refer to the page listed on the medication card, and the person with the medication card would count the number of tablets and ensure they matched.On 7/9/26 at 2:50 p.m., the pharmacist (PHARM) confirmed all three areas regarding the above listed order, narcotic book, and the card should all match, and if there was a change in dose or tablet strength, the card should have had a sticker or another connotation to denote the change, however, it did not. The PHARM stated their expectation was for staff to be comparing the name/strength/dose of the medication during narcotic counts and during medication administration, and the importance of completing those checks to reduce the likelihood of medication errors.On 7/9/26 at 4:51p.m., the director of nursing (DON) stated their expectation was staff entered orders received from the pharmacy, two nurses counted the medications and ensured they were correct and matched. Then write the correct directions for use in the narcotic book and were to be given a number from the index. Additionally, the DON stated they expect the staff members compared all areas listed above during narcotic count and medication administration, to ensure the resident received the correct medication, therapeutic dose, and to prevent diversion of medications.A policy for medication transcription was requested, however none was 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were labeled with an opened-on date as well as an expiration date for 1 of 4 medication carts (500 wing cart) reviewed for medication storage and labeling.Findings include:On [DATE] at 1:50 p.m., during review of the 500 wing medication cart with licensed practical nurse (LPN-A) the following was observed: 1 Lantus insulin pen with no expiration date noted.A box containing 2 bottles of Systane eye drops: bottle 1 indicated an open date of [DATE], but lacked an expiration date. Bottle 2 lacked both an opened on and expiration date. LPN-A stated when new medications were delivered the nurse who received the medications was to place an opened-on/Expired sticker on the medication and when the medication was first used that date, as well as the expiration date was written on the sticker. LPN-A opened medication cart to demonstrate the process, however, could not find any of the stickers needed for proper labeling. LPN-A stated without the opened-on or expiration date staff wouldn't know how long a medication was opened and whether or not it was safe to use. Further, LPN-A stated eyedrops expired in 28 days after opening, and the eyedrops dated [DATE] were past expiration. During interview on [DATE] at 4:51 p.m., Director of Nursing (DON) stated she expected when staff checked in medications from pharmacy, they should place an opened-on and expires-on sticker to medications such as eye drops, insulin, nasal sprays, and inhalers. DON stated it was important to have this information on the medications to make sure the medication was safe to use and given appropriately, and still within its therapeutic level to prevent infections and to prevent a resident from receiving a non-therapeutic dose. A policy related to medication labeling and storage was requested but not provided.