STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Lutheran Home	800 Home Street, Box 747 Rushford, MN 55971

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 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** 49616 Based on observation, interview, and record review the facility failed to comprehensively assess and monitor high blood pressure and rectal bleeding for 1 of 3 residents (R2) reviewed for change in condition. Findings include The American Heart Association (AHA) defines hypertensive crisis as a systolic blood pressure higher than 180 and/or diastolic pressure higher than 120. Blood pressure in this range can result in but not limited to stroke, heart attack, loss of kidney function, and aortic dissection. AHA directs for blood pressures that meet this criteria to wait at least 1-2 minutes and take the blood pressure again and consult your doctor immediately. R2's face sheet dated 2/12/25, identified diagnoses of malignant neoplasm (cancerous tumor) of left lower lobe, neoplasm of bone, type 2 diabetes (condition that affects how the body uses sugar as fuel), hypertension (high blood pressure), anemia (low red blood cells), thrombocytopenia (low platelets), irritable bowel syndrome (chronic stomach and intestinal disorder that causes diarrhea, abdomen pain, cramps, bloating, and gas), gastroenteritis and colitis (inflammation of the digestive tract), and diverticular disease of intestines (inflammation or infection of the pouches formed in the colon). R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 did not have cognitive impairment, R2 needed maximum assistance with toilet hygiene, and staff assistance on and off the toilet. R2 was continent of bowel and had occasional incontinence of bladder. R2's progress note dated 12/31/24 at 3:43 a.m., identified at 12:45 a.m. R2 fell while self transferring from toilet to wheelchair. A medium amount of blood was noted in the toilet. Blood pressure reading was 200/72 (normal blood pressure range for adults is 120/80). The note did not identify where the blood originated from. In review of R2's record dated 12/31/24, there was no indication R2 vital signs were rechecked or monitored nor a comprehensive assessment and monitoring of the bleeding until approximately 3:00 a.m. when R2 had large amounts of bleeding from the rectum. R2's progress note dated 12/31/24 at 3:51 a.m., identified at 3:30 a.m., R2 was sent to the hospital via ambulance for large amount of rectal bleeding/clotting. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's ambulance run report dated 2/12/25, identified ambulance dispatched to facility at 3:04 a.m., and arrived at emergency department at 4:21 a.m. for hemorrhage with primary impression blood in vomit or stood (GI bleed). Blood pressure readings from ambulance were as follows: -3:34 a.m. 138/64 -3:39 a.m. 111/62 -4:00 a.m. 119/63 -4:14 a.m. 97/62 R2's hospital discharge summary dated 1/6/25, identified R2 had an intensive care unit (ICU) hospital stay from 12/31/24-1/6/25 with a diagnosis of hemorrhagic shock (life threatening condition that occurs when a person loses a lot of blood and the body cannot get enough oxygen to the organs), gastrointestinal hemorrhage, secondary to a colonic arterial bleed as per imaging of the abdomen, and underwent inferior mesenteric artery embolization and given a blood transfusion. discharged back to facility 1/6/25. During a phone interview on 2/13/25 at 9:41 a.m., nursing assistant (NA)-A stated R2 had been in bed at the beginning of the shift on 12/31/24. R2 required assistance of one person to transfer and was surprised when R2's bathroom call light was on. NA-A went to R2's room and found her on the floor in the bathroom. NA-A noted blood in the toilet but R2 did not complain of pain or tenderness and did not appear hurt from the fall. NA-A assisted R2 back to bed after licensed practical nurse (LPN)-A assessed R2. NA-A stated not long after the fall, R2 again put her call light on and when she entered her room R2 said I think I made a mess in my pants. NA-A noted R2's brief was full of bright red blood and completely full. NA-A left room to get supplies and notified the nurse of blood overflowing from R2's brief. NA-A called LPN-A to the room when she realized that the blood was not stopping and they could not get ahead of it. NA-A told LPN-A that she thought R2 should be sent in and LPN-A agreed and called an ambulance. NA-A stated R2 required three complete bed changes before the ambulance got there from all the blood. NA-A was not sure if LPN-A had taken R2's vital signs again after she had fallen. During a phone interview on 2/13/25 at 9:27 a.m., LPN-A stated R2 fell while transferring from the toilet to the wheelchair on 12/31/24. LPN-A was surprised R2 did not call for help to transfer from the toilet as she required assistance of one staff for help. LPN-A noted a small amount of blood in the toilet and examined R2's rectal area and saw a small amount of blood but thought it was from hemorrhoids. R2's blood pressure was elevated at 200/72 at the time of the fall. A short time after the fall, R2 put her call light on again and said she had an incontinent episode, the incontinent garment contained a significant amount of blood. LPN-A stated she missed documentation of the incident. LPN-A stated she did recheck R2's blood pressure in-between the times R2 put in her call light on, but did not document it and did not recall what the vital signs were or if they were abnormal. During an interview on 2/15/25 at 9:13 a.m., LPN-B was unsure what signs or symptoms to monitor for high blood pressure aside from providing ordered medications and giving water to drink. LPN- B reviewed R2's chart for vital signs and fall follow-up from 12/31/24 and verified no vital signs were completed after the initial set after R2's fall and no additional documentation was completed on rectal bleeding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 10:02 a.m., registered nurse (RN)-A stated after a fall vital signs are done immediately and then residents are assessed for the next three shifts for fall follow-up but that did not necessarily include completing vital signs. High blood pressure is typically above 140-150 systolic (top number). Right after a fall a fall you would expect the blood pressure to be a little bit higher, however, LPN-A should have re-checked R2's blood pressure to verify it did not remain that high. R2 did not have rectal bleeding prior to the fall. During an interview on 2/12/25 at 12:50 p.m., director of nursing (DON) stated anything greater than 140 systolic medical doctor (MD)-A was to be notified. 200/72 is a high blood pressure. DON would expect the licensed nurses to complete an assessment and take a manual blood pressure to verify the blood pressure results. DON felt the assessments and vital signs were taken but just not documented after the fall. DON stated every person is different and it being emergent would depend on the individual situation. MD-A was always available and requested phone calls if staff were on the fence about a situation. During a phone interview on 2/13/25 at 10:21 a.m., MD-A stated he would want to be notified of a blood pressure that was 180 or above systolically and would want the blood pressure monitored every few minutes to see if it comes down. The facilities blood pressure monitoring guidelines, undated, identified to provide trained medication aides and licensed nurses with direction regarding blood pressure and pulse monitoring when a resident is prescribed an ace inhibitor/angiotensin receptor blocker, or beta blocker. The policy does not address when high or low blood pressure is obtained when not taking these medications. The facilities procedure for falls dated 8/22, identified the nurse call MD-A's cell phone directly (with the phone number provided) as needed. MD-A must be notified by phone if a resident is on a blood thinner with active bleeding/bruising/head injury, or internal injury is suspected related to unstable vital signs, neuro exam or if the resident sustains other significant injury resulting in new or worsening pain.