

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Good Shepherd Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care) was completed and provided for 1 of 1 resident (R7) reviewed for activities of daily living (ADLs) and who was dependent on staff for their care. Findings Include: R7's comprehensive Minimum Data Set (MDS) assessment, dated 4/3/26, identified R7 had severe cognitive impairment, and was dependent for personal hygiene which include nails care. R7's care plan dated 3/8/24 indicated bath and nailcare will be offered by nurse aid every week. R7s electronic medical record (EMR) lacked weekly nail care provided with baths. Facility Nursing Assistant Bath Day sheet dated 5/7/26 indicated nails were cleaned and not needed to be clipped. During an observation on 05/11/26 10:34 a.m., R7 was found sitting in the dining room with noted long fingernails grown passed fingertips curving downward and visible dark matter under the fingernails. During an observation on 05/12/26 9:07 a.m., R7 was assisted back from breakfast by licensed practical nurse, (LPN)-A. R 7's fingernails remained unchanged in length with noted half of a fingernail broken off a finger on the right hand. During an interview on 05/12/26 9:08 a.m., LPN-A verified R7's fingernails are long, they should have been completed last week. During an interview on 05/12/26 at 9:17 a.m., case manager and registered nurse (RN)- A confirmed, R7's fingernails were long and stated, it was unacceptable. Facility policy titled, Nursing Assistants Policies, Definitions and Standards of Care Good [NAME] Lutheran Home, reviewed on 1/6/15, indicates, resident's usual care level and minimum degree of assistance that should be provided by staff is documented in the resident's individual care plan. The plan of care is followed unless the NA recognize a decline in the resident's status.</p>

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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<p>F 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and document review, the facility failed to notify the Office of the State Long-Term Care (LTC) Ombudsman for calendar years 2025 and 2026, reviewed for hospitalizations, discharges, and transfers. Findings Include: During an interview on 5/7/26 at 4:07 p.m., ombudsman (OM)-A stated she had not received any hospitalizations, discharges, and transfer notices for the year of 2025 and no notices for 2026. During an interview on 5/11/26 at 2:46 p.m., social services (SS)-A stated she is responsible for sending notification to the ombudsman about hospitalizations, discharges, and transfers; these notifications are supposed to be sent monthly. SS-A confirmed she is behind a little with submitting the notifications to the ombudsman. SS-A stated ombudsman notifications are important, so residents have an advocate if they feel they have been wrongly hospitalized, discharged, or transferred. During an interview on 5/11/26 at 3:25 p.m., administrator stated social service is responsible for sending notices about hospitalizations, discharges, and transfers to the ombudsman monthly. The administrator stated social services told her they were behind with sending notices to the ombudsman. The administrator confirmed the notices had not been sent for over a year. The administrator stated it is important to send notices to the ombudsman because the ombudsman is a resource for the residents and can support the resident if they have an issue with hospitalization, discharge, and transfer. A facility policy titled Discharge Planning dated 12/25 was provided, this policy failed to address the process for sending ombudsman notifications.</p>		