

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Lutheran Home of the Good Shepherd		STREET ADDRESS, CITY, STATE, ZIP CODE 1226 1st Ave N New Rockford, ND 58356	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the care plans to reflect residents' current status for 1 of 12 sampled residents (Resident #24). Failure to review and revise the care plan limited staff's ability to communicate needs, ensure continuity of care, and may negatively impact the care provided to the resident.</p> <p>Findings include:</p> <p>Review of the facility policy titled Care Plans occurred on 07/09/24. This policy, dated August 2022, stated, . Care plans are revised as changes in the resident's condition dictates.</p> <p>Review of Resident #24's medical record occurred on all days of survey. The current care plan stated, Transfers with supervision. I like to ambulate throughout the wing but will often refuse staff to walk with me. EZ stand with leg strap. It is recommended that I use a walker to stabilize my gait . I ambulate with a stumped over posture and shuffled gait . Encourage me to take rest periods after walking as I will walk aimlessly. The Minimum Data Set (MDS) dated [DATE], identified the resident utilized wheelchair for mobility.</p> <p>Observations on all days of survey showed Resident #24 in a wheelchair, moving herself throughout the unit using her feet.</p> <p>During an interview on the afternoon of 07/09/24, an administrative staff member (#1) confirmed the facility failed to update Resident #24's care plan regarding the mobility 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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477</p> <p>Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled residents (Resident #15) observed receiving a topical medication and 1 supplemental resident (Resident #6) observed during medication administration. Failure to obtain a physician's order and to properly administer medications may result in a resident receiving an ineffective dose and/or experiencing adverse reactions.</p> <p>Findings include:</p> <p>Review of the facility policy titled Administration of Medications occurred on 07/10/24. This policy, dated March 2023, stated, 1. Medication administration must safely be performed according to the six rights of administration. e. The medication is given by the right route. 3. Physician orders are obtained through faxing or calling physician for either written or verbal orders.</p> <p>Mosby's 2023 Nursing Drug Reference, 36th ed., Elsevier, Inc., Missouri, page 1046, stated, . Administer Drugs Safely, Accurately, and Professionally . Do not break, crush, or chew ext [NAME] [extended release] tabs [tablets] .</p> <p>- Observation on 07/09/24 at 8:54 a.m., showed a medication aide (#3) applied Nystatin powder to Resident #15's perineal area while completing cares.</p> <p>Review of Resident #15's medical record occurred on 07/09/24. The record lacked a physician's order for Nystatin powder.</p> <p>The medication aide (#3) applied a topical medication without an order.</p> <p>- Observation on 07/10/24 at 8:23 a.m., showed a nurse (#2) crushed and administered a Potassium Chloride tablet in pudding to Resident #6.</p> <p>Review of Resident #6's medical record occurred on 07/10/24. A physician's order stated, Potassium Chloride ER [extended release] oral tablet . give 1 tablet by mouth one time a day .</p> <p>During an interview on the afternoon of 07/10/24, an administrative staff member (#1) confirmed the nurse (#2) administered the tablet incorrectly, and confirmed that all medications should have a physician's order.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>28611</p> <p>1. Based on observation and staff interview, the facility failed to ensure an environment free from accident hazards on 1 of 1 special care unit. Failure to ensure residents do not have access to laundry and soiled utility rooms placed them at risk for exposure to chemicals and other accident hazards.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - Observation on 07/08/24 at approximately 2:10 p.m. showed Resident #23 opened the door to an unlocked laundry room on the special care unit, and the door closed behind her. A few minutes later, an unidentified staff member entered the laundry room to redirect the resident. Observation showed containers of bleach and laundry detergent next to the washing machine. A cupboard contained other laundry detergents, Sani-Cloth disinfecting wipes, and hair spray. Observation on 07/08/24 at 4:08 p.m. showed this door remained unlocked. <p>During an interview on the morning of 07/09/24, an administrative nurse (#1) reported the laundry room door, when closed tightly, should automatically lock.</p> <ul style="list-style-type: none"> -Observations on 07/08/24 from 4:07 p.m. until 5:37 p.m. showed the door of the soiled utility room on the special care unit unlocked. The room contained Comet disinfecting cleaner with bleach, Clorox urine remover, mop detergent, four bottles of antibacterial liquid hand soap, two containers of hand sanitizer, and Sani-Cloth germicidal disposable wipes. <p>On 07/09/24 at 8:25 a.m., observation showed the soiled utility room door locked. A housekeeping staff member (#7) stated the door should always be locked.</p> <p>During an interview on 07/09/24 at 4:04 p.m., an administrative staff member (#8) stated she expected staff to keep the soiled utility room door locked at all times.</p> <p>2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate assistance and/or assistive devices for 1 supplemental resident (Resident #25) observed during a toileting transfer. Failure to use a gait belt and provide appropriate assistance during a transfer placed residents at risk for accidents, falls, and/or injuries.</p> <p>Findings include:</p> <p>Review of the facility policy titled Transfers with use of Transfer Belts/Mechanical Lifts occurred on 07/10/24. This policy, dated January 2018, stated, . If a resident needs hands on assistance of trained staff for balance or lifting and maintaining standard position, transfer belt/gait belt must be used, unless otherwise care planned.</p> <ul style="list-style-type: none"> -Review of Resident #25's medical record occurred on 07/10/24. The care plan stated, . Will ambulate but requires walker, staff using gait belt with hands on assist. Transfers with one assist and FWW [front wheeled walker]. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/08/24 at 4:15 p.m. showed two certified nurse aides (CNAs) (#5 and #6) assisted Resident #25 from the wheelchair to a standing position by lifting under the resident's arms and transferred the resident to the toilet without the use of a gait belt. After toileting the resident, both CNAs (#5 and #6) lifted Resident #25 under the arms, and without the use of a gait belt, transferred Resident #25 back to the wheelchair.</p> <p>During an interview on the afternoon of 07/10/24, an administrative staff member (#1) confirmed staff should be following policy and resident care plans.</p> <p>46477</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>28611</p> <p>Based on observation, review of professional reference, and staff interview, the facility failed to label medications in accordance with professional standards for 2 of 4 supplemental residents (Resident #8 and #22) observed during medication pass. Failure to ensure appropriate labeling of medications placed residents at risk for medication errors.</p> <p>Findings include:</p> <p>Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 834, stated, . Check Three Times for Safe Medication Administration . First Check . Read the MAR [medication administration record] and remove the medication(s) from the client's drawer. Verify that the client's name and room number match the MAR. Page 838 stated, . Compare the label of the medication container or unit-dose package against the order on the MAR or computer printout. Rationale: This is a safety check to ensure that the right medication is given. If these are not identical, recheck the prescriber's written order in the client's chart. If there is still a discrepancy, check with the pharmacist.</p> <p>- Observation on 07/08/24 at 4:06 p.m. showed a nurse (#4) prepared medications for Resident #8. The nurse removed a bottle of artificial tears from the drawer. The box/bottle lacked a label with identifying information (such as the resident's name). The nurse administered the eye drops to Resident #8.</p> <p>- Observation on 07/09/24 at 8:27 a.m. showed a nurse (#9) removed nasal spray from the medication cart for Resident #22. The label on the medication identified two sprays to each nostril twice daily; however, the MAR and the physician's order identified two sprays each nostril once daily.</p> <p>During an interview on the morning of 07/09/24, an administrative nurse (#1) identified she would clarify the nasal spray order, and staff should label over the counter medications with the resident's name and the date they opened the medication.</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>28611</p> <p>Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to follow infection control standards for 3 of 3 residents (Resident #7, #8, and #41) observed during blood glucose testing. Failure to properly disinfect glucometers may result in the spread of bloodborne pathogens between residents.</p> <p>During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 07/08/24 at 5:55 p.m. The IJ resulted from a staff member improperly cleaning a glucometer and attempting to use it with another resident. This finding placed residents in immediate danger due to the potential for exposure to bloodborne pathogens.</p> <p>*07/08/24 at 6:27 p.m., The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the IJ.</p> <p>*07/09/24 at 9:44 a.m., The survey team reviewed and accepted the facility's removal plan for the IJ.</p> <p>The removal plan contained the following:</p> <ul style="list-style-type: none"> *Immediate disinfection of all glucometers using an approved method (i.e., Sani-Cloths) *Ensured all residents requiring blood glucose checks (accuchecks) were assigned individual glucometers *Education provided to all staff who complete accuchecks on proper disinfecting process <p>*07/09/24 at 10:04 a.m., The survey team verified the implementation of the removal plan as of 07/08/24 and the IJ removal. The deficient practice remained at a D scope and severity following the removal of the IJ.</p> <p>Findings include:</p> <p>Review of the manufacturer's instructions for the Assure Prism blood glucose meter (glucometer) identified, . Cleaning and Disinfecting . The cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter and lancing device before performing the disinfection procedure. The disinfection procedure is needed to prevent transmission of blood-borne pathogens. The meter should be cleaned and disinfected after use on each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed. We have validated . PDI Super Sani-Cloth Germicidal Disposable Wipe for disinfecting the Assure Prism multi meter. Only wipes with EPA [Environmental Protection Agency] registration numbers listed in the previous tables have been validated for use in cleaning and disinfecting the meter. The manufacturer's instructions did not list isopropyl alcohol wipes as an approved cleaner/disinfectant.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- Observation on 07/08/24 at 4:06 p.m. showed a nurse (#4) checked Resident #8's blood sugar with a glucometer labeled with the resident's name. The nurse then cleaned the meter with an alcohol wipe and placed it back in the case. The nurse stated she normally used a Sani-Cloth to clean the meter but there were none in the cart, and each resident had their own individual glucometer.</p> <p>- Observation on 07/08/24 at 4:18 p.m. showed a nurse (#4) checked Resident #41's blood sugar with a glucometer labeled with the resident's name. The nurse then cleaned the meter with an alcohol wipe and placed it back in the case.</p> <p>- Observation on 07/08/24 at 4:27 p.m. showed a nurse (#4) attempted to check Resident #7's blood sugar using Resident #8's glucometer. The nurse stated, She's [Resident #7] not one we do routinely [check blood sugars], so we use someone else's [glucometer]. Observation showed the nurse took Resident #8's glucometer from the medication cart and attempted to enter Resident #7's room. The surveyor intervened and requested the nurse disinfect the glucometer with a Sani-Cloth.</p> <p>During an interview on the afternoon of 07/08/24, an administrative nurse (#1) stated she expected staff to clean glucometers with Sani-Cloths and not share meters between residents.</p>		