STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home of the Good Shepherd	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:Based on record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #36) who was injured during van transport. Failure to provide the appropriate level of assistance ensuring Resident #36's extremities remained within the frame of the wheelchair/were supported while loading her into the van, resulted in a major injury to her left foot.Findings include:Review of the facility policy titled Safe Lift and/or Ramp Usage in the Vans occurred on 08/28/25. This policy, revised 2022, stated, . Open doors and Lower lift, Load resident with brakes on, Transfer resident into placement . The policy failed to address the need to ensure a resident's extremities remain within the frame of the wheelchair/are supported while loading him/her into the van.Review of Resident #36's medical record occurred on all days of survey. Diagnoses included laceration/nondisplaced fracture of the middle phalanx of the left lesser toe, polyneuropathy (a condition where multiple peripheral nerves throughout the body become damaged or malfunction), reduced mobility, and severe obesity. The current care plan identified, . I am at risk for falls r/t [related to] . being unaware of safety needs and inability to use my legs . Anticipate . my needs .The progress notes identified the following:* 06/28/25 at 4:00 p.m., Late Entry: This nurse was informed of [an] incident involving [the] resident during transfer into . [the] facility van. [Facility] maintenance staff (x2) [times two] and CNAs [certified nurse aides] (x2) report that [the] resident was transfered [sic] via wheelchair onto the loading platform on the back of [the] facility van. Staff completed saftey [sic] checks prior to raising [the] platform. Staff report that they ensured resident's arms and legs were in proper position. [The] Resident had gripper socks on. While raising the platform to assist [the] resident into the van staff noticed that the tip of [the] resident['s] left gripper sock was caught in between [the] platform and [the] van. [The] Sock [was] removed from [the] stuck position and [the] resident and [the] wheelchair [were] secured into the back of the van. While on the transport back to [the] facility [a] staff member noticed [the] resident's left foot ?sitting in a small pool of blood.' Staff then removed [the] resident's left sock and noted significant bleeding from [the] resident's 4th toe. Staff notifed [sic] this nurse of [the] incident and stated they were taking [the] resident back to [the] ER [emergency room] for evaluation. This nurse approved and updated [hospital] staff of [the] resident return to [the] ER.* 06/28/25 at 4:45 p.m., Late Entry: This nurse recieved [sic] [a] call from [the] [hospital] staff nurse . It was reported that [the] resident broke her 4th [forth] toe on her left foot. [A] 0.5 cm [centimeter] laceration present to top of 4th toe, 5 [five] sutures placed.A Facility Reported Incident (FRI) report, dated 06/30/25, stated, . LPN [licensed practical nurse] made the decision to have 4 staff members go with [the] [facility] transport van to pick up [the] resident. This decision was made as [the] resident is obese and is a difficult transfer . The staff then noted the resident's sock was caught in a pinch point on the platform . While driving back . [staff] noticed resident's left sock was soaked with blood. [Staff] removed her sock, noted the injury and applied pressure to the area of her left toe . Staff education provided to increase awareness with bariatric transfer . Occupational Therapy Assistant . re-evaluated the bariatric transport chair and added a foot board to the chair .A (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	van transportation handout, dated 07/01/25, stated, . [Resident #36's] regular wheelchair will not fit on the van. The footboard and leg support is [sic] on the transport wheelchair. Make sure [the] leg rests are elevated to allow [the] wheelchair to fit on the van lift. Make sure all body parts are within the frame of the wheelchair and supported prior to lifting [the resident] and lowering [him/her] on [the] lift. Staff failed to add the transport interventions to Resident #36's care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure staff followed professional standards of practice for 2 of 4 sampled residents (Resident #6 and #36) observed during medication administration. Failure to prime insulin pens correctly and failure to administer medications at the scheduled times may impede the therapeutic effectiveness of the medications.Findings include:The facility failed to provide a policy on medication administration and documentation.Review of the facility policy titled Insulin Pen Use occurred on 08/27/25. This policy, dated 2021, stated, . prime pen with 2 units of insulin pointing the pen with the needle upwards. Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 836, stated, . Ten Rights of Medication Administration . Right Documentation . Document medication administration after giving it . The record [medication administration record (MAR)] should . include the exact time of administration .-Review of Resident #36's medical record occurred on all days of survey and included physician's orders for Gabapentin (a pain medication) by mouth three times per day. The MAR listed the administration times at 7:00 a.m., 2:00 p.m., and 7:00 p.m.Observation on 08/26/25 at 4:30 p.m. showed a nurse (#7) conducted a narcotic count on the Grace Unit. Resident #36's Gabapentin narcotic record showed 2 tablets. The count showed 3 tablets of the Gabapentin remaining in the resident's medication cartridge. Resident #36's MAR reflected the nurse (#7) signed off the Gabapentin as given at 2 p.m. However, observation showed the nurse (#7) administered the Gabapentin at 4:30 p.m., resulting in late administration. During an interview on 08/27/25 at 10:05 a.m., an administrative nurse (#10) confirmed staff failed to administer the medication in a timely manner.-Review of Resident #6's medical record occurred on all days of survey. Diagnoses included type 2 Diabetes Mellitus and insulin dependence. Physician's orders included Novolog 70/30 insulin (for blood glucose control) with meals and sliding scale. Observation on 08/26/25 at 4:50 p.m. showed a nurse (#9) primed Resident #6's insulin pen pointed sideways. During an interview on 08/27/25 at 8:30 a.m., an administrative nurse (#10) confirmed the nurse failed to correctly prime the insulin pen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 14 sampled residents (Resident #3 and #6) observed during cares. Failure to practice infection control standards related to hand hygiene and glove use has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Personal Protective Equipment occurred on 08/28/25. This policy, revised July 2022, stated, . Gloves . Perform hand hygiene before donning [applying] gloves and after removal. Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another . -Observation on 08/25/25 at 1:15 p.m. showed a certified nurse aide (CNA) (#2) utilized a sit-to-stand lift to transfer Resident #3 from a wheelchair to the toilet. The CNA applied gloves, performed perineal cares, removed the soiled gloves, and transferred the resident back into the wheelchair. Without performing hand hygiene, the CNA (#2) opened the room blinds, moved the overbed table within the resident's reach, then performed hand hygiene and exited the resident's room. -Observation on 08/25/25 at 4:12 p.m. showed two CNAs (#5 and #6) performed Resident #6's perineal cares while in bed. Without changing the soiled gloves, the CNA (#5) opened the resident's nightstand drawer, removed a container of bag balm (a protective skin barrier), opened and reached into the container with a dirty gloved hand, and applied the bag balm to the resident's inner thighs. After cares were completed, the CNAs transferred the resident from the bed into a wheelchair, and without changing the soiled gloves and performing hand hygiene, the CNA (#6) adjusted the resident's necklace. The CNA (#5) failed to remove the soiled gloves, perform hand hygiene, and apply new gloves before obtaining and applying the bag balm. The CNA (#6) failed to remove the soiled gloves and perform hand hygiene prior to adjusting the resident's necklace. -Observation on 08/27/25 at 10:25 a.m. showed a nurse (#7) performed Resident #6's dressing change while in bed. The nurse performed hand hygiene, applied gloves, used gauze to pat the open skin on the resident's inner thighs, discarded the gauze, removed the soiled right glove, and without removing the soiled left glove and performing hand hygiene, exited the room. The nurse unlocked the nurse's cart, opened a cart drawer, and obtained more dressing supplies with the ungloved hand. The nurse reentered the resident's room, removed her soiled left glove, performed hand hygiene, applied new gloves, and finished the dressing change. The nurse (#7) failed to remove the soiled left glove and perform hand hygiene prior to exiting the resident's room and opening the nurse's cart/drawer and obtaining the dressing supplies. During an interview on 08/28/25 at 9:26 a.m., an administrative staff member (#4) stated she expected staff to remove gloves, perform hand hygiene, and apply clean gloves between clean and dirty tasks and remove gloves and perform hand hygiene prior to exiting resident rooms.