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 _____	C 01/20/2022

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and a complaint survey started on 01/18/22 and concluded 01/20/22.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		1/25/22

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

Electronically Signed | 02/14/2022

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the residents' rights to request, refuse, and/or discontinue treatment for 1 of 13 sampled residents (Resident #30) reviewed for advance directives. Failure of staff to ensure a resident's legal representative (Power of Attorney) signed documentation regarding his/her wishes limited the facility's ability to communicate to direct care staff and emergency personnel the resident's/representative's wishes in the event of a medical emergency. Findings include: Review of the facility policy titled "Advance Directives" occurred on 01/20/22. This policy, revised October 2017, stated, ". . . The facility will . . . approach the . . . legal representative if the resident is determined not to have decision making capacities. . . . During the care planning process, the facility will review with the . . . legal representative whether they desire to make any changes related to the Advanced directives. . . ." - Review of Resident #30's medical record occurred on all days of survey and showed a family member versus the power of attorney	F 578	F578-Request/Refuse/Discontinue Treatment; Formulate Advanced Directive 1. A new Code Level Status consent was provided to the appointed Power of Attorney for resident #30 to be reviewed and signed. 2. All residents who do not have the decision-making capability and require a power of attorney have the potential to be affected. 3. An audit was completed by the Director of Nursing on all residents on 1/25/2022 to ensure Code Level Status Consents for each resident accurately reflected the appropriate signature by the elected Power of Attorney. New Code Level Status consents were provided to the appropriate Power of Attorney to be reviewed and signed. The Director of Nursing or designee will verify with Social Service prior to sending out annual Code Level Status consents to assure they are provided to the appropriate Power of Attorney for review and signature. Social Services will communicate any new or changes in Power of Attorney for residents as they occur. 4. The Director of Nursing or designee(s)	

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F 578	Continued From page 2 signed the code status form on file. The record lacked evidence of a discussion with the power of attorney regarding what his/her current wishes entailed regarding Resident #30's code status. During an interview on 01/20/22 at 1:30 p.m., an administrative staff member (#1) acknowledged staff failed to ensure Resident #30's power of attorney signed the code status form.	F 578	will review Code Level Status Consents on all new admissions weekly X 4, monthly X 3, and quarterly X 2 to assure the consents are signed by the appropriate Power of Attorney or individual responsible for making Health Care Decisions on resident□s behalf who do not have decision making capabilities. We will reevaluate for further monitoring or interventions.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		2/22/22

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F 580	Continued From page 3 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff and family interviews, the facility failed to notify the resident's representative (family/legal guardian) of a change in condition for 1 of 1 resident (Resident #4) reviewed for a fall with injury. Failure to notify the resident's representative of a change in condition does not allow the representative to be fully informed of the resident's status and limits their ability to make informed decisions regarding their medical care. Findings include:	F 580	1. Family was notified of fall resident□s fall on 1/17/2022 so no immediate action was taken for resident #4. 2. All residents that have a change in condition and family or family representative are not notified properly have the potential to be affected. 3. The staff member responsible for not notifying the family according to LHGS policy was reeducated on 1/17/22 on the day of the fall. All nursing staff were reeducated on 1/20/22 through the message board on Point Click Care and again at an in-service meeting on 1/25/22	

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F 580	Continued From page 4 Review of the facility policy titled "Incident and Accident" occurred on 01/20/22. This policy, dated March 2016, stated, ". . . Notify family of accident, status and orders for care. If incident occurs between 8:00 AM and 10:00 PM the family/legal guardian will be notified in a timely manner as the situation allows. If incident occurs after 10 PM and does not require immediate medical attention, the family will be notified the next morning . . . Family/Legal guardian must be notified immediately on falls occurring after 10pm requiring immediate medical attention; this would include falls with a head injury.. . ." Review of Resident #4's medical record occurred on all days of survey. Nursing progress notes, dated 01/17/22 at 4:45 a.m. stated, "Resident found on floor at [4:45 a.m.] bed alarm in place and on at time of fall. CNA [Certified Nursing Assistant] found resident on floor. Upon entering room author noted resident lying on right side next to bed. Blood noted on floor. Resident wearing gripper socks on feet bilat. [bilaterally]. Neuro [Neurological] assessment initiated. PERRLA [Pupils equal, round, reactive to light and accomodation]. Hand grasps strong. speech unchanged. Author noted large bump on right side of forehead. Small cut noted in center of bump. Bleeding ceased with pressure." During an interview on 01/19/22 at 11:39 a.m., Resident #4's Power of Attorney (POA)/Emergency contact stated she came to visit Resident #4 on Monday 01/17/22 and noticed a "gash" on the resident's forehead. The POA asked staff about the injury's origin and staff informed her of Resident #4's fall earlier that morning. The POA expressed frustration with not	F 580	regarding the requirement that family or legal guardian must be notified immediately on falls occurring after 10 pm requiring immediate medical attention; this would include falls with a head injury or if resident is unable to state for certain a head injury occurred. Nursing staff will be reeducated again on 2/15/2022 on LHGS Notification of Change Policy along with the Incident and Accident Policy. LHGS has added a column to their daily nursing report sheet to include an area that can be marked when a family or legal guardian has not been notified so the following shift can assure notification takes place. 4. The Director of Nursing or Designee(s) will complete auditing of incident reports and/or progress notes weekly X 4, monthly X3, a quarterly X 2 for appropriate and timely documentation of family/representative notification following falls. Further interventions will be determined and implemented if needed.	

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F 580	Continued From page 5 being notified of the fall prior to the visit. The medical record lacked evidence staff notified the resident representative of Resident #4's fall. During an interview on 01/20/22 at 1:19 p.m., an administrative staff member (#1) confirmed staff failed to notify the resident representative of Resident #4's fall with injury.	F 580		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		2/22/22

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F 755	Continued From page 6 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of narcotics records, and staff interview, the facility failed to ensure an accurate count for 2 of 2 residents' (Resident #40 and #43) controlled medications. Failure to account for missing controlled medications in a timely manner increases potential for medication error, loss, or diversion. Review of the facility policy titled "Controlled Drug Count" occurred on 01/20/22. This policy, revised October 2021, stated, " . . . To maintain an accurate count of the controlled drugs in the facility . . . scheduled 2, 3, 4 and 5 drugs . . . will be counted every shift by the oncoming and off going nurse . . . each nurse will mark the count and sign the appropriate place on the form . . . any discrepancies will be resolved immediately, if unable to resolve, contact the Resident Care Coordinator or the Director of Nursing . . ." - Observation of the Peace medication room on 01/19/22 at 11:46 a.m., showed Resident #40's medication cartridge labeled "Tramadol 50 mg [milligrams] take 1 tablet PO [oral] daily at 12 noon." The narcotic count log showed one tablet missing from 12/20/21 to 01/19/22 and staff failed to report the missing narcotic. - Observation of the Peace medication room on	F 755	1. Immediate corrective action taken was completed by ordering a medication to replace the missing medication for resident #40 and #43. 2. Failure to account for missing controlled medications in a timely manner, increasing the potential for medication error, loss or diversion, can affect all resident□s receiving a narcotic. 3. Nurses and med aids were educated on 1/25/22 on the expectations that all scheduled, and PRN narcotic medication be counted by the nurse/med aid leaving their shift with the nurse/med aid coming on to their shift. PRN and Scheduled Narcotic sheets were revised to include why the medication was wasted, that the Director of Nursing is notified of any missing medication, and that the medication is reordered immediately. The Control Drug Count Policy was updated and revised, and nurses and med aids will be reeducated on 2/15/22 on the revised policy along with the change in Narcotic count sheets. 4. The Director of Nursing or Designee(s) will perform audit checks weekly X 4, monthly X 3, and quarterly X 2 on 10% of the resident□s receiving PRN and Scheduled Narcotics to assure count is	

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F 755	Continued From page 7 01/19/22 at 11:48 a.m., showed Resident #43's medication cartridge labeled "Lyrica 75 mg 1 tablet TID [three times a day] at 1900 [7 PM]." The narcotic count log showed one tablet missing from 12/20/21 to 01/19/22 and staff failed to report the missing narcotic. During an interview on 01/20/22 at 10:29 a.m., a nurse administrator (#1) confirmed staff are expected to immediately report any controlled medication discrepancies.	F 755	appropriate for the week. Further interventions will be determined and implemented if needed.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal	F 761		2/22/22

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F 761	Continued From page 8 and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and staff interview, the facility failed to label and date 4 of 4 opened multi-dose insulin pens and correctly prime 2 of 4 insulin pens observed during medication administration. Failure to correctly label and date insulin pens when opened and correctly prime insulin pens increases the risk of residents receiving outdated medications with reduced efficacy and inaccurate doses of medications. Findings include: Review of the facility policy titled "Insulin Pen Storage and Labeling" occurred on 01/20/22. This policy, revised October 2021, stated, ". . . .To assure appropriate storage and labeling of pens . . . Insulin pens will be dated and initialed when first opened . . ." Review of the facility checklist titled "Insulin Pen Competency checklist" occurred on 01/20/22. This checklist, revised July 2021, stated, ". . . prime pen with 2 units pointing the pen with the needle upwards . . ." - Observation on 01/19/22 at 4:15 p.m., showed opened multi-dose insulin pens for Resident #2, #3, #11, and #28 without an open date or initials. During an interview on 01/20/22 at 11:02 a.m., an administrative nurse (#1) confirmed the insulin pens lacked an open date and initials.	F 761	1. The facility could not immediately label opened insulin pens as open date could not be determined. When reviewing ordered doses for residents receiving insulin it was determined that current insulin pens being used would be used prior to their expiration date. Resident□s currently receiving insulin are administered large enough doses to sufficiently use one insulin pen within amount of time prior to expiration. 2. All residents receiving insulin have the potential to receive outdated medications if insulin is used after its expiration date. All residents receiving insulin have the potential to receive inaccurate doses of insulin if insulin pen is not correctly primed prior to use. 3. Bright yellow labels have been provided in the nurse□s cart which will be applied to all insulins that are opened. Nurses will be required to indicate the date of when the insulin is opened and the date that it is expected to expire. A list of insulins currently used along with the recommended storage time after opened was provided at each nurse□s station. Nurses were educated on 1/25/22 on the requirements on labeling medication with the expiration date when applicable. Another in-service will be held on 2/15/22. Nurses and med aids were reeducated on the Insulin Pen Administration and Insulin Pen Storage and Labeling Policies. Nurses and med aids will be reeducated	

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F 761	Continued From page 9 - Observation during medication administration on 01/19/22 at 4:38 p.m., a nurse (#2) prepared an insulin pen with 22 units of Novolog 70/30 to administer to Resident #28 at the evening meal. The pen was primed in a horizontal position. - Observation during medication administration on 01/19/22 at 4:48 p.m., a nurse (#2) prepared an insulin pen with 12 units of Novolog 70/30 to administer to Resident #2 at the evening meal. The pen was primed in a horizontal position. During an interview on 01/20/22 at 11:02 a.m., an administrative nurse (#1) confirmed the insulin pens should be primed in a vertical position.	F 761	on Administration of Insulin and will be required to provide a return demonstration to assure their competency. Administration of Insulin competencies have been started. 4. The Director of Nursing or Designee(s) will complete a QA on all residents receiving insulin to assure all insulins that have been opened, are labeled appropriately with the date opened and the expiration date. Audits will also be completed on nurses and med aids to assure insulin is primed in the appropriate upright position. This will be done weekly X 4, monthly X 3, and quarterly X 2. Further interventions will be determined and implemented if needed.	
F9999	FINAL OBSERVATIONS Based on observation, record review, policy review, and resident, family, and staff interviews, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		