STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	**1226 1ST AVE N , NEW ROCKFORD, North Dakota, 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
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident and a complaint was completed on June 4, 2025. During the investigation, the facility was found noncompliant with regulatory requirements.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on review of a facility reported incident (FRI) investigation, record review, review of facility policy review, and staff interview, the facility failed to ensure residents have the right to remain free from possible physical abuse/neglect for 1 of 1 sampled resident (Resident #3) with a fracture or unknown source. Failure to provide necessary service to protect residents from physical harm resulted in Resident #3 sustaining a fracture from an unknown source. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following discovery of the incident.	F0600	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N , NEW ROCKFORD, North Dakota, 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
F0600 SS = G	Continued from page 1 Findings include: The surveyor determined a deficient practice existed on 05/26/25. The facility implemented corrective action immediately, completed corrective action on 05/28/25, and continues with staff education and monitoring. Review of the facility policy titled "Safe Operating Procedures (Resident Transfers)" occurred on 06/04/25. This policy, revised September 2023, stated, ". . . Hoyer [full-body mechanical lift] Lift Transfer: . . . Use of 2 staff for all Hoyer lift transfers. . . ." Review of Resident #3's medical record occurred on June 4, 2025. Diagnoses included mild dementia, anxiety, and left-side hemiplegia and hemiparesis following cerebral infarction (stroke). The care plan stated, ". . . Hoyer Lift for all transfers for safety. . . ." The Minimum Data Set (MDS), dated 05/01/25, identified a Brief Interview for Mental Status (BIMS) of 14, indicating cognitively intact, and dependent on staff for all transfers. The facility reported incident investigation, dated 05/28/25, stated, ". . . [nurse's name] was informed by [Certified nurse aide (CNA) #1] at 9 AM on 05/25/25 that [Resident #3] was complaining about her foot hurting during a hoyer lift transfer from her bed prior to her bath and during her bath. [Nurse name] then assed [sic] resident's right ankle as the CNA notice swelling with no visible signs of bruising. . . . Per [nurse's name] resident did not appear in any pain unless her right ankle was physically touched. [Nurse's name] did question resident at time of assessment where she thinks she may have obtained her injury. She reported to this nurse that she fell this AM. She reported a CNA had transferred her without using her correct lift and dropped her. She was unable to state how she got back to bed. She pointed at a CNA in the room [CNA #1's name]. [CNA #1] stated that she did not drop her. . . . Upon questioning [CNA #3's name], who worked . . . the evening before the event . . . [CNA #3] stated . . . she assisted her [Resident #3] to bed via hoyer lift around 8:00 PM . . . It was validated on video that [CNA #3] did go into residents' room during the evening hours with hoyer lift and brought it out after cares. . . . Both [CNA #3's name and CNA #1's name] were suspended . . . It is the facilities responsibility to have 2 staff assist with hoyer transfers. . . . it's inconclusive of what occurred or	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N , NEW ROCKFORD, North Dakota, 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
F0600 SS = G	Continued from page 2 that any willful neglect and/or abuse occurred." A physician's progress note, dated 05/27/25, stated, "[Right] ankle pain [and]swelling. New over weekend. Resident reporting possible fall but resident is a hoyer transfer [with] [left] side paralysis post CVA [stroke]. . . ." Another note dated the same day, stated, "Per my review, appears to have hairline fracture of R) [right] distal fibula, as well as possible hairline fracture of proximal 5th metatarsal. . . ." During an interview on 06/04/25 at 2:50 p.m., an administrative nurse (#4) stated on the evening of 05/25/25 the CNA (#3) transferred Resident #3 to bed with the lift by herself, and the CNA (#1) on the day shift of 05/26/25 confirmed she transferred the resident with the Hoyer lift without a second staff present. The CNA (#1) denied dropping her or bumping her leg on anything. The facility failed to ensure two staff assisted while transferring Resident #3 with a mechanical lift. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions for all residents who may be affected by the deficient practice as follows: * Completed an investigation into Resident #3's ankle fracture. * Both CNAs were suspended from work until completion of the investigation and then terminated. * Re-education regarding following residents' care plans for method of transfer and use of two staff members for Hoyer transfers sent via Smartlinx (electronic) message to all staff and a memo to all nursing staff at nurses' stations on 05/27/25 and again on 06/03/25. * Staff required to sign they received and read the above education.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	**1226 1ST AVE N , NEW ROCKFORD, North Dakota, 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
F0600 SS = G	Continued from page 3 * Orientation for all agency staff included resident transfer methods.	F0600		