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 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, 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 The Standard Medicare/Medicaid recertification survey and complaint and facility reported incident (FRI) surveys started on 08/25/25 and concluded on 08/28/25. During the FRI survey, the facility was found noncompliant with regulatory requirements.	F0000		09/17/2025
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: 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	F0658	Plan of Correction: F0658 1. Deficiency Identification Citation: F0658 – 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. Specifically, staff failed to prime insulin pens correctly and failed to administer medications at the scheduled times, which may impede the therapeutic effectiveness of the medications. Regulation Reference: 42 CFR §483.21(b)(3)(i) – Professional Standards of Quality 2. Corrective Action for Affected Residents and for Other Residents Immediate Actions for Affected Residents: No adverse reactions were identified for Resident #6 and Resident #36. Identification and Protection of Other Residents: No other residents were found to have missed or improperly administered insulin or time-sensitive medications. 3. Systemic Changes	09/22/2025

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 08/28/2025

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F0658 SS = D	Continued from page 1 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.	F0658	Continued from page 1 Policy Update: The Medication Administration Policy was reviewed and revised to include step-by-step procedures for priming insulin pens and ensuring timely medication administration, referencing current professional standards and manufacturer guidelines. Staff Education & Competency: Immediate education was provided for identified staff on the day of deficient practice. Licensed nursing staff received re-education on: 08/29/2025 through communication on Point Click Care Dashboard and again on 09/02/2025 via Weekly Communication Document of preliminary survey results. On 09/18/2025 licensed nursing staff received mandatory in-service training again on final state survey results related to the following: Proper priming and administration of insulin pens. The importance of adhering to scheduled medication times. Documentation requirements for medication administration. Competency Validation: Licensed nurses were required to demonstrate competencies in insulin pen priming and administration, as well as understanding of medication timing protocols, with return demonstration observed by the Director of Nursing. 4. Monitoring and Quality Assurance Medication Administration Audits: The Director of Nursing or designee will conduct random audits of medication administration, including insulin pen use and medication timing, for 5% of residents weekly for 4 weeks, then monthly for 3 months. Quality Assurance and Performance Improvement (QAPI): Audit results and any identified trends will be reviewed monthly at the QAPI committee meeting. Additional corrective actions will be implemented as needed based on findings.	

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F0658 SS = D		F0658	Continued from page 2 Resident Monitoring: Ongoing monitoring of residents receiving insulin and time-sensitive medications for adverse effects. 5. Responsible Parties Director of Nursing (DON)/ Designee 6. Compliance Date The facility will be in full compliance with F0658 by: 09/22/2025 This plan of correction constitutes our credible allegation of compliance. We respectfully request consideration for removal of the cited deficiency upon validation of sustained compliance.	
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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:	F0689	Plan of Correction: F0689 1. Deficiency Identification Citation: F0689 – Free of Accident Hazards/Supervision/Devices Regulation: 42 CFR §483.25(d) Deficiency: Based on record review, facility policy review, 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. The facility did not ensure Resident #36's extremities remained within the frame of the wheelchair and were supported while loading her into the van, resulting in a major injury to her left foot. 2. Corrective Action for Residents Affected and for Other Residents Immediate Action for Resident #36: Resident #36 was assessed immediately following the incident by ER staff and provided treatment. Resident #36's care plan was reviewed and updated to include specific interventions for safe van transport, including additional supervision and use of assistive devices to secure extremities.	09/22/2025

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F0689 SS = G	Continued from page 3 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	F0689	Continued from page 3 Identification and Protection of Other Residents: All residents had their care plans reviewed for appropriate supervision and assistive device needs. Immediate re-education was provided to all staff involved in resident transport regarding safe loading/unloading procedures and the importance of supporting resident extremities. 3. Systemic Changes Facility policy on resident transport was reviewed and revised to include: Step-by-step procedures for safe loading/unloading of residents, with emphasis on extremity support. All staff responsible for resident transport received in-service training on the revised policy and procedures. Immediate education was provided for identified staff on 07/01/2025 & again on 08/29/2025 through communication on Point Click Care Dashboard and again on 09/02/2025 via Weekly Communication Document of preliminary survey results. On 09/18/2025 staff received mandatory in-service training again on final state survey results related to the safe van transportation. 4. Monitoring and Quality Assurance The Director of Nursing or designee will conduct a van transport audit 1 time a week for four weeks, then monthly for three months, and quarterly thereafter to ensure compliance with revised procedures. Audit results will be reviewed at the facility’s monthly Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will result in immediate	

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F0689 SS = G	Continued from page 4 [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 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.	F0689	Continued from page 4 re-education and corrective action. Ongoing monitoring will be incorporated into the facility's routine quality assurance program. 5. Responsible Parties Director of Nursing Designee 6. Compliance Date The facility will be in full compliance with F0689 by: 09/22/2025 This plan of correction constitutes our credible allegation of compliance. We respectfully request consideration for removal of the cited deficiency upon validation of corrective actions.	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the	F0880	1. Deficiency Identification Citation: F0880 – Infection Prevention & Control Regulation: 42 CFR §483.80(a)(1)(2)(4)(e) Deficiency: 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. Specifically, staff did not adhere to proper hand hygiene and glove use, which has the potential to spread infection throughout the facility. 2. Corrective Action for Residents Affected and for Other Residents Immediate Actions for Affected Residents No adverse outcomes were identified for Residents #3 and #6 The staff members involved received re-education on proper hand hygiene and glove use per facility policy.	09/22/2025

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F0880 SS = D	Continued from page 5 facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP	F0880	Continued from page 5 Actions for Other Residents No additional residents were found to be affected. On 08/29/2025 all nursing staff were provided education through communication on Point Click Care Dashboard and again on 09/02/2025 via Weekly Communication Document regarding preliminary survey results. 3. Systemic Changes Facility infection control policy and procedure for hand hygiene and glove use was reviewed and revised as needed to ensure alignment with CDC and CMS guidelines. On 09/18/2025 nursing and direct care staff received mandatory in-service training again on final state survey results related to infection control practices, with emphasis on hand hygiene and glove use. 4. Monitoring and Quality Assurance The Infection Preventionist or designee will conduct 5% of random audits for hand hygiene and glove use during resident care weekly times 4 weeks, then monthly for 3 months. Audit results will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Any identified non-compliance will result in immediate re-education. Ongoing infection surveillance will be conducted to monitor for any increase in infection rates. 5. Responsible Parties Director of Nursing (DON)/Designee Infection Preventionist/Designee 6. Compliance Date The facility will be in full compliance with F0880 by:	

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F0880 SS = D	Continued from page 6 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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	F0880	Continued from page 6 09/22/2025 This plan of correction constitutes our credible allegation of compliance. We respectfully request consideration for removal of the cited deficiency upon validation of corrective actions.	

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F0880 SS = D	Continued from page 7 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.	F0880		