DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 48T6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00285

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245429**
2.STATE VENDOR OR MEDICAID NO.
(L2) **068252700**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWEETEN LUTHERAN HEALTH CARE CENTER**
(L4) **125 5TH AVENUE SOUTHEAST**
(L5) **SPRING GROVE, MN** (L6) **55974**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/15/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 12/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/18/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245429

December 18, 2014

Ms. Michelle Borreson, Administrator
Tweeten Lutheran Health Care Center
125 5th Avenue Southeast
Spring Grove, Minnesota 55974

Dear Ms. Borreson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 10, 2014 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 17, 2014

Ms. Michelle Borreson, Administrator
Tweeten Lutheran Health Care Center
125 5th Avenue Southeast
Spring Grove, Minnesota 55974

RE: Project Number S5429024

Dear Ms. Borreson:

On November 12, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 24, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2014, effective December 10, 2014 and therefore remedies outlined in our letter to you dated November 12, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245429	A. Building B. Wing	12/15/2014

Name of Facility	Street Address, City, State, Zip Code
TWEETEN LUTHERAN HEALTH CARE CENTER	125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **11/21/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/10/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/10/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/10/2014**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/10/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GPN/kf	**Date:** 12/17/2014	**Signature of Surveyor:** 19694	**Date:** 12/15/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/31/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245429	A. Building / B. Wing: **01 - MAIN BUILDING 01**	11/24/2014

Name of Facility	Street Address, City, State, Zip Code
TWEETEN LUTHERAN HEALTH CARE CENTER	125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0052	Correction Completed **11/14/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	12/17/2014	25822	11/24/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/30/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 48T6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00285

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245429**
2.STATE VENDOR OR MEDICAID NO.
(L2) **068252700**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWEETEN LUTHERAN HEALTH CARE CENTER**
(L4) **125 5TH AVENUE SOUTHEAST**
(L5) **SPRING GROVE, MN** (L6) **55974**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/31/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 11/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/17/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 12, 2014

Ms. Michelle Borreson, Administrator
Tweeten Lutheran Health Care Center
125 5th Avenue Southeast
Spring Grove, Minnesota 55974

RE: Project Number S5429025

Dear Ms. Borreson:

On October 31, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached

deficiencies.
Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 10, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 10, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its

effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will

recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 31, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies.

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,
Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTER	**125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974**

(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 facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		11/21/14

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

Electronically Signed | 11/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTER	**125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974**

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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R53) reviewed for Medicare denial letters had identified whether or not to submit the bill to Medicare for review. Findings Include: R53 was discharged from Medicare on 8/20/14, due to daily skilled care not needed, according to the Notice of Exclusions from Medicare Benefits Skilled Nursing Facility (NEMB-SNF), issue dated of 8/18/14. Document review of facility NEMB-SNF, issue dated of 8/18/14, revealed a family member was notified of Medicare non coverage by voicemail on 8/18/14 and signed the NEMB-SNF on	F 156	F156 Gundersen Tweeten Care Center will continue to inform each resident before or at the time of admission, and periodically during the resident□s stay of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility□s per diem rate. The facility will ensure that all Medicare Denial forms are completed in full. The DON will continue to notify residents with a minimum of 48 hours□ notice of a Medicare Denial notice. The Office Manager will monitor all forms to ensure that forms are completed in full.	

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F 156	Continued From page 3 8/19/14. The Medicare denial letter lacked decision to submit or not submit bill to Medicare for review. On 10/29/14 at 9:46 a.m. the director of nursing (DON) verified R53 was discharged from Medicare Part A services and still resided in the facility. The DON verified R53's NEMB-SNF lacked decision to submit or not submit the bill to Medicare for review. The DON verified that there was no policy concerning the procedure for demand bill and stated the facility follows the regulation.	F 156		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 5 of 5 residents (R22, R38, R20, R19 and R34) who ate in the main dining room and required assistance to eat their meals and in addition the facility failed to ensure personal cares were provided in a dignified manner for 1 of 1 residents (R24) reviewed for dignity. Findings Include: R22, R38, R20, R19, and R34 were observed during a dining experience on 10/27/14 starting at	F 241	F241 Gundersen Tweeten Care Center will continue to promote care for residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. All staff were re-educated on what a dignified dining experience should look like including to ensure you are at the same level if possible when assisting residents, not making the resident feel hurried, ensuring mealtimes are pleasant, and giving the resident(s) your complete attention. Along with this, all nursing staff were	12/10/14

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F 241	Continued From page 4 5:00 p.m. R20 and R19 were seated at the same table and R22, R38 and R34 were seated at the same table in the main dining room. Nursing assistant (NA)-C was observed to walk back and forth between R38, R22, R19, R20 and R34 and noted to stand by their wheelchairs and assist them to eat by giving a few bites then moving on to another resident, giving a few bites then moving on to another resident and this was continued for all five residents. At 5:25 p.m. NA-C was observed to leave the dining room and there was no staff assisting the five identified residents to eat their meals. NA-C returned to the dining room at 5:26 p.m. and resumed assisting all five residents to eat. Nursing assistants (NA)-A and (NA)-B were observed to enter the dining room between 5:26 p.m. and 5:31 p.m. and NA-A, NA-B and NA-C were all three observed to walk back and forth between the 5 identified residents, stand by their wheelchairs and assist them to eat a few bites and drink a few sips of their meals. At 5:31 p.m. NA-A, NA-B and NA-C retrieved a dining room chair and sat down between the five identified residents and assisted them to eat the rest of their meals. On 10/27/14 at 5:35 p.m. NA-C verified she walked back and forth between R22, R38, R20, R19 and R34, stood by their wheelchairs and assisted them to eat. NA-C stated there were usually black stools in the dining room for staff to sit on when they assisted residents to eat, but she wasn't sure where they were. NA-C stated, "Staff should feed two residents at a time" and stated it was, " not very good to feed five residents at a time." R38 was observed during a dining experience on 10/28/14 starting at 11:46 a.m. NA-D was	F 241	re-educated on what a dignified manner of assisting residents with their ADLs includes. All nursing assistants will be required to demonstrate proficiency with ADL skills. ADL monitoring will be done by charge nurses and the interdisciplinary team weekly x1 month and then monthly x6 if no problems are found.	

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F 241	Continued From page 5 observed to be standing by R38's wheelchair assisting her to eat lunch. R38's nutritional care plan dated 7/16/14 read, "Resident has a HX [history] of weight loss R/T [related to] poor intakes/advancing Alzheimer's/depression. Current body weight 128# [pounds]. Acceptable body weight 120-130#. Interventions Included: liquefied puree with small servings and supplements. Serve all foods from cup. Provide full assistance for meals." The quarterly Minimum Data Set (MDS) dated 10-7-14 indicated R38 required total dependence of 1 staff for eating. The nutrition therapy re-assessment dated 10/230/14 indicated R34 required the following assistance with dining needs: totally dependent for eating. R22's nutritional care plan dated 11/08/14 read, "Staff to feed R22 all meals ... Offered a liquefied puree diet. May serve from mug prn [as needed] for optimal intake, and small servings." The quarterly MDS dated 8-5-14 indicated R22 required total dependence of 1 staff for eating. The nutrition therapy re-assessment dated 5/7/14 indicated R22 required the following assistance with dining needs: totally dependent for eating. R19 care plan dated 2/7/12 read, "Staff to assist with meals as needed." The annual MDS dated 9-23-14 indicated R19 required total dependence of 1 staff for eating. The nutrition therapy re-assessment dated 4/4/14 indicated R22 required the following assistance with dining needs: totally dependent for eating. R20's care plan dated 10/11/13 read, " Staff to feed all meals ... Offered a pureed diet with small servings. Liquefy prn [as needed]. " The annual	F 241		

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F 241	Continued From page 6 MDS dated 10-7-14 indicated R20 required total dependence of 1 staff for eating. The nutrition therapy re-assessment dated 4/10/14 indicated R20 required the following assistance with dining needs: totally dependent for eating. R34's nutritional status care plan dated 10/20/11 indicated she was on a general diet with small servings and staff to assist with eating as needed (PRN). The quarterly MDS dated 8/12/14 indicated R34 required extensive assist of one staff for eating. The nutrition therapy re-assessment dated 8/20/14 indicated R34 required the following assistance with dining needs: tray set up, supervise, cue and assist. Comments: Cue/assist with feeding PRN. R34 can be resistive to staff feeding. On 10/29/14 at 11:00 a.m. the director of nursing (DON) stated she expected staff to be seated and to assist two residents at a time. The DON verified feeding five residents at one time and standing by their wheelchairs as they were assisted to eat would not be a dignified dining experience. These comments were made in regards to the observations of R22, R38, R20, R19 and R34. On 10/29/14 at 11:09 a.m. the dietary director (DD)-A stated she would expect staff to sit between residents and be at eye level with them when they assisted residents with their meals. The DD-A verified feeding multiple residents at the same time between two tables and standing by their wheelchairs when assisting them to eat was not providing residents with a dignified dining experience. Review of Feeding the Resident (Dependent	F 241		

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F 241	Continued From page 7 Eating) undated procedure read, "8. Never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident if possible." Review of the Quality of Life Policy undated read, "Quality of Life. The facility will care for residents in a manner and environment that promotes maintenance or enhancement of each resident's quality of life, including dignity and respect with full recognition of his/her individuality." The resident bill of rights dated 7/1/07, read, "Facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality." Lack of promoting dignity when resident requested assistance for toileting: R24's quarterly MDS dated 7/22/14, revealed R24 had diagnoses of cerebrovascular accident and hemiplegia. R24 had a brief interview for mental status score of 12, which indicated moderate cognitive impairment and had clear comprehension with ability to understand others. R24 required extensive assistance with two staff with toileting, dressing, personal hygiene, bed mobility and transfers. During an interview on 10/27/14 at 4:50 p.m. family member (FM)-A shared a concern regarding the following incident. R24 told a staff member he needed to go to the bathroom and was told to, " Just go [urinate or stool] in your pants as he would be getting a bath that day." FM-A stated R24 asked the staff member, " Is	F 241		

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F 241	Continued From page 8 that what your mom told you, when you were little?" FM-A stated the staff member did then help R24 to the bathroom. FM-A stated she reported this concern to a staff person. During an interview on 10/29/14 at 2:34 p.m. social services (SS)-A stated FM-A discussed this concern at the care conference held on 5/1/14, however verified the facility had no documentation regarding this concern or if a facility investigation was completed. SS-A verified it was a dignity concern to tell a resident to go to the bathroom in their pants.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		12/10/14

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F 279	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop dialysis care plan interventions for 1 of 1 resident (R13) in the sample who received dialysis services. Findings include: R13 was admitted 10/26/13, with diagnosis that included renal insufficiency and heart failure according to the facility face sheet. The facility identified (R13) on the annual Minimum Data Set (MDS), an assessment dated 7/29/14, to have intact cognition and received dialysis. R13's care plan dated 11/6/13 was reviewed. Although the care plan directed staff to administer pain medication when R13 returned from dialysis on Monday, Wednesday, and Friday, there was no other identification of dialysis interventions for staff. The care plan lacked vital information in regards to location of fistula site, monitoring and identification of the fistula site, medications to administer or hold for dialysis, dialysis protocols and emergency protocols. During interview on 10/29/14, at 1:30 p.m., director of nursing verified R13's care plan lacked identification of dialysis, including location of fistula site, monitoring and identification of fistula site, medications to administer or hold for dialysis, dialysis protocols and emergency protocols.	F 279	F279 Gundersen Tweeten Care Center will continue to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Dialysis care plan interventions were added to the comprehensive care plan for Resident (R13). All other residents□ care plans were reviewed and updated as needed to ensure care plan is comprehensive. IDT will monitor at quarterly care plan conferences.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		12/10/14

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F 282	Continued From page 10 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the care plan to monitor pressure ulcers for 1 of 2 residents (R57) in the sample with pressure ulcers. Findings include: R57 was admitted to the facility on 6/9/14, with diagnosis that included malignant bladder cancer with metastasis and palliative care, according to physician orders dated 6/9/14. R57 had been admitted to hospice on 3/22/14, according to hospice face sheet. The facility identified R57 on the admission Minimum Data Set (MDS), an assessment dated 6/19/14, to have moderate cognitive impairment, required extensive assistance of two staff for activities of daily living, at no risk for pressure ulcers, was admitted with no pressure ulcers, and had an open lesion. Document review of facility care area assessment (CAA) for pressure ulcers dated 6/22/14 identified no risk for pressure ulcers. CAA did not identify right leg ulcer. Document review of the facility skin risk assessment dated 6/9/14, identified terminal illness, wound on lower leg, open lesion other than ulcer, not at risk of developing pressure	F 282	F282 Gundersen Tweeten Care Center will continue to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident□s written plan of care. Wound nurse was re-educated on the wound monitoring policy. All other residents with wounds will be monitored according to the wound monitoring policy as well. DON to monitor weekly.	

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F 282	Continued From page 11 ulcers. Document review of facility skin risk assessment dated 6/24/14, revealed wound on right leg, open lesion other than ulcer, "healing site on right leg which was open on admission d/t (due to) pressure from cath (catheter) line and elastic," and at risk for developing pressure ulcers related to decline and less mobile. Document review of facility skin risk assessment dated 6/27/14, revealed wound on right leg, excoriation on perirectal area and coccyx, " healing site on right leg which was open on admission d/t (due to) pressure from cath (catheter) line and elastic. Have moved cath tubing to other leg, wash with soap and water daily. Has excoriated area stage 1 on coccyx. Has excoriated area stage 1 below scrotum; both sites not present last week. Barrier cream applied and turn/reposition q2hrs (every two hours), offer bowel toileting q2hrs," and at risk for developing pressure ulcers related to decline and less mobile. Document review of facility skin integrity conditions dated 6/25/14, revealed " coccyx small open area noted about the size of a dime. Barrier cream applied will continue to monitor, " and no tunneling, no exudate, and surrounding tissue erythema. Document review of R57 ' s care plan dated 6/27/14, revealed pressure ulcer on admission on lower right leg, excoriated site on coccyx. Goal "ulcer on coccyx will heal without complications." Interventions included assess and record condition of skin around the pressure ulcer, assess pressure ulcer for location, stage, size	F 282		

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F 282	Continued From page 12 (length, width, and depth), presence/absence of granulation tissue and epithelization. Goal- right lower leg ulcer will not increase in size and will not exhibit signs of infection. Interventions included all the same as for the coccyx ulcer and in addition to assess site weekly. Care plan treatment included stage 2 wound on right lower leg, wash with soap and water, pat dry, apply Combiderm, once an evening on Sunday and Thursday. Document review of facility progress notes dated 6/9/14, revealed R57 was admitted from Mayo Hospice, had indwelling Foley catheter, and right leg had stage 2 wound on admit related to rubbing of catheter straps. Facility progress notes dated 6/25/14, revealed a dime size open area on coccyx. Facility progress notes dated 7/3/14, revealed right shin dressing change and noticed what appeared to be a new opening next to the old wound. Document review of facility weekly wound summary revealed the following wound monitoring: 6/11/14--right shin pressure wound measured 0.6 by 0.6 and 0.5 by 0.2 6/18/14-- right shin pressure measured 0.6 by 0.6 and 0.5 by 0.2 and "Hospice does" 6/24/14--right shin "Hospice does" Document review of physician orders dated 6/12/14, revealed orders for stage 2 wound on right lower leg, wash with soap and water, pat dry, apply Combiderm Sunday and Thursday. Document review of facility treatments administration history dated 6/9/14-7/11/14,	F 282		

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	245429	A. BUILDING _____ B. WING _____	10/31/2014

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F 282	Continued From page 13 revealed the following: Stage 2 wound on lower right leg, start date of 6/12/14--wash with soap and water, pat dry, apply Combiderm Sunday and Thursday. Documentation revealed treatment completed on 6/12, 15, and 22, 26, 29/14, and 7/3/14. Documentation on 6/19/14, revealed done by hospice. Barrier cream to area on coccyx, start date of 6/25/14. Treatments were documented done as ordered. Document review of hospice visit documentation dated 6/9/14 to 7/7/14 revealed the following: 6/12/14--right shin dressing changed. Site pretty much healed. 6/30/14--right shin dressing changed and has small amount bloody drainage. 6/19/14--minor redness on bottom. Dressing changed over right shin, has minor scabbing. 6/23/14--skin looks ok. Bottom fine. 6/30/14-barrier cream to bottom, red but not open. 7/7/14-right shin dressing changed which has a red open area and a scab present. Barrier to the coccyx. Although treatments were provided as ordered, the facility failed to provide evidence of wound monitoring according to the care plan. The facility measured the shin two times, did not identify if measurements were inches or centimeters, did not identify, stage, size, undermining,/tunneling, wound bed, drainage, need for debridement, and presence of odor. The facility described the coccyx ulcer as dime size with no measurements and no other description available. Document review of facility skin integrity policy	F 282		

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F 282	Continued From page 14 dated 10/31/08, revealed the following: "1. All residents are screened by a Registered Nurse upon admission for pressure ulcer risk by using a Braden Scale and Skin Care Risk Factors/Intervention form." "3. ....NOTE: ANYONE BEING ADMITTED WITH A PRESSURE ULCER OR HISTORY OF PRESSURE ULCERS IS IMMEDIATELY PLACED INTO THE HIGH RISK CATEGORY." "4. Treatments for exiting ulcers and/or prevention of ulcers for high risk residents will be communicated to staff through the care plan and TAR." "5 ... The assessment includes location, stage, size, undermining,/tunneling, wound bed, drainage, need for debridement, and presence of odor. The effectiveness of the pressure ulcer management/treatment approach for each resident having a pressure ulcer is monitored with weekly wound measurements. During interview on 10/30/14, at 11:00 a.m., director of nursing verified R57 had right shin pressure ulcer on admit and developed coccyx pressure ulcer on 6/25/14. She stated she expected weekly wound monitoring according to facility policy and care plan. Director of nursing verified the facility lacked evidence of weekly monitoring of R57 ' s leg ulcer and coccyx ulcer.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		12/10/14

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F 309	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor 24 hour fluid restriction for 1 of 1 resident (R13) with physician ordered fluid restriction. Findings include: R13 was admitted 10/26/13, with diagnosis that included stage 3 kidney disease and dialysis, according to the facility resident admission record. The facility identified (R13) on the annual minimum data set (MDS), an assessment dated 7/29/14, to have intact cognition, independent in eating, received mechanically altered therapeutic diet, and received dialysis. Document review of nutrition therapy assessment dated 8/1/14, page 2, comments, read, and " Fluid intake low even considering restriction " . Document review of facility care area assessment dated 8/7/14, revealed nutritional status, 1500 cc fluid restriction and proceed to care plan. Observations on 10/27/14, at 4:20 p.m., revealed R13 returned from dialysis. Dialysis site located on right upper chest, covered with clear dressing, clean and dry. During interview at that time, R13 stated she received dialysis Monday, Wednesday, and Friday. Observations at that time revealed ½ glass of water on R13's over the bed table.	F 309	F309 Gundersen Tweeten Care Center will continue to ensure that each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. R13 continues to remain within the 1500cc fluid restriction as ordered. All other residents on fluid restrictions were reviewed and found to remain within their fluid restrictions as well. System was reviewed and revised to have an up-to-date posting of all residents on fluid restrictions for all staff, policy revised on fluid restrictions, and electronic medical record revised to have all fluid intakes recorded under the vitals section of the resident□s chart and tally fluid totals. RD will monitor weekly and a monthly summary will be documented on all residents with fluid restrictions.	

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F 309	Continued From page 16 Observations on 10/28/14, at 5:35 p.m., revealed R13 feeding self-supper in the facility dining room. Fluids at that time included ½ glass each of milk, juice, water, and 1/2 cup of coffee. During interview at 5:46 p.m., dietary aide-A (DA)-A stated R13 received 60 cubic centimeters (cc) of each fluid provided. DA-A stated R13 fluid intake for that meal was a total of 40 cc. Document review of R13's care plan dated 11/27/12, directed R13 required 1500 cc fluid restriction according to physician orders. Goal: encourage to remain within 1500 cc fluid restriction daily. Interventions included dietary to provide 780 cc daily, nursing 720 cc (3 glasses) daily, activities to give 120 cc (1/2 glass) daily. Fluids monitored and recorded each meal. Document review of physician orders dated 2/5/14, revealed orders for 1500 cc fluid restriction. Document review of facility fluid restriction instructions dated 1/24/14, for 1500 cc restriction, revealed the following: Dietary to serve 660 cc daily, nursing to give 720 cc daily, activities to give 120 cc daily. Document review of facility treatments administration history dated 10/1/14 to 10/29/14, read, "Record amount of fluids offered by nursing this shift," frequency "Every Shift," "Special Instructions: With 1500 cc fluid restriction dietary to serve 780 cc daily, nursing to provide 720 cc (3 glasses) daily, activities to give 120 cc (1/2 glass) daily. Start date of 2/22/14." Review of this document revealed amount of fluids offered by nursing each shift.	F 309		

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F 309	Continued From page 17 Document review of vitals results facility fluid monitoring dated 10/1/14 to 10/29/14, revealed dietary fluid monitoring one to three times a day. Monitoring included 27 times -no fluids recorded during that time period. Document review of dialysis clinical support notes dated 10/1/14 to 10/27/14, revealed total fluids removed at dialysis ranged from 1.46 kilograms (kg) to 3.14 kg. During interview on 10/29/14, at 1:35 p.m., dietary director stated she did not review 24 hour fluid totals. She verified fluid monitoring was not reviewed with interdisciplinary notes dated 8/7/14. During interview on 10/29/14, at 9:00 a.m., nursing assistant (NA)-E stated R13 requested ice water. NA-E stated did not keep track of how much fluids R13 drank and did not tell the nurse how much fluids provided to R13. During interview on 10/29/14, at 9:03 a.m., licensed practical nurse (LPN)-A stated fluids provided in the dining room are charted by dietary department and fluids provided by nursing are charted by nursing. LPN-A stated she was not aware of who monitored 24 hour fluid totals. During interview on 10/29/14, at 9:10 a.m., NA-H and NA-G stated R13 used to be on 1500 cc fluid restriction when weight was higher but is not on restriction now. NA-H and NA-G stated nursing assistants only write down fluid intake if the nurse asked for it. Both stated they do not write down or report fluid intakes for R13. During interview on 10/29/14, at 9:17 a.m., NA-H	F 309		

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F 309	Continued From page 18	F 309		

and NA-G returned to tell surveyor that R13 received 720 cc fluids, about 3 glasses a day from the floor; charge nurse charts this and will ask nursing assistants about intake. Both stated R13 was on a "strict schedule" of a glass in morning, afternoon, and evening. They stated the nurse writes down 720 cc and if nursing assistants give more or less, they report to the nurse.

During interview on 10/29/14, at 11:35 a.m., dietary director verified R13 was on physician ordered 1500 cc fluid restriction. She stated dietary staff recorded fluid intake with each meal in the dining room. She stated nursing department did their own fluid monitoring. When asked who monitored 24 hour fluid intake totals, dietary manager stated she and director of nursing "periodically" looked at fluid intake. Dietary director stated R13 is very compliant. Dietary director stated fluid totals were on the computer under vital signs. Reviewed computer fluid intake at that time with dietary director, who verified all the zero entries. She stated she did not know what fluids R13 received at dialysis. Dietary director stated the quarterly nutrition therapy assessment completed with the MDS, reviewed fluid intakes. Reviewed most recent quarterly nutrition therapy assessment dated 8/1/14, with dietary director. She verified the assessment identified 1500 cc fluid restriction, intervention was to "encourage 1500 cc fluid limit daily," and verified that was her monitoring of fluid restriction intakes.

During interview on 10/29/14, at 11:45 a.m., director of nursing stated nurses document fluid intake on electronic treatment sheet. Director of nursing verified no staff monitored 24 hour fluid

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F 309	Continued From page 19 restriction totals. Although the facility documented fluids provided by nursing, it did not monitor amount of fluids taken, did not consistently monitor fluid intake by dietary, did not monitor fluids provided by nursing assistants or at dialysis. The facility did not monitor physician ordered 1500 cc fluid restriction.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and monitor pressure ulcers for 2 of 2 residents reviewed (R57, R62) in the sample. Findings include: R57 was admitted to the facility on 6/9/14, with diagnosis that included malignant bladder cancer with metastasis and palliative care, according to physician orders dated 6/9/14. R57 had been admitted to hospice on 3/22/14, according to hospice face sheet.	F 314	F314 Gundersen Tweeten Care Center will continue to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual□s clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Wound nurse was re-educated on the wound monitoring policy. All other residents with wounds will	12/10/14

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F 314	Continued From page 20 The facility identified R57 on the admission Minimum Data Set (MDS), an assessment dated 6/19/14, to have moderate cognitive impairment, required extensive assistance of two staff for activities of daily living, at no risk for pressure ulcers, was admitted with no pressure ulcers, and had an open lesion. Document review of facility care area assessment (CAA) for pressure ulcers dated 6/22/14 identified no risk for pressure ulcers. CAA did not identify right leg ulcer. Document review of the facility skin risk assessment dated 6/9/14, identified terminal illness, wound on lower leg, open lesion other than ulcer, not at risk of developing pressure ulcers. Document review of facility skin risk assessment dated 6/24/14, revealed wound on right leg, open lesion other than ulcer, "healing site on right leg which was open on admission d/t (due to) pressure from cath (catheter) line and elastic," and at risk for developing pressure ulcers related to decline and less mobile. Document review of facility skin risk assessment dated 6/27/14, revealed wound on right leg, excoriation on perirectal area and coccyx, " healing site on right leg which was open on admission d/t (due to) pressure from cath (catheter) line and elastic. Have moved cath tubing to other leg, wash with soap and water daily. Has excoriated area stage 1 on coccyx. Has excoriated area stage 1 below scrotum; both sites not present last week. Barrier cream applied and turn/reposition q2hrs (every two	F 314	be monitored according to the wound monitoring policy as well. DON to monitor weekly.	

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F 314	Continued From page 21	F 314		

hours), offer bowel toileting q2hrs," and at risk for developing pressure ulcers related to decline and less mobile.

Document review of facility skin integrity conditions dated 6/25/14, revealed " coccyx small open area noted about the size of a dime. Barrier cream applied will continue to monitor, " and no tunneling, no exudate, and surrounding tissue erythema.

Document review of R57 ' s care plan dated 6/27/14, revealed pressure ulcer on admission on lower right leg, excoriated site on coccyx. Goal "ulcer on coccyx will heal without complications." Interventions included assess and record condition of skin around the pressure ulcer, assess pressure ulcer for location, stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization.

Goal- right lower leg ulcer will not increase in size and will not exhibit signs of infection. Interventions included all the same as for the coccyx ulcer and in addition to assess site weekly. Care plan treatment included stage 2 wound on right lower leg, wash with soap and water, pat dry, apply Combiderm, once an evening on Sunday and Thursday.

Document review of facility progress notes dated 6/9/14, revealed R57 was admitted from Mayo Hospice, had indwelling Foley catheter, and right leg had stage 2 wound on admit related to rubbing of catheter straps. Facility progress notes dated 6/25/14, revealed a dime size open area on coccyx. Facility progress notes dated 7/3/14, revealed right shin dressing change and noticed what appeared to be a new opening next

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F 314	Continued From page 22 to the old wound. Document review of facility weekly wound summary revealed the following wound monitoring: 6/11/14--right shin pressure wound measured 0.6 by 0.6 and 0.5 by 0.2 6/18/14-- right shin pressure measured 0.6 by 0.6 and 0.5 by 0.2 and "Hospice does" 6/24/14--right shin "Hospice does" Document review of physician orders dated 6/12/14, revealed orders for stage 2 wound on right lower leg, wash with soap and water, pat dry, apply Combiderm Sunday and Thursday. Document review of facility treatments administration history dated 6/9/14-7/11/14, revealed the following: Stage 2 wound on lower right leg, start date of 6/12/14--wash with soap and water, pat dry, apply Combiderm Sunday and Thursday. Documentation revealed treatment completed on 6/12, 15, and 22, 26, 29/14, and 7/3/14. Documentation on 6/19/14, revealed done by hospice. Barrier cream to area on coccyx, start date of 6/25/14. Treatments were documented done as ordered. Document review of hospice visit documentation dated 6/9/14 to 7/7/14 revealed the following: 6/12/14--right shin dressing changed. Site pretty much healed. 6/30/14--right shin dressing changed and has small amount bloody drainage. 6/19/14--minor redness on bottom. Dressing changed over right shin, has minor scabbing. 6/23/14--skin looks ok. Bottom fine.	F 314		

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F 314	Continued From page 23 6/30/14-barrier cream to bottom, red but not open. 7/7/14-right shin dressing changed which has a red open area and a scab present. Barrier to the coccyx. Although treatments were provided as ordered, the facility failed to provide evidence of wound monitoring according to the care plan. The facility measured the shin two times, did not identify if measurements were inches or centimeters, did not identify, stage, size, undermining,/tunneling, wound bed, drainage, need for debridement, and presence of odor. The facility described the coccyx ulcer as dime size with no measurements and no other description available. Document review of facility skin integrity policy dated 10/31/08, revealed the following: "1. All residents are screened by a Registered Nurse upon admission for pressure ulcer risk by using a Braden Scale and Skin Care Risk Factors/Intervention form." "3. ....NOTE: ANYONE BEING ADMITTED WITH A PRESSURE ULCER OR HISTORY OF PRESSURE ULCERS IS IMMEDIATELY PLACED INTO THE HIGH RISK CATEGORY." "4. Treatments for exiting ulcers and/or prevention of ulcers for high risk residents will be communicated to staff through the care plan and TAR." "5 ... The assessment includes location, stage, size, undermining,/tunneling, wound bed, drainage, need for debridement, and presence of odor. The effectiveness of the pressure ulcer management/treatment approach for each resident having a pressure ulcer is monitored with weekly wound measurements.	F 314		

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F 314	Continued From page 24 During interview on 10/30/14, at 11:00 a.m., director of nursing verified R57 had right shin pressure ulcer on admit and developed coccyx pressure ulcer on 6/25/14. She stated she expected weekly wound monitoring according to facility policy and care plan. Director of nursing verified the facility lacked evidence of weekly monitoring of R57 ' s leg ulcer and coccyx ulcer.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor weights and reassess for significant weight loss for 1 of 3 residents (R51) who had been reviewed for nutritional status. Findings Include: R51's admission Minimum Data Set (MDS) dated 10-1-14, identified diagnoses of Alzheimer ' s disease, dementia and depression. A brief interview for mental status (BIMS) score of 5	F 325	F325 Gundersen Tweeten Care Center will continue to ensure that a resident (1) maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident□s clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem. Electronic health record was updated to notify staff of significant weight changes and staff was educated on this system improvement. All other residents	12/10/14

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TWEETEN LUTHERAN HEALTH CARE CENTER	125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974

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F 325	Continued From page 25 indicated severe cognitive impairment and needed supervision of one staff member for eating. Review of R51's weights was documented as follows: 9-19-14: (admission weight) 130 lbs. (pounds) 9-29-14: 130 10-4-14: 116 10-23-14: 110 R51 had a 20 lbs. weight loss in the first 35 days since admission; this was 15.38% weight loss. The initial nutritional therapy assessment dated 9/23/14 read R51, "... Weight 130 lbs., Diet Order: Regular ...Portion size: Regular ...Nutrition Prescription & Intervention: ...Continue with regular servings diet until eating pattern established. Adjust nutrition prn [as needed]. Nutrition Monitoring: weight, labs and diet." R51's care nutritional care plan dated 9/29/14 read, " R51 weighs 130# (pounds). R51 will be encouraged to remain within DBW (desirable body weight) range of 125-135# [pounds] over the quarter. Approach Start Date: 09/29/2014 Weighed weekly x [times] 4 weeks then monthly or per MD order." On 10/29/14 at 11:13 a.m. the dietary director (DD)-A stated she looked at residents ' weights on a monthly basis after the initial nutritional assessment was completed. The DD-A stated nursing staff entered the weights into the computer but did not monitor the weights for weight loss. The DD-A stated she noticed R51's weight loss on 10/29/14 as she was getting ready to complete the monthly review. The DD-A stated	F 325	were reviewed for weight loss and RD will continue to monitor residents experiencing weight loss and inform physician as necessary. Case managers to monitor weights according to individual resident□s orders and needs.	

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with the current facility system for monitoring weights it could be a month after a new admission before a weight loss was noticed for residents as this is when she looked at residents for weight loss. The DD-A verified R51 had a 20 lbs. weight loss in the first 35 days since admission; and had a significant weight loss of 15.38%. The DD-A stated no nutritional interventions had been completed for R51 as she was unaware of the significant weight loss until 10/29/14. The DD-A stated now that she was aware of the significant weight loss R51 would be started on a supplement and referred to speech therapy. The DD-A stated she would continue to monitor R51's weight on a monthly basis.

On 10/29/14 at 3:36 p.m. the director of nursing (DON) stated when a nurse entered a weight into the computer system they are not able to see if there was a weight loss unless they would manually go to the vital section and look. The DON stated the DD-A would see the weight loss when she completed the resident monthly review. When asked what her expectation was for monitoring residents for significant weight loss, she initially stated, " I am not going to answer that." The DON then verified R51 had a 20 lbs. weight loss in the first 35 days since admission; and had a significant weight loss of 15.38% and verified there was no weight monitoring in place to alert the facility of the significant weight loss until the DD-A completed a monthly review for R51.

Review of the Policy and Procedures Tracking Weight Changes dated 10-31-08 read, " Policy: Weights will be documented for all individuals, for purpose of assessing significant weight changes ...Procedure: When there is a weight change of

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F 325	Continued From page 27 5# [pounds] or greater in a residents weight nursing will reweigh the resident. If the initial weight change is accurate nursing will notify the Dietician/Dietary Manager will then assess the resident and determine if the weight change is significant. If the change is not significant the Dietician/Dietary Manager will continue to monitor successive weights. If noted to be a significant Dietician/Dietary Manager will perform a comprehensive reassessment of resident and evaluate possible causes. Recommendations will be made and the Physician will be notified."	F 325		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431		12/10/14

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F 431	Continued From page 28 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 and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accurate pharmacy labels for 1 of 1 insulin observed (R11) during observation of medication pass and failed to secure 2 of 2 medication carts on the 100 wing from medication aversion. Findings include: Accurate pharmacy labels on resident labels: R11 was admitted 7/29/14, with diagnosis that included diabetes mellitus and chronic kidney disease, stage 3. Document review of physician orders dated 9/5/14, revealed orders for Novolog insulin, 30 units subcutaneous once a morning 11:00 am-1:30 p.m.. Document review of the facility medication administration record dated 10/1-10/28/14, revealed R11 received Novolog 30 units as ordered. Document review of facility blood sugar	F 431	F431 Gundersen Tweeten Care Center will continue to ensure that all 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. Along with this, the facility will continue to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. Nursing staff was re-educated on the 5 Rights of Medication Passes and the expectation of keeping the medication and treatment cart keys available for authorized personnel only. Case Managers to monitor weekly x1 month and then monthly x6 if no problems are found and report to DON.	

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monitoring dated 10/1-10/28/14; revealed blood sugars were monitored daily 11:00 a.m.-12:00 p.m. and ranged from 79-358.

During observations of the medication pass on 10/28/14, at 11:03 a.m., registered nurse (RN)-A drew up 30 units of Novolog insulin into a syringe for R11. Observation of the Novolog insulin vial pharmacy label at that time and the pharmacy label on the small plastic bag that contained the insulin, both revealed instructions to administer 35 units of Novolog insulin at noon. Both the insulin vial and the small plastic bag pharmacy labels had the dispense date of 10/24/14. The Novolog insulin vial had a hand written date opened of 10/26/14. During interview at that time, RN-A stated the Novolog insulin order changed on 9/5/14, from 35 units to 30 units at noon. During observations at that time, RN-A administered 30 units of Novolog insulin to R11. RN-A stated when a new medication order was received, a nurse or case manager notified the pharmacy.

During interview on 10/28/14, at 5:25 p.m., director of nursing stated she expected nursing to fax medication order changes to the pharmacy. She stated she expected order change stickers applied to medication labels when there was a medication order change.

Document review of facility Medication Ordering and Receiving from Pharmacy policy dated 4/2012, revealed the following:
F. 1. "If the physician's directions for use change or the label is inaccurate, the nurse may place a "change of order-check chart" label on the container indicating there is a change in directions for use, taking care not to cover

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F 431	Continued From page 30 important label information." 2. "When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physician's order for current information." 3. "The dispensing pharmacy is informed prior to the next refill of the prescription so the new container will contain an accurate label." SECURED MEDICATIONS FROM AVERSION: During observations on 10/28/14, at 5:52 p.m., licensed practical nurse (LPN)-B locked four boxes of fentanyl patches in the 100 wing medication cart narcotic box, locked the medication cart, and laid the medication keys on top of the treatment cart. At that time, LPN-B stated was leaving for supper. Observation at that time revealed LPN-B left the floor. The keys were left on top of the treatment cart. The 100 wing medication cart was positioned against the nurse ' s desk on the 100 wing. The 100 wing treatment cart was across the hall from the medication cart, near the nurses ' desk, between rooms 112 and utility room 66. Observations at 5:56 p.m., revealed three residents moved by the treatment cart in wheelchairs and two staff walked by. Medication keys remained on top of the treatment cart Observations at 5:59 p.m., two nursing assistants and two residents walked by the treatment cart. Observations at 6:02 p.m., revealed a visitor walked by the treatment. Observations at 6:04 p.m., another visitor walked by the treatment cart. Observations at 6:05 p.m., revealed nursing assistant stopped at treatment cart to use hand	F 431		

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sanitizer, and then walked on down hall.

Observations at 6:07 p.m. revealed LPN-B returned to the treatment cart and picked up the medication keys.

Observations at 6:10 p.m., LPN-B removed insulin from the treatment cart, drew up insulin, locked the treatment cart, laid medication cart keys on top of the treatment cart, and went into a resident room to administer insulin

Observations at 6:11 p.m., LPN-B returned to the treatment cart. During interview at that time, LPN-B verified treatment cart contained four vials of insulin, syringes, and treatment supplies. She stated she moved all insulins from the medication cart to the treatment cart on the evening shift in order to administer insulins from the treatment cart.

Observations at 6:13 p.m. revealed LPN-B unlocked the treatment cart and drew up another syringe of insulin. LPN-B unlocked the medication cart narcotic box to remove medication.

Observations at 6:31 p.m., registered nurse-B (RN-B) asked LPN-B "can I get into the med cart?" LPN-B replied, " the keys are right here," and pointed to the treatment cart. RN-B removed the keys from the treatment cart and unlocked the medication car.

Observations at 6:32 p.m., LPN-B returned keys to the treatment cart. Observations at that time revealed two sets of keys on top of the treatment cart. During interview at that time, RN-B verified one set was hers and the other set was for the 100 wing narcotic box. RN-B removed her set keys and left the narcotic medication cart keys on top of the treatment cart

Observations at 6:35 p.m., LPN-B returned

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F 431	Continued From page 32 to the treatment cart, unlocked the treatment cart, removed treatment supplies, and locked the cart. LPN-B carried the keys with her. During interview 10/28/14, at 6:48 p.m., LPN-B verified it was not a good practice to leave the keys on the cart. LPN-B stated the keys were heavy and easier to leave on top of the cart. During observations on 10/30/14, at 8:00 a.m., registered nurse-A (RN-A) was observed to leave medication cart keys on top of the medication cart when she went into room 127 to administer medications. During observations on 10/30/14, at 8:35 a.m., 100 wing medication cart keys laid on top of the medication cart which was positioned by the nurses ' desk. There was no staff present although RN-A was observed three room doors away from the cart and walked toward the cart. During interview on 10/30/14, at 8:45 a.m., RN-A verified the 100 wing medication cart contained three drawers of medication on cards for morning, noon, evening, and as needed medications. RN-A verified the narcotic drawer contained fentanyl patches, oxycodone, Lortabs, and morphine. Document review of facility Pharmacy Services Policy, not dated, identified the following: page 104-"Storage of drugs. All drugs and biologicals are stored in locked compartments under proper temperature controls. Only authorized personnel are permitted to have access to the medication keys. The separately locked and permanently affixed compartments are provided for storage of controlled drugs listed	F 431		

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F 431	Continued From page 33 in Schedule 2 of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse." During interview on 10/29/14, at 8:50 a.m., director of nursing stated she expected keys to be carried with the assigned nurse at all times. Director of nursing verified the key ring contained keys for the medication cart, narcotic box, treatment cart, e-kit, and other keys that she did not know about. Director of nursing verified the narcotic box currently contained fentanyl patches, Lortabs, oxycodone, and morphine. Director verified the treatment cart contained treatment supplies, creams, essential oils and insulin.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		12/10/14

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F 441	Continued From page 34 isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control practices were followed during personal cares for 1 of 1 resident (R24) observed during cares and failed to ensure that food was handled in a sanitary manner during dining observation. Findings Include: R24'a quarterly Minimum Data Set (MDS) dated 7/22/14, revealed R24 had diagnoses of cerebrovascular accident and hemiplegia. R24 had a brief interview for mental status score of 12, which indicated moderate cognitive impairment and had clear comprehension with ability to understand others. R24 required extensive assistance with two staff with toileting, dressing, personal hygiene, bed mobility and transfers.	F 441	F441 Gundersen Tweeten Care Center will continue to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. All staff were re-educated on the infection control policies of the facility in regards to the handling of food and soiled linens as well as when providing ADLS. All nurses aides will be required to demonstrate proficiency on providing ADLs staying within the infection control guidelines. ADL monitoring will be done by charge nurses and the interdisciplinary team weekly x1 month and then monthly x6 if no problems are found.	

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F 441	Continued From page 35 During an observation of personal care for R24 on 10/30/14 at 7:32 a.m. nursing assistant (NA)-E provided morning cares. Bed linens and the soiled incontinent product were placed on the floor by NA-E. R24 used the urinal and NA-E placed the urinal with urine on the floor. At 7:41 a.m. nursing assistant (NA)-F entered and assisted with cares. R20 was rolled to the left side and right side and NA-E used a wash cloth and water to clean R20's bottom. R20 was then positioned on his back and NA-E used the same soiled wash cloth that was used to clean the bottom to clean R24's groin area. R24 was then dressed, positioned in the wheelchair and requested to use the urinal. NA-E stated to NA-F, "He already used the urinal." NA-E picked the urinal up off of the floor, went to the bathroom emptied and rinsed the urinal out and brought the urinal to R24. After R24 used the urinal NA-E placed the urinal back on the floor with urine in it. On 10/30/14 at 11:26 a.m. NA-F verified she observed the soiled incontinent product, the dirty linens and the urinal with urine that was placed on the floor during cares by NA-E. NA-F stated the first thing staff should do before they start cares with a resident is to get a trash bag for the dirty linen and used incontinent product. NA-F stated you should gather all of the supplies needed to complete resident cares before starting the cares. NA-F verified the urinal with urine was placed on the floor two times by NA-E during the observation of cares. NA-F stated staff should always wash the groin before you wash the bottom of a resident. NA-F verified NA-E did not change the wash cloth after washing R20's bottom and then washing the groin area. On 10/30/14 at 12:08 p.m. the administrator stated the used incontinent product and dirty linen	F 441		

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F 441	Continued From page 36 should have placed in a bag rather than placed on the floor. The administrator stated the urinal with urine should be placed into the bathroom rather than on the resident floor. The administrator verified these identified issues were infection control concerns. Review of the ACTIVITIES OF DAILY LIVING (ADL) (DAILY LIVING FUNCTIONS) undated read, " GENERAL INFECTION CONTROL GUIDELINES 1. Observe (standard) universal precautions or other infection control standards as approved by the appropriate facility committee. " A policy for infection control practices during personal cares was requested and not provided. During dining observation on 10/27/14 at 5:30 p.m., nursing assistant (NA)-C was observed feeding residents while standing and moving from table to table. NA-C was observed picking up a hamburger bun from a resident ' s plate that was in front of the resident with un-gloved or un-sanitized hands and then put the hamburger bun back on the hamburger and pat it down. NA-C then went to another resident and without washing hands continued to feed other residents without washing her hands or wearing gloves. At no time did NA-C wash her hands during these observations. During an interview on 10/27/14 at 5:30 p.m. NA-C confirmed that she picked up the hamburger bun without gloves and put it on top of the hamburger. During an interview with the Director of Nursing (DON) on 10/29/14 at 3:00 p.m., the DON stated that the nursing assistant should have washed her hands before picking up the hamburger bun. During an interview with the dietary director (DD)-A on 10/29/14 at 3:05 p.m., the DD-A stated	F 441		

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TWEETEN LUTHERAN HEALTH CARE CENTER	**125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974**

(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 441	Continued From page 37 that the nursing assistant should have washed her hands and worn gloves when touching food. An undated policy titled Feeding The Resident (Dependent Eating), instructed staff to observe (standard) universal precautions or other infection control standards as approved by appropriate facility committee. They were to wash hands before and after all procedures. Wear gloves when appropriate.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTER	**125 5TH AVENUE SOUTHEAST** **SPRING GROVE, MN 55974**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Tweeten Lutheran Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2014**

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TWEETEN LUTHERAN HEALTH CARE CENTER	**125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974**

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Tweeten Lutheran Health Care Center is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1967, addition was constructed to the South Wing that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTER	**125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72 Table 7-2.2 (16) (b). This could effect all 45 residents. Findings include: On facility tour between 12:45 PM and 3:15 PM on 10/30/2014, observation revealed the following: 1. Testing of the primary transmission line by unplugging the phone line revealed, that there was no trouble signal with-in 4 minutes to the premises fire alarm system 2. It could not be confirmed that the facility has	K 052	K052 Gundersen Tweeten Care Center will continue to ensure that a fire alarm system is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. On November 14, 2014 the annual inspection with sensitivity for the fire alarm system was completed. At this time, 1 RJ31X for quick disconnect was added for the second phone line. Both lines continue to be supervised and if one or both lines fail Gundersen Tweeten Care Center is notified by the UL approved monitoring company. All devices and system were identified to work as designed at this time.	11/14/14

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	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2014**

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K 052	Continued From page 3 two phone lines for the fire alarm dialer This deficient practice was confirmed by the Administrator (MB) and Facility Maintenance Director (CM) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 052		