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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 93JU

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 **04/01/2014** (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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 04/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/06/2014 (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
04/08/2014
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5429

On April 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit and on March 18, 2014 the Minnesota Department of Public Safety also completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 13, 2014. Based on our visit, the facility has corrected the deficiencies issued pursuant to our extended survey, completed on February 13, 2014, as of March 21, 2014. The facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 13, 2014. Refer to the CMS 2567b for both health and life safety code.

Effective March 21, 2014, the facility is certified for 50 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245429 Electrically Sent

May 6, 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 March 21, 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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 16, 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 March 7, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 12, 2014. (42 CFR 488.422)

On March 11, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of $5050.00, effective February 12, 2014 for a total of $5050.00. (42 CFR 488.430 through 488.444)

- Per day civil money penalty of $250.00, effective February 13, 2014. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 13, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on February 13, 2014. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On April 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit and on March 18, 2014 the Minnesota Department of Public Safety also completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on February 13, 2014, as of March 21, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 21, 2014.

However, as we notified you in our letter of March 7, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 13, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 11, 2014:

- Per day civil money penalty of $250.00, effective February 13, 2014. be discontinued as of March 21, 2014. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 13, 2014 be rescinded as of March 21, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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, 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	4/1/2014

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **03/21/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/21/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/21/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/21/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/21/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/21/2014**
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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	05/14/2014	19694	04/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00285	A. Building B. Wing	4/1/2014

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **04/01/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **04/01/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **04/01/2014**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **04/01/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **04/01/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	05/14/2014	19694	04/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2014				

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245429	A. Building 01 - MAIN BUILDING 01 B. Wing	3/18/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	02/17/2014	ID Prefix Reg. # NFPA 101 LSC K0038	02/17/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	04/17/2014	25822	03/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
2/14/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00285	A. Building B. Wing	4/1/2014

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **03/31/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **03/31/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **03/31/2014**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **03/31/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **03/31/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	04/17/2014	19694	04/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 93JU

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 **02/13/2014** (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):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Michele McFarland HFE NE II — 03/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 04/07/2014 (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
04/08/2014
(L33)

DETERMINATION APPROVAL

On February 13, 2014 we completed an extended survey at this facility. The conditions in the facility constituted both Substandard Quality of Care and Immediate Jeopardy to residents' health or safety. The IJ was identified on February 12, 2014 at 6:47pm (the IJ began on 12/15/13 at 12:25am) and the IJ was abated on February 13, 2014 at 3pm. The most serious deficiencies were cited at a Scope/Severity level of J. As a result this Department imposed the Category 1 remedy of State Monitoring, effective March 12, 2014.

In addition we are recommending the following remedies to the CMS RO for imposition:

CMP for deficiency cited at F157, effective February 12, 2014
CMP for deficiency cited at F309, effective February 12, 2014

The facility is subject to a two year loss of NATCEP beginning February 13, 2014 due to an extended survey resulting in SQC. The facility was not given an opportunity to correct before remedies are imposed. Please refer to the CMS 2567. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
March 7, 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 February 14, 2014, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on February 13, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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, Supervisor
Rochester Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
gary.nederhoff@state.mn.us

Telephone: (507) 206-2731
Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 12, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

• Civil money penalty of for the deficiency cited at F157, effective February 12, 2014. (42 CFR 488.430 through 488.444)

• Civil money penalty of for the deficiency cited at F309, effective February 12, 2014. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Tweeten Lutheran Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 13, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality

of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An electronic PoC 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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 May 13, 2014 (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 August 13, 2014 (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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Electronically submitted to the facility.
Licensing and Certification File

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 _____	02/13/2014

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. An extended survey was conducted by the Minnesota Department of Health on February 9, 10, 11, 12 and 13, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F157 and F309 related to the facility's failure to initiate cardio-pulmonary resuscitation (CPR) as expressly requested by a resident, and due to the facility's failure to have notified the physician of a blood sugar of 600 mg/dl (milligrams/deciliter). The lack of these two interventions resulted in the high potential for harm and/or death. Facility staff were notified of the IJ on 2/12/14 at 6:47 p.m. for the IJ that began on 12/15/13 at 12:25 a.m. when the facility failed to promptly notify the physician of an elevated blood sugar reading of a "H [high]" (according to the glucose monitoring machine, a reading of an "H" indicated the resident's blood level was at a minimum at or above 600 mg/dl). In addition, on 12/1/13 at 4:00 a.m. R61 was found to be unresponsive, no pulse, respirations, and no blood pressure and the nurse did not start CPR as directed by the R61's documented advanced directive. The IJ was removed on	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/14/2014

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.

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F 000	Continued From page 1 2/13/14 at 3:00 p.m., however non-compliance remained at the lower s/s of a G.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		3/21/14

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F 157	Continued From page 2 by: Based on interview and document review, the facility failed to ensure changes in clinical status, including significantly elevated blood sugars and/or results that were a change of condition, were promptly reported to the physician for 1 of 5 residents (R61) reviewed who had diabetes. The lack of clinical monitoring and failure to notify the physician resulted in an Immediate Jeopardy (IJ) situation with the potential to affect 5 current diabetic residents who required blood glucose monitoring. The deficient practice resulted in actual harm for R61 who required emergency medical interventions on 12/15/13, and later expired. The immediate jeopardy began on 12/15/13 at 12:25 a.m. when the facility failed to promptly notify the physician of an elevated blood sugar, and was identified on 2/12/14. The administrator and director of nursing were notified of the immediate jeopardy on 2/12/14, at 6:47 p.m. The immediate jeopardy was removed on 2/13/14, at 3:00 p.m. but non-compliance remained at the lower scope and severity of a G (isolated, with actual harm that is not immediate jeopardy.) Findings include: R61's record was reviewed and according to the admission sheet, R61 had been admitted to the facility on 12/4/13. A hospital discharge summary dated 12/4/13, indicated R61 had been hospitalized prior to admission to the nursing home with an infection and had required a peripherally inserted central catheter (PICC) for infusion of cefazolin (ancef) (an antibiotic medication) until 1/13/14. In addition, the hospital discharge summary indicated the resident was to	F 157	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Tweeten Care Center will continue to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in o483.12(a). Tweeten Care Center provided immedidate (2/12/14)re-education on	

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F 157	Continued From page 3 maintain blood glucose (a test that measures the amount of a type of sugar in your blood) goal of 120-180 mg (milligrams)/dl (deciliter) due to advanced age, a HgbA1c (hemoglobin A1c, test used as a standard tool to determine the blood sugar control for patients with diabetes over a three month period), and indicated on 11/27/13 R61's HgbA1c measured 9.5 percent (%) (reflecting an indication of not having good control of blood sugar readings) with the goal for the HgbA1c of 8% due to advanced age. The discharge summary also indicated the resident had been taking Novolin N (intermediate-acting insulin with a slower onset of action and a longer duration of activity, up to 24 hours) twice daily prior to admission to the hospital and that while hospitalized, R61 had experienced an episode of hypoglycemia (low blood sugar) and that her insulin dose would likely require adjustment. The resident's diagnoses were identified as including Type II diabetes and hypertension. The admission Minimum Data Set (MDS) dated 12/11/13; indicated R61 had a BIMS (Brief Interview for Mental Status) score of 13, indicating R61 was cognitively intact. A review of R61's medication administration record (MAR) from admission 12/4/13, to death on 12/15/13 at 4:00 a.m., revealed the resident's blood glucose levels had fluctuated from 63 to 597 mg/dl and that the resident had experienced four blood glucose readings of "HI". The manufacturer's guidance for the glucose meter the facility utilized (Assure Platinum), was reviewed and indicated that a "HI" reading indicated the blood glucose reading was at or above 600 mg/dl. The manufacturer directions also indicated the blood glucose should be	F 157	reporting blood glucose levels greater than 500mg/dl or "HI" reading to all nursing staff that were scheduled on the evening of 2/12/14 and the night and day shifts for 2/13/14. The DON also had a mandatory nurses meeting on 2/13/14 at 12:30 pm with all nursing staff to re-educate on facility policy and standing order to notify physician of blood glucose levels greater than 500mg/dl or "HI" readings. All current diabetic residents were reviewed and blood sugars were found to be handled as needed according to our current Policy and Procedure. Medical Director reviewed Facility Standing Orders and will continue with current standing order to notify physician with blood sugar higher than 500mg/dl on 2/25/14. Mandatory nurses meeting on 3/18/14 to review policy mentioned above. DON will do monthly blood sugar audits x6 to ensure Facility Policy and Procedures for blood sugar reporting are being followed.	

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F 157	Continued From page 4	F 157		

retested with a new test strip when there was a "HI" reading, and that the health care professional should be contacted. Although the progress notes indicated R61's physician had been contacted for readings over 400 mg/dl, and had given orders for additional insulin coverage and monitoring, the notes indicated the physician had not been notified of the "HI" reading identified on 12/15/13 at 12:25 a.m.

A nursing progress note entry written by registered nurse (RN)-C dated 12/14/13 at 9:42 a.m., indicated R61's blood sugar reading reading had registered as "HI" at 7:00 a.m. that morning and that the physician had been notified and had ordered 5 units of Novolog (short acting insulin) to be administered, and to recheck the resident's blood sugar at 8:00 a.m.. The progress note indicated the reading had been "HI" again at 8:00 a.m., that another call had been placed to the on-call physician, and orders had been received to administer 15 units of Novolog and to recheck the blood sugar in a couple of hours. The progress note indicated R61 had also expressed concern about the high blood sugar readings and would not eat until the blood sugar registered at a reasonable level. The note indicated the resident was alert but making nonsensical statements and unable to find the right words for what she was wanted to say. According to this progress note, R61's blood sugar had been rechecked at 9:30 a.m., and had registered as 546 mg/dl and that a call had been placed to the on-call physician, and orders received to administer another 10 units of Novolog "STAT [immediately]" and recheck sugars every hour times two and call back.

A nursing progress note entry written by licensed practical nurse (LPN)-A dated 12/14/13 at 4:06

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p.m., indicated R61 had a blood sugar reading of 74, the physician had been notified, and orders had been received to provide a glass of juice and to monitor blood sugars every hour until the resident's blood sugars were normal several times, and to call the physician with updated readings. At 4:19 p.m. on 12/14/13, LPN-A had documented a progress note identifying that R61 would take 1.5 ounces of juice before wanting to rest, family (F) members at bedside, that the resident was able to speak in full sentences clearly and opened her eyes when spoken to. The note indicated R61 recognized F-G upon arrival to the resident's room. At 4:45 p.m. on 12/14/13, LPN-A documented in the progress notes that R61's blood sugar had been checked and measured 111. That progress note also indicated the physician had been notified with an update, and had directed LPN-A to hold the resident's p.m. (evening) dose of Novolog that day, and to call the physician with any concerns.

A nursing progress note entry written by registered nurse (RN)-E dated 12/15/13, at 4:51 a.m. included: "Res. [resident] was resting well at 1225 [12:25 a.m.] when this writer entered her room. A blood sugar check was done at that time which read HI. Res. was aroused easily and cooperative with procedure. She did verbalize usual aches and back pain. At that time she was given an oxycodone [pain medication] 5 mg tab. After approx. [approximately]. 15 min [minutes]. res. was observed to be resting quietly with head of bed elevated and snoring loudly. Call light was in place and no further complaints or requests were noted. T [temperature]-97.0. While doing 4 AM [4:00 a.m.] rounds, res. was found slumped slightly in her bed, color very pale, unresponsive, cool, clammy to touch, and unresponsive. No B/P

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[blood pressure], No resp [respirations], No pulse. [MD (medical doctor)-A] on call for [MD-B], -gave order to declare death and release body to the funeral home at 4:25 AM. [F-A] was called and gave clearance to allow funeral home to come. [F-A] stated the family had anticipated this call and would not be coming to facility until later this morning to pick up [R61's] belongings."

RN-E, who had worked the night shift on 12/15/13, was interviewed on 2/12/14 at 3:00 p.m.. When asked by the surveyor what protocol she would follow if a resident had a "HI" blood sugar reading, RN-E stated she would usually call the doctor. However, RN-E stated she'd been informed by the evening nurse from 12/14/13, that R61 had been having "HI" blood sugar readings on the evening shift so she'd thought she didn't needed to call the doctor because he had previously been aware of the resident's high readings. RN-E added, "I probably should have called the doctor."

MD-A (the facility's medical director) was interviewed on 2/13/14, at 12:00 p.m. about R61's status on 12/14 and 12/15/13. MD-A stated he would expect a nurse to call the physician, or on call physician, if a resident had a blood sugar reading of "HI" in order to determine what adjustments might be needed for medications (referring to insulin), or to determine whether the resident needed immediate services from the emergency department.

R61's care plan dated 12/6/13, identified a problem of diabetes mellitus II including approaches to administer insulin as ordered, monitoring blood sugar four times daily per physician orders, observe for signs and

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

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F 157	Continued From page 7 symptoms of hyperglycemia (high blood sugar), hypoglycemia (low blood sugar level), report any blood sugar readings out of acceptable range 60-400. The facility's Physicians' Standing Orders dated 2/24/12, were reviewed and included: "28. For signs/symptoms of hyperglycemic reaction, initiate following protocol: b. If BS [blood sugar] > [greater] than 500, call M.D. [medical doctor]." The facility's policy, Diabetes Mellitus, Guidelines for (NURSING CARE OF RESIDENT WITH) undated, read, "PURPOSE 4. Recognize, treat or prevent complications commonly associated with diabetes. GENERAL GUIDELINES FOR ASSESSMENT MAY INCLUDE, BUT ARE NOT LIMITED TO: Blood sugar level. GENERAL DOCUMENTATION GUIDELINES 8. Notification of physician of change in condition." The immediate jeopardy that began on 12/15/13 at 12:25 a.m., was removed on 2/13/14, at 3:00 p.m. after the facility had implemented a corrective action plan which included, immediate education of all nursing staff responsible for taking blood glucose testing to follow the current policy and physician orders/physician standing orders for reporting blood glucose levels greater than 400 mg/dl. This was confirmed by interviews conducted with licensed and unlicensed nursing staff on 2/13/14.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		3/21/14

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 _____	02/13/2014

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F 225	Continued From page 8 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report and thoroughly investigate, allegations of resident neglect for 1 of	F 225	Tweeten Care Center will continue to not employ individuals who have been found guilty of abusing, neglecting, or	

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F 225	Continued From page 9 3 residents (R61) whose closed records were reviewed. Findings include: R61's record was reviewed. According to the nursing progress notes, R61 had a blood glucose reading of over 600 mg (milligrams)/dl (deciliter) on 12/15/13 at 12:25 a.m. however, the nurse did not contact the physician. In addition, the progress notes indicated R61 had been found in her bed at 4:00 a.m. on 12/15/13, unresponsive, and without respirations or pulse. The nurse had not initiated cardiopulmonary resuscitation (CPR.) Although R61's care plan dated 12/6/13, clearly identified approaches for the management of diabetes, including: administering insulin as ordered, monitoring blood sugar four times daily per physician orders, observe for signs and symptoms of hyperglycemia (high blood sugar), hypoglycemia (low blood sugar level), report any blood sugar readings out of acceptable range 60-400, and approaches including, "[R61 name] (Full code)," the facility had not reported or comprehensively investigated these care related issue as allegations of potential neglect. R61's record was reviewed and according to the admission face sheet, R61 had been admitted to the facility on 12/4/13. A hospital discharge summary dated 12/4/13, indicated R61 had been hospitalized prior to admission to the nursing home with an infection and had required a peripherally inserted central catheter (PICC) for infusion of cefazolin (ancef) (an antibiotic medication) until 1/13/14. In addition, the hospital discharge summary indicated the resident was to maintain blood glucose levels (a test that measures the amount of a type of sugar in your	F 225	mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. Tweeten Care Center will continue to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). Tweeten Care Center will continue to have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. Tweeten Care Center reviewed current Plan for Abuse Prevention and The Reporting Policy and updated effective 2/21/14 to reflect the need to report any suspected abuse immediately to the MDH. Re-education for all staff will be done by 3/21/14 on procedure for reporting allegations of abuse/neglect according to facility policy. All VA alleged violations will	

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F 225	Continued From page 10 blood) with goal of 120-180 mg (milligrams)/dl (deciliter). The resident's diagnoses were identified as including Type II diabetes and hypertension. The admission Minimum Data Set (MDS) dated 12/11/13; indicated R61 had a BIMS (Brief Interview for Mental Status) score of 13, indicating R61 was cognitively intact. A nursing progress note entry written by registered nurse (RN)-E dated 12/15/13, at 4:51 a.m. read, "Res. [resident] was resting well at 1225 [12:25 a.m.] when this writer entered her room. A blood sugar check was done at that time which read HI. Res. was aroused easily and cooperative with procedure. She did verbalize usual aches and back pain. At that time she was given an oxycodone [pain medication] 5 mg tab. After approx. [approximately]. 15 min [minutes]. res. was observed to be resting quietly with head of bed elevated and snoring loudly. Call light was in place and no further complaints or requests were noted. T [temperature]-97.0. While doing 4 AM [4:00 a.m.] rounds, res. was found slumped slightly in her bed, color very pale, unresponsive, cool, clammy to touch, and unresponsive. No B/P [blood pressure], No resp [respirations], No pulse. [MD (medical doctor)-A] on call for [MD-B], -gave order to declare death and release body to the funeral home at 4:25 AM. [F-A] was called and gave clearance to allow funeral home to come. [F-A] stated the family had anticipated this call and would not be coming to facility until later this morning to pick up [R61's] belongings." The manufacturer's guidance for the Assure Platinum, the glucose meter the facility utilized, was reviewed and indicated that a reading of "HI" indicated the blood glucose reading was at or	F 225	continue to be reported immediately and investigated by the IDT team. IDT to monitor weekly x6 months.	

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F 225	Continued From page 11	F 225		

above 600 mg/dl. The manufacturer's directions also indicated the blood glucose should be retested with a new test strip when there was a "HI" reading, and that the health care professional should be contacted.

Review of R61's physician's orders from admission 12/4/13, included; Code Status: FULL CODE.

The facility's Physicians' Standing Orders dated 2/24/12, were reviewed and included: "28. For signs/symptoms of hyperglycemic reaction, initiate following protocol: b. If BS [blood sugar] > [greater] than 500, call M.D. [medical doctor]."

RN-E, who had worked the night shift on 12/15/13, was interviewed on 2/12/14 at 3:00 p.m.. When asked by the surveyor what protocol she would follow if a resident had a "HI" blood sugar reading, RN-E stated she would usually call the doctor. However, RN-E stated she'd been informed by the evening nurse from 12/14/13, that R61 had been having "HI" blood sugar readings on the evening shift so she'd thought she didn't needed to call the doctor because the doctor had previously been aware of the resident's high readings. RN-E added, "I probably should have called the doctor." RN- E also stated she had called the doctor first when she'd found R61 unresponsive at 4:00 a.m. on 12/15/13. However, she had not been able to get through and the operator had said she'd have the doctor call back. RN-E stated, "In the meantime, I called the administrator and told her [R61] had passed away and was a full code." RN-E stated, "The administrator told me to call [R61's] family, and the family agreed not to do CPR. The doctor did not call me back within a half an hour so I called

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F 225	Continued From page 12	F 225		

the doctor again. I called the doctor then to verify [R61's] death." When asked what she was supposed to do if someone was a full code and found with no pulse and no respirations, RN-E stated, "Generally I would start CPR, but [R61] was well gone when I got in the room. It was obvious [R61] was gone already."

During interview on 2/12/14, at 12:45 p.m.., the director of nursing (DON) stated she would expect the physician to be notified of a blood sugar reading of "HI," and would expect CPR to be initiated for a resident with a full code status. The DON stated following the incident with R61, there had been no re-education provided, or any other interventions modified to prevent reoccurrence for other residents related to the lack of physician notification when the blood sugar level was greater than 600 mg/dl, or related to the nurse's failure to initiate CPR.

MD-A (the facility's medical director) was interviewed on 2/13/14, at 12:00 p.m. about R61's status on 12/14 and 12/15/13. MD-A stated he would expect a nurse to call the physician, or on call physician, if a resident had a blood sugar reading of "HI" in order to determine what adjustments might be needed for medications (referring to insulin), or to determine whether the resident needed immediate services from the emergency department. MD-A was asked about R61's full code status and how he would have expected the staff to proceed with providing CPR. MD-A stated generally with a full code, the resident should be provided CPR. However, MD-A added, in cases where rigidity has set in, if they're not going to conduct CPR, detailed policies should indicate when a resident should not be coded. MD-A also stated he would expect

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F 225	Continued From page 13 a resident with change in condition, or declining health status, to be re-assessed and to have their code status re-addressed. During additional interview with the DON on 2/13/14, at 1:20 p.m., the DON stated when a resident had a declining health status she would expect staff to notify the doctor, to notify her, to do an assessment and evaluate the situation, and to notify family. The DON said if someone had a declining status and was a full code, she would expect the resident's code status to be re-assessed if possible. The DON also stated the definition of neglect would include not providing a resident with care they needed. However, the DON stated she had not reported the "HI" blood sugar incident or the lack of starting CPR for R61 because she did not think it was reportable. During an interview on 2/13/14 at 1:15 p.m. the social service designee (SSD)-Z stated, "The facility has twenty-four hours to make a report to the Minnesota Department of Health (MDH) through the electronic record system." The SSD-Z verified the facility's Plan for Abuse Prevention, and The Reporting Policy, indicated reports needed to be made to MDH within 24 hours. The facility's policy Plan for Abuse Prevention dated 6/13/11, and the Reporting Policy included, "Neglect: is understood as any failure by staff members to provide necessary medical care or supervision, food clothing or assistance as needed with ADLs [activities of daily living]. An error will not be deemed to be maltreatment (neglect) pursuant to an error that resulted in harm to a vulnerable adult if six conditions are met:	F 225		

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F 225	Continued From page 14 1. The necessary care is given in a timely fashion. 2. The attending physician expects the person's health status to be restored to the level prior to the mistake. 3. The error is not part of a pattern of errors by the individual. 4. The mistake is immediately reported and recorded internally in the facility. 5. The facility takes appropriate corrective and preventative actions. 6. The facility documents its reporting and actions. If there is determination of maltreatment solely because the facility failed to comply with any of the last three requirements listed above, then the individual will not be determined to have committed maltreatment. If maltreatment is suspected, The DON [directive of nursing] or SSD [social service designee] will submit an electronic report to MDH [Minnesota Department of Health] within 24 hours."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 226	Tweeten Care Center will continue to	3/21/14

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F 226	Continued From page 15 facility failed to ensure policies were developed and implemented, related to the immediate reporting and thorough investigation of an instance of significantly elevated blood sugar without prompt notification to the physician for further instruction, and failure to initiate CPR (cardiopulmonary resuscitation) for a resident who had orders for CPR, for 1 of 3 residents (R61) whose closed records were reviewed. Findings include: The facility's policy Plan for Abuse Prevention dated 6/13/11, and the Reporting Policy included, "Neglect: is understood as any failure by staff members to provide necessary medical care or supervision, food clothing or assistance as needed with ADLs [activities of daily living]. An error will not be deemed to be maltreatment (neglect) pursuant to an error that resulted in harm to a vulnerable adult if six conditions are met: 1. The necessary care is given in a timely fashion. 2. The attending physician expects the person's health status to be restored to the level prior to the mistake. 3. The error is not part of a pattern of errors by the individual. 4. The mistake is immediately reported and recorded internally in the facility. 5. The facility takes appropriate corrective and preventative actions. 6. The facility documents its reporting and actions. If there is determination of maltreatment solely because the facility failed to comply with any of	F 226	ensure that there are written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Tweeten Care Center reviewed current Plan for Abuse Prevention and The Reporting Policy and updated effective 2/21/14 to reflect the need to report any suspected abuse immediately to the MDH. Re-education for all staff will be done by 3/21/14 on procedure for reporting allegations of abuse/neglect according to facility policy. All VA alleged violations will continue to be reported immediately and investigated by the IDT team. IDT to monitor weekly x6 months.	

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F 226	Continued From page 16 the last three requirements listed above, then the individual will not be determined to have committed maltreatment. If maltreatment is suspected, The DON [directive of nursing] or SSD [social service designee] will submit an electronic report to MDH [Minnesota Department of Health] within 24 hours." R61's record was reviewed. According to the nursing progress notes, R61 had a blood glucose reading of over 600 mg (milligrams)/dl (deciliter) on 12/15/13 at 12:25 a.m. however, the nurse did not contact the physician. In addition, the progress notes indicated R61 had been found in her bed at 4:00 a.m. on 12/15/13, unresponsive, and without respirations or pulse. The nurse had not initiated cardiopulmonary resuscitation (CPR). Although R61's care plan dated 12/6/13, clearly identified approaches for the management of diabetes, including: administering insulin as ordered, monitoring blood sugar four times daily per physician orders, observe for signs and symptoms of hyperglycemia (high blood sugar), hypoglycemia (low blood sugar level), report any blood sugar readings out of acceptable range 60-400, and approaches including, "[R61 name] (Full code)," the facility had not reported or comprehensively investigated these care related issue as allegations of potential neglect. R61's record was reviewed and according to the admission face sheet, R61 had been admitted to the facility on 12/4/13. A hospital discharge summary dated 12/4/13, indicated R61 had been hospitalized prior to admission to the nursing home with an infection and had required a peripherally inserted central catheter (PICC) for infusion of cefazolin (ancef) (an antibiotic medication) until 1/13/14. In addition, the hospital	F 226		

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F 226	Continued From page 17	F 226		

discharge summary indicated the resident was to maintain blood glucose levels (a test that measures the amount of a type of sugar in your blood) with goal of 120-180 mg (milligrams)/dl (deciliter). The resident's diagnoses were identified as including Type II diabetes and hypertension.

The admission Minimum Data Set (MDS) dated 12/11/13; indicated R61 had a BIMS (Brief Interview for Mental Status) score of 13, indicating R61 was cognitively intact.

A nursing progress note entry written by registered nurse (RN)-E dated 12/15/13, at 4:51 a.m. included: "Res. [resident] was resting well at 1225 [12:25 a.m.] when this writer entered her room. A blood sugar check was done at that time which read HI. Res. was aroused easily and cooperative with procedure. She did verbalize usual aches and back pain. At that time she was given an oxycodone [pain medication] 5 mg tab. After approx. [approximately]. 15 min [minutes]. res. was observed to be resting quietly with head of bed elevated and snoring loudly. Call light was in place and no further complaints or requests were noted. T [temperature]-97.0. While doing 4 AM [4:00 a.m.] rounds, res. was found slumped slightly in her bed, color very pale, unresponsive, cool, clammy to touch, and unresponsive. No B/P [blood pressure], No resp [respirations], No pulse. [MD (medical doctor)-A] on call for [MD-B], -gave order to declare death and release body to the funeral home at 4:25 AM. [F-A] was called and gave clearance to allow funeral home to come. [F-A] stated the family had anticipated this call and would not be coming to facility until later this morning to pick up [R61's] belongings." The manufacturer's guidance for the Assure Platinum,

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the glucose meter the facility utilized, was reviewed and indicated that a reading of "HI" indicated the blood glucose reading was at or above 600 mg/dl. The manufacturer's directions also indicated the blood glucose should be retested with a new test strip when there was a "HI" reading, and that the health care professional should be contacted.

Review of R61's physician's orders from admission 12/4/13, included; Code Status: FULL CODE.

The facility's Physicians' Standing Orders dated 2/24/12, were reviewed and included: "28. For signs/symptoms of hyperglycemic reaction, initiate following protocol: b. If BS [blood sugar] > [greater] than 500, call M.D. [medical doctor]."

RN-E, who had worked the night shift on 12/15/13, was interviewed on 2/12/14 at 3:00 p.m.. When asked by the surveyor what protocol she would follow if a resident had a "HI" blood sugar reading, RN-E stated she would usually call the doctor. However, RN-E stated she'd been informed by the evening nurse from 12/14/13, that R61 had been having "HI" blood sugar readings on the evening shift so she'd thought she didn't needed to call the doctor because he had previously been aware of the resident's high readings. RN-E added, "I probably should have called the doctor." RN- E also stated she had called the doctor first when she'd found R61 unresponsive at 4:00 a.m. on 12/15/13. However, she had not been able to get through and the operator had said she'd have the doctor call back. RN-E stated, "In the meantime, I called the administrator and told her [R61] had passed away and was a full code." RN-E stated, "The

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administrator told me to call [R61's] family, and the family agreed not to do CPR. The doctor did not call me back within a half an hour so I called the doctor again. I called the doctor then to verify [R61's] death." When asked what she was supposed to do if someone was a full code and found with no pulse and no respirations, RN-E stated, "Generally I would start CPR, but [R61] was well gone when I got in the room. It was obvious [R61] was gone already."

During interview on 2/12/14, at 11:05 a.m., the administrator stated, "RN-E called me at time of R61's death and asked what to do. RN-E said she'd found R61 on rounds expired. Administrator stated she knew R61 was full code and told nurse to check with family as R61 had been declining through the day and the family had been at her bedside. The administrator stated the nurse had called R61's family and that they'd known R61 was declining and had agreed to let R61 go.

During interview on 2/12/14, at 12:45 p.m.., the administrator stated she did not know about R61's blood sugar reading of "HI." During the interview, the director of nursing (DON) who was also present, stated she would expect the physician to be notified of a blood sugar reading of "HI," and would expect CPR to be initiated for a resident with a full code status. The DON stated following the incident with R61, there had been no re-education provided, or any other interventions modified to prevent reoccurrence for other residents related to the lack of physician notification when the blood sugar level was greater than 600 mg/dl, or related to the nurse's failure to initiate CPR.

MD-A (the facility's medical director) was

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interviewed on 2/13/14, at 12:00 p.m. about R61's status on 12/14 and 12/15/13. MD-A stated he would expect a nurse to call the physician, or on call physician, if a resident had a blood sugar reading of "HI" in order to determine what adjustments might be needed for medications (referring to insulin), or to determine whether the resident needed immediate services from the emergency department. MD-A was asked about R61's full code status and how he would have expected the staff to proceed with providing CPR. MD-A stated generally with a full code, the resident should be provided CPR. However, MD-A added, in cases where rigidity has set in, if they're not going to conduct CPR, detailed policies should indicate when a resident should not be coded. MD-A also stated he would expect a resident with change in condition, or declining health status, to be re-assessed and to have their code status re-addressed.

During additional interview with the DON on 2/13/14, at 1:20 p.m., the DON stated when a resident had a declining health status she would expect staff to notify the doctor, to notify her, to do an assessment and evaluate the situation, and to notify family. The DON said if someone had a declining status and was a full code, she would expect the resident's code status to be re-assessed if possible. The DON also stated the definition of neglect would include not providing a resident with care they needed. However, the DON stated she had not reported the "HI" blood sugar incident or the lack of starting CPR for R61 because she did not think it was reportable.

During an interview on 2/13/14 at 1:15 p.m. the social service designee (SSD) stated, "The facility has twenty-four hours to make a report to

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F 226	Continued From page 21 the Minnesota Department of Health (MDH) through the electronic record system." The SSD verified the facility's Plan for Abuse Prevention, and The Reporting Policy, indicated reports needed to be made to MDH within 24 hours.	F 226		
F 309 SS=J	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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure changes in clinical status, including significantly elevated blood sugar levels, were clinically monitored and promptly reported to the physician for 1 of 5 residents reviewed with diabetes (R61); and failed to initiate cardiopulmonary pulmonary resuscitation (CPR) for 1 of 5 residents (R61) who had a physician's order for CPR to be initiated if needed . The lack of clinical monitoring and failure to initiate CPR resulted in an immediate jeopardy situation. This resulted in harm for R61 who did not receive monitoring and care for an elevated blood sugar, and who did not receive CPR when her heart stopped. These two deficient practices resulted in an Immediate Jeopardy (IJ). The IJ was identified on 2/12/14, and began on 12/15/13 at 12:25 a.m..	F 309	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. Tweeten Care Center provided immediate (2/12/14) re-education on reporting blood glucose levels greater than 500mg/dl or "HI" reading and to initiate and provide CPR for residents who had made a choice to have CPR to all nursing staff that were scheduled on the evening of 2/12/14 and the night and day shifts for 2/13/14. The DON also had a mandatory nurses meeting on 2/13/14 at 12:30 pm with all	3/21/14

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F 309	Continued From page 22 The administrator and the director of nursing were notified of the IJ on 2/12/14, at 6:47 p.m. The immediate jeopardy was removed on 2/13/14, at 3:00 p.m., but non-compliance remained at the lower scope and severity of a G (actual harm that is not immediate jeopardy.) Findings include: R61's record was reviewed and according to the admission face sheet, R61 had been admitted to the facility on 12/4/13. A hospital discharge summary dated 12/4/13, indicated R61 had been hospitalized prior to admission to the nursing home with an infection and had required a peripherally inserted central catheter (PICC) for infusion of cefazolin (ancef) (an antibiotic medication) until 1/13/14. In addition, the hospital discharge summary indicated the resident was to maintain blood glucose levels (a test that measures the amount of a type of sugar in your blood) with goal of 120-180 mg (milligrams)/dl (deciliter) due to advanced age, a HgbA1c (hemoglobin A1c, test used as a standard tool to determine the blood sugar control for patients with diabetes over a three month period), and indicated on 11/27/13 R61's HgbA1c measured 9.5 percent (%) (reflecting an indication of not having good control of blood sugar readings) with the goal for the HgbA1c of 8% due to advanced age. The discharge summary also indicated the resident had been taking Novolin N (intermediate-acting insulin with a slower onset of action and a longer duration of activity, up to 24 hours) twice daily prior to admission to the hospital and that while hospitalized, R61 had experienced an episode of hypoglycemia (low blood sugar) and that her insulin dose would likely require adjustment. The resident's diagnoses	F 309	nursing staff to re-educate on facility policy and standing order to notify physician of blood glucose levels greater than 500mg/dl or "HI" readings. They were also informed of the revised policy for CPR according to AHA recommendations. All current residents with a full code status on 2/13/14 were informed of the revised policy for CPR. Revised CPR Policy will be placed in Admission Packet for all new residents. Code status on all residents was reviewed. Residents electing to have FULL CODE status are noted on 24 hour nurses report sheets and CNA assignment sheets. All nursing staff will educated or re-educated on policies mentioned above by 3/21/14. DON will do random blood sugar audits monthly x6 to ensure standing orders are being followed and weekly audits x4 and then monthly audits x5 to be sure changes re: Code status are updated on assignment sheets and 24 hour report sheets.	

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were identified as including Type II diabetes and hypertension.

The admission Minimum Data Set (MDS) dated 12/11/13; indicated R61 had a BIMS (Brief Interview for Mental Status) score of 13, indicating R61 was cognitively intact.

A review of R61's medication administration record (MAR) from admission 12/4/13, to death on 12/15/13 at 4:00 a.m., revealed the resident's blood glucose levels had fluctuated from 63 to 597 mg/dl and also had experienced four blood glucose readings of "HI." The manufacturer's guidance for the Assure Platinum, glucose meter the facility utilized was reviewed and indicated that a reading of "HI" indicated the blood glucose reading was at or above 600 mg/dl. The manufacturer directions also indicated the blood glucose should be retested with a new test strip when there was a "HI" reading, and that the health care professional should be contacted. Although the progress notes indicated R61's physician had been contacted for readings over 400 mg/dl, and had given orders for additional insulin coverage and monitoring, the notes indicated the physician had not been notified of the "HI" reading identified on 12/15/13 at 12:25 a.m.

A nursing progress note entry written by registered nurse (RN)-C dated 12/14/13 at 9:42 a.m., indicated R61's blood sugar reading had registered as "HI" at 7:00 a.m. that morning and that the physician had been notified and had ordered 5 units of Novolog (short acting insulin) to be administered, and then to recheck the resident's blood sugar at 8:00 a.m. The progress note indicated the reading had been "HI" again at

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8:00 a.m., another call had been placed to the on-call physician, and orders had been received to administer 15 units of Novolog and to recheck the blood sugar in a couple of hours. The progress note indicated R61 had also expressed concern about the high blood sugar readings and would not eat until the blood sugar registered at a reasonable level. The note indicated the resident was alert but making nonsensical statements and unable to find the right words for what she was wanted to say. According to this progress note, R61's blood sugar had been rechecked at 9:30 a.m., and had registered as 546 mg/dl and that a call had been placed to the on-call physician. The on call physician ordered another 10 units of Novolog "STAT [immediately]" and recheck sugars every hour times two and call back.

At 10:36 a.m. on 12/14/13, RN-C's progress note indicated R61 had a blood sugar reading of 423 mg/dl, and that R61 had told the nursing assistant that she thought her family should be there, "just in case something happens." The note described R61 as "continues to be lethargic, lying with eyes closed, will open and attempt to answer questions, but falls asleep in mid-sentence." At 10:43 a.m. RN-C had documented that she'd attempted to reach R61's family (F)-E member and F-F, and that R61 was resting quietly in bed. At 11:44 a.m. RN-C had documented that F-F had been updated on R61's blood sugar from 11:30 a.m. which had measured 282 mg/dl and had updated F-F on R61's confusion/lethargy. The note indicated RN-C was going to wait one hour to reassess and administer sliding scale and scheduled Novolog per physician.

At 2:47 p.m. on 12/14/13, RN-C had documented a progress note that identified R61's blood sugar

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reading at 12:30 p.m. as having been 208 mg/dl, and that 9 units of Novolog had been administered. The note indicated R61 had attempted to eat lunch, however a nursing assistant had reported R61 wouldn't eat, but did drink 120 cc (cubic centimeters) of chocolate milk. The note described R61 as comfortable and less lethargic, and that per physician RN-C would continue to recheck blood sugar every hour to ensure that R61's level did not drop too low.

A nursing progress note entry written by licensed practical nurse (LPN)-A dated 12/14/13 at 3:47 p.m. indicated R61's blood sugar had been taken at 2:30 p.m. and had registered as 97 mg/dl. The LPN's entry indicated the RN (did not identify which nurse) had spoken to the physician, and had been told to give R61 a drink, and to recheck the blood sugar again at 3:30 p.m. and call physician with results. The progress note indicated R61's blood sugar had been rechecked at 3:30 p.m. and had registered as 57 mg/dl so the resident had been given 5.5 ounces of a protein drink. In addition, a call had been placed to the physician and orders had been received to administer one tube of Glucose 15 (a concentrated sugar mixture) STAT (immediately) and to recheck the blood sugar at 3:50 p.m. The LPN's note indicated R61 had consumed the tube of Glucose 15, and that her family had been at her bedside and had been kept updated.

A nursing progress note entry written by licensed practical nurse (LPN)-A dated 12/14/13 at 4:06 p.m., indicated R61 had a blood sugar reading of 74, the physician had been notified, and orders had been received to provide a glass of juice and to monitor blood sugars every hour until the resident's blood sugars were normal several

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times, and to call the physician with updated readings. At 4:19 p.m. on 12/14/13, LPN-A had documented a progress note identifying that R61 would take 1.5 ounces of juice before wanting to rest, family (F) members at bedside, that the resident was able to speak in full sentences clearly and opened her eyes when spoken to. The note indicated R61 recognized F-G upon arrival to the resident's room. At 4:45 p.m. on 12/14/13, LPN-A documented in the progress notes that R61's blood sugar had been checked and measured 111. The progress note also indicated the physician had been notified with an update, and had directed LPN-A to hold the resident's p.m. (evening) dose of Novolog that day, and to call the physician with any concerns.

A nursing progress note entry written by registered nurse (RN)-E dated 12/15/13, at 4:51 a.m. read, "Res. [resident] was resting well at 1225 [12:25 a.m.] when this writer entered her room. A blood sugar check was done at that time which read HI. Res. was aroused easily and cooperative with procedure. She did verbalize usual aches and back pain. At that time she was given an oxycodone [pain medication] 5 mg tab. After approx. [approximately]. 15 min [minutes]. res. was observed to be resting quietly with head of bed elevated and snoring loudly. Call light was in place and no further complaints or requests were noted. T [temperature]-97.0. While doing 4 AM [4:00 a.m.] rounds, res. was found slumped slightly in her bed, color very pale, unresponsive, cool, clammy to touch, and unresponsive. No B/P [blood pressure], No resp [respirations], No pulse. [MD (medical doctor)-A] on call for [MD-B], -gave order to declare death and release body to the funeral home at 4:25 AM. [F-A] was called and gave clearance to allow funeral home to come.

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F 309	Continued From page 27 [F-A] stated the family had anticipated this call and would not be coming to facility until later this morning to pick up [R61's] belongings." In addition, during review of R61's record it was revealed the resident had a physician's order from admission 12/4/13,which included; Code Status: FULL CODE. RN-E, who had worked the night shift on 12/15/13, was interviewed on 2/12/14 at 3:00 p.m.. When asked by the surveyor what protocol she would follow if a resident had a "HI" blood sugar reading, RN-E stated she would usually call the doctor. However, RN-E stated she'd been informed by the evening nurse who worked the evening shift on 12/14/13, that R61 had been having "HI" blood sugar readings on the evening shift so she'd thought she didn't needed to call the doctor because the doctor had previously been aware of the resident's high readings. RN-E then added, "I probably should have called the doctor." During an interview with LPN-A on 2/12/14 at 4:30 p.m., LPN-A stated that when she'd reported off to RN-E at the end of her evening shift, she had informed RN-E of R61's blood sugars and that the last one had registered on the high side, but stated she couldn't remember now what that blood sugar had been. LPN-A stated RN-E had stated she would watch R61 and would take another blood sugar around 11:00 p.m. or 12:00 a.m. MD-A (the facility's medical director) was interviewed on 2/13/14, at 12:00 p.m. about R61's status on 12/14 and 12/15/13. MD-A stated he would expect a nurse to call the physician, or on	F 309		

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F 309	Continued From page 28 call physician, if a resident had a blood sugar reading of "HI" in order to determine what adjustments might be needed for medications (referring to insulin), or to determine whether the resident needed immediate services from the emergency department. R61's care plan dated 12/6/13, identified a problem of diabetes mellitus II including approaches to administer insulin as ordered, monitoring blood sugar four times daily per physician orders, observe for signs and symptoms of hyperglycemia (high blood sugar), hypoglycemia (low blood sugar level), report any blood sugar readings out of acceptable range 60-400. The care plan also included, "[R61 name] (Full code) ..." The facility's Physicians' Standing Orders dated 2/24/12, were reviewed and included: "28. For signs/symptoms of hyperglycemic reaction, initiate following protocol: b. If BS [blood sugar] > [greater] than 500, call M.D. [medical doctor]." The facility's policy, Diabetes Mellitus, Guidelines for (NURSING CARE OF RESIDENT WITH) undated, read, "PURPOSE 4. Recognize, treat or prevent complications commonly associated with diabetes. GENERAL GUIDELINES FOR ASSESSMENT MAY INCLUDE, BUT ARE NOT LIMITED TO: Blood sugar level. GENERAL DOCUMENTATION GUIDELINES 8. Notification of physician of change in condition." Interviews specific to CPR: During interview on 2/12/14, at 11:55 a.m., director of nursing (DON) stated the facility utilized the Physicians' Orders for Life Sustaining Treatment (POLST) for documenting advance	F 309		

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directive wishes of residents. Use of the POLST is a national approach to end-of-life planning based on conversations between patients, loved ones, and medical providers. The POLST Paradigm is designed to ensure that seriously ill patients can choose the treatments they want to ensure their wishes are honored by medical providers. The DON stated the POLST was supposed to be filled out on every resident at the time of admission. She stated when residents are admitted from the hospital, and if a POLST has already been filled out, the facility would use the POLST to determine the resident's code status. However, the DON verified there had been no POLST documented for R61.
During interview with the facility's administrator at 12:45 p.m. on 2/12/14, when asked how she expected staff to proceed for a resident who was a full code, the administrator stated she would expect staff to involve the resident's family as each case is individual.

The administrator was interviewed again on 2/12/14 at 2:15 p.m.. The administrator stated RN-E had called her first when RN-E had found R61 to be without pulse or respirations. The administrator stated RN-E had told her R61 was a full code and had asked what to do. The administrator stated, "I told her to call the family and ask what they wanted." The administrator stated she had called the nurse back and was told the family "was good with it" because they had been at the facility during the day and had said their goodbyes. The administrator stated she did not know when RN-E had called the resident's doctor. Administrator verified that although the family had been at the facility during the day on 12/14/14, there had been no discussion about the resident's code status being

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F 309	Continued From page 30 modified. During interview on 2/12/14, at 2:30 p.m., social service designee (SSD)-Z stated F-E had stated to her on 12/14/13, R61 "is giving up, in so much pain with this abscess, it has been so much for [R61] including the trip to have the PICC replaced was hard on R61." The SSD-Z also stated, "[F-E] had stated [R61] was comfortable" and "let's keep it that way." However, the SSD-Z confirmed she had not discussed R61's code status, or comfort cares with F-E. During the interview with RN-E on 2/12/14, at 3:00 p.m., RN- E stated she had called the doctor first when she'd found R61 unresponsive at 4:00 a.m. on 12/15/13. However, she had not been able to get through and the operator had said she'd have the doctor call back. RN-E stated,"In the meantime, I called the administrator and told her [R61] had passed away and was a full code." RN-E stated, "The administrator told me to call [R61's] family, and the family agreed not to do CPR. The doctor did not call me back within a half an hour so I called doctor again. I called the doctor then to verify [R61's] death." When asked what she was supposed to do if someone was a full code and found with no pulse and no respirations, RN-E stated, "Generally I would start CPR, but [R61] was well gone when I got in the room. It was obvious [R61] was gone already." SSD-Z was interviewed again on 2/13/14, at 11:00 a.m. When asked about the facility's practice for assessing advanced directives for each resident, SSD-Z said advance directives are supposed to be reviewed with each resident at the time of admission, and that staff were supposed to abide by the orders on hospital	F 309		

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	245429	A. BUILDING _____ B. WING _____	02/13/2014

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discharge summary for code stats when admitted. SSD-Z stated when residents were admitted, the staff inform the resident of the POLST and give them an option to fill it out if they want, or ask them if they want to use a copy of one already in place from a previous provider upon admission to their facility. SSD-Z said they only redo a POLST if a resident wants changes and then they would have the PA (physician assistant) or NP (nurse practitioner) go over it with the resident. The SSD-Z stated if there was no PA or NP available, she would go over it with the resident and the NP or PA would sign off the form when next at the facility for rounds. The SSD-Z stated R61 had declined to fill out a POLST on admission, and that R61 had wanted to go by what was on the hospital discharge orders. The SSD-Z verified she had not documented her conversation with R61 regarding the resident's preference for advance directives.

During the interview with MD-A at 12:00 p.m. on 2/13/14, MD-A was asked about R61's full code status and how he would have expected the staff to proceed.
MD-A stated generally with a full code the resident should be provided CPR. However, MD-A added, in cases where rigidity has set in, if they're not going to conduct CPR, detailed policies should indicate when a resident should not be coded. MD-A also stated he would expect a resident with change in condition, or declining health status, to be re-assessed and to have their code status re-addressed.

During interview on 2/13/14, at 1:20 p.m., the DON stated when a resident had a declining status she would expect staff to notify the doctor, to notify her, to do an assessment and evaluate

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the situation, and to notify family. The DON said if someone had a declining status and was a full code, she would expect the resident's code status to be re-assessed if possible.

The facility policy, CONDITION CHANGE, OF THE RESIDENT (OBSERVING, RECORDING AND REPORTING) undated, included: "PROCEDURE 5. Monitor resident's condition frequently until stable."

The facility policy, EMERGENCY CARE, GENERAL GUIDELINES FOR undated, included: "PROCEDURE 7. If a resident expires, initiate CPR unless ordered otherwise. Call paramedics. Call the attending physician and resident's family or responsible party, as appropriate."

The facility policy, CARDIOPULMONARY RESUSCITATION (CPR) undated, included: "GENERAL RESIDENT RIGHTS GUIDELINES- Explain advance directive rights to resident on admission; include the resident's family and representatives. Have the physician explain the following to the resident and the resident's representative to assist in making advanced directive decisions: a. CPR and reason for procedure to the resident. B. Benefits of the procedure to the resident. C. Adverse affects, risks, and /or complications of the procedure to the resident." The facility's policy did not identify any instructions for when initiation of CPR, for a resident who had requested to be a full code, would not be appropriate based on the clinical signs and symptoms present at the time the resident was found without a pulse or respirations.

The facility policy, ADVANCE DIRECTIVES dated

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F 309	Continued From page 33 7/15/13, read, "PROCEDURE: All residents are asked upon admission if they have completed a health directive or a power of attorney for healthcare or any other document which expresses their views or choices on healthcare issues. Information regarding healthcare directives is included in their admission packet. The resident or resident's representatives' signature is obtained on the admission form verifying they received the information upon admission on advance directives. Directives are placed on face sheet and scanned onto the computer. Once an advance directive is completed, it will be reviewed quarterly and with significant changes with care plan conferences by the IDT (interdisciplinary team), resident and resident's representative. The Power of Attorney for Healthcare or Physician's Order for Life-Sustaining Treatment (POLST) forms are two options to be completed at our facility. The physician or nurse practitioner will discuss the options with the resident or resident's representative and will sign and complete the POLST form. The Power of Attorney for Healthcare form can be completed with the resident by Social Services Designee if able to do so and notarized/witnessed accordingly." The facility policy, NOTIFICATION OF RIGHTS and SERVICES dated 12/15/03, read, "A facility must immediately inform resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a need to discontinue an existing form of treatment	F 309		

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F 309	Continued From page 34 due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s 483.12(a)." The IJ that began on 12/15/13, was removed on 2/13/14, at 3:00 p.m. when the facility implemented a corrective action plan which included, immediate education of all nursing staff to initiate and provide CPR for residents who had made a choice to have CPR initiated if found with signs and symptoms of death, and the facility's development of a policy that reflected the resident's choice to be a full code status. In addition, the facility had initiated immediate education of all nursing staff to follow their current policy, and standing orders, for reporting blood glucose levels greater than 500 mg/dl. The implementation of these interventions were confirmed by interviews conducted with licensed and unlicensed nursing staff on 2/13/14, and review of the facility's revised policies.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		3/21/14

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F 329	Continued From page 35 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to ensure a system was in place to monitor individualized, targeted behaviors for antipsychotic medications, for 3 of 5 residents (R58, R10 and R16) reviewed for unnecessary medications. Finding Include: R58's admission Minimum Data Set (MDS) dated 12/6/13, revealed diagnoses including non-Alzheimer's dementia. The MDS noted R58 had signs and symptoms of delirium including inattention and disorganized thinking. The MDS also identified behaviors including rejection of care and wandering. R58's admission Care Area Assessment (CAA) dated 12/613, indicated behavior symptoms including, "[R58] wanders almost daily and needs frequent staff intervention, as will wander into other resident rooms and will scratch herself when nervous and anxious. At risk for injuring self and elopement." R58's psychotropic medication	F 329	Tweeten Care Center will ensure that each resident's drug regimen will be free from unnecessary drugs. Tweeten Care Center reviewed the system that is in place to monitor individualized, targeted behaviors for antipsychotic medications. Resident R58, R10 and R16's Plan of Care and Point of Care for tracking individualized behaviors were reviewed and updated as needed to include targeted behavior monitoring. All residents utilizing antipsychotic medications were reviewed and targeted behaviors were identified and will be tracked. All new orders scanned into Matrix are reviewed by IDT to ensure targeted behaviors are identified for any new or revised antipsychotic orders. DON & SSD will re-educate all nursing staff on the importance of identifying and tracking clinical symptoms to warrant the ongoing use of a psychoactive medication as well the need to track targeted	

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F 329	Continued From page 36 use CAA indicated, "[R58 had] frontotemporal dementia and scans show brain is shrinking. She is on buspar, effexor, and trazodone for mood and anxiety. At risk for side effects." R58's current electronic Physician's Orders directed: "Zyprexa 10 mg [milligrams] by mouth every evening at bedtime," with a start date of 1/13/14. Review of R58's medical record lacked identification of individualized target behaviors for her antipsychotic medications and monitoring of those behaviors to evaluate efficacy. R10's admission physician orders dated 4/15/13, revealed diagnoses including non-organic psychosis and senile dementia. The current electronic physician's orders directed Zyprexa 5 mg one tablet every evening. R10's care plan dated 10/22/13, identified disruptive episodes with yelling out and potential for verbal abuse toward staff. The long term goal was for R10 to show a decrease in abusive/disruptive behavior. Approaches included providing activities of interest, administering the medication Zyprexa and instructions to monitor and record the effectiveness of interventions. The care plan directed if R10 had delusions/hallucinations, staff were not to try to reason with or confront the resident. Instead, reassurance was to be offered. Psychosocial Well-Being behavior management follow-up reports dated 9/10/13, 10/10/13, 11/12/13, and 12/6/13, directed staff to continue to monitor R10. The reports indicated R10's mood had improved, with less disruptive episodes of yelling for staff. However, there was no quantitative monitoring of paranoia/delusions. The follow-up report dated 1/10/14, included	F 329	behaviors by 3/21/14. DON re-educated PA-C on the need to include targeted behaviors when ordering antipsychotic medications on 3/18/14. DON & SSD will monitor targeted behaviors monthly to ensure continued need for antipsychotic medication is necessary. Consulting pharmacist monitors monthly for the use of antipsychotic medications and will make recommendations for gradual dose reductions to medical provider when warranted.	

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F 329	Continued From page 37 target behaviors of verbally abusive, physically abusive, disruptive, rejection of cares, and wandering. The note indicated the Zyprexa was added for paranoia and that R10's mood had improved, with less disruptive episodes of yelling for staff. There was no mention of quantitative monitoring for R10's paranoia/delusions. R10's Interdisciplinary Notes dated 1/30/14, indicated Zyprexa 5 mg every evening was added on 8/19/13, for paranoia/delusions and had been effective. There was no quantitative analysis of her behaviors noted. Review of R10's medical record lacked any further identification of individualized, target behaviors for the use of antipsychotic medications and lacked monitoring of those behaviors to evaluate efficacy. R16's undated care plan indicated diagnoses including psychosis. Review of the current physician orders directed Seroquel 12.5 mg at bedtime, with start date of 1/4/13. The quarterly MDS dated 12/17/13, indicated R16 had no cognitive impairment and no behavior problems. Review of R16's medical record lacked identification of individualized, target behaviors for the use Seroquel and lacked monitoring of the target behaviors to evaluate whether the medication had been effective. During an interview on 2/12/14, at 8:40 a.m. the social service designees (SSD) verified the facility did not currently have a system in place to monitor individualized, target behaviors as the facility's electronic record system did not allow for specific resident, target behaviors to be imputed for monitoring. The SSD stated she was aware	F 329		

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F 329	Continued From page 38 the facility's electronic record system lacked this capability to monitor specific individualized, target behaviors and had brought this to the facility's attention, but in the meantime should have come up with a system for monitoring. On 2/12/14, at 10:17 a.m. the director of nursing (DON) verified the facility was not currently monitoring individualized, targeted behaviors for residents who received antipsychotic medications. The facility's Behavior Tracking Record policy dated 2/20/06, read, "Behavior Tracking Record will be used on residents displaying behavior symptoms and/or receiving meds that alter mood/behavior symptoms to include antipsychotic and anti-anxiety medications."	F 329		
F 441 SS=F	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	F 441		3/21/14

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F 441	Continued From page 39 determines that a resident needs isolation to prevent the spread of infection, the facility must 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 interview and document review, the facility failed to establish an infection control (IC) program to track resident infections so they could be analyzed for trends and patterns in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. This had the potential to affect all 47 residents who resided in the facility. Findings include: A review of the facility's Monthly Infection Control Log(s) from March 2013 through January 2014 revealed the logs lacked: organism of infection, signs and symptoms of infection, date of onset of the symptoms, culture results, whether the infection was community or facility acquired and the effectiveness of the treatment.: During these months the logs indicated the following number of urinary tract infections (UTI): March, 1; April, 6;	F 441	Tweeten Care Center will maintain an Infection Control Program to track infections to be analyzed for trends and patterns in order to prevent and control, to the extent possible, the onset and spread of infection within the facility. The Infection Control RN will continue to maintain the infection control logs monthly; to include the organism of infection, date of onset of the infection, culture results and whether the infection was community or facility aquired, signs and symptoms and the effectiveness of the treatment. DON re-educated Infection Control RN on need to track and trend infections on 3/12/14. The Infection Control RN will continue to	

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F 441	Continued From page 40 May, 5; June, 1; July ,4 with one resident having two courses of antibiotics on August, 1; September, 2; October, 3; November, 5; and December, 1. The January 2014 log indicated no UTIs, three infections with no signs or symptoms listed, whether the infection was community or facility acquired nor the effectiveness of the treatment. One infection also did not include the onset of infections. The facility did not provide the February 2014, Monthly Infection Control Log. The director of nursing (DON) was interviewed on 2/12/14 at 9:10 a.m., the DON stated that registered nurse (RN)-A normally fills out the Monthly Infection Control Log, and that she received them when they were completed. RN-A was interviewed on 2/12/14 at 9:15 a.m.. RN-A stated that she had not gotten around to putting the causative organisms on the monthly log. RN-A also verified she did not track or trend infections, and did not provide education to staff for the prevention of infections. The facility's policy Infection Control Surveillance dated 2010, indicated the infection control practitioner was supposed to gather data for infection tracking and reporting, and was to provide consultation and education as needed. The policy further indicated descriptive documentation would provide the nursing home summarized observations related to the investigation of the causes of an infection and/or would identify the underlying causes of infection trends.	F 441	educate nursing staff of trends in infections. Report will be given to DON monthly and also reviewed quarterly at QA meeting.	

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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 | 03/14/2014

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.

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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
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 and battery operated smoke alarms in all resident rooms. The facility has a capacity of 50 beds and had a census of 48 at the time of the survey.	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 _____	**02/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 48 residents. Findings include: On facility tour between 9:15 AM and 11:45 AM on 02/14/2014, observation revealed that the following the following doors did not shut and latch: 1. Soiled utility room # 66 2. Dirty laundry room - south door	K 029	Tweeten Lutheran Healthcare Center will continue to ensure that one hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. On 2/17/14 the door to the soiled utility room #66 and dirty laundry room □south door were fixed to ensure that they self □closed and latched.	2/17/14

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K 029	Continued From page 3 These deficient practices were confirmed by the Director of Maintenance (CM) and Administrator (MB) at the time of discovery.	K 029	Compliance and monitoring will be conducted by the Maintenance/Housekeeping Director.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2 and 7.1.10.1. The deficient practice could affect all 20 out 48 residents. Findings include: On facility tour between 9:15 AM and 11:45 AM on 02/14/2014, observation revealed, that 2 out of 10 required exit discharge to the public way have ice and snow build up on them. This deficient practice was confirmed by the Director of Maintenance (CM) and Administrator (MB) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 038	Tweeten Lutheran Healthcare Center will continue to ensure that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 On 2/14/14 the ice and snow build up was removed from 2 out of 10 doors that required exit discharge to the public way. Compliance and monitoring will be conducted by the Maintenance/Housekeeping Director.	2/17/14