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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9OML

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00285

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/18/2015** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 12/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245429

December 29, 2015

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

Dear Ms. Borreson:

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

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

Effective December 15, 2015 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
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

Electronically delivered
December 29, 2015

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

RE: Project Number S5429026

Dear Ms. Borreson:

On November 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 5, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 17, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 5, 2015, effective December 15, 2015 and therefore remedies outlined in our letter to you dated November 24, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245429	A. Building B. Wing	12/18/2015

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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/15/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/15/2015**	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	GPN/kfd	12/29/2015	10160	12/18/2015
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
11/5/2015			

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: **01 - MAIN BUILDING 01**	12/17/2015

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 K0154	**12/08/2015**	ID Prefix: Reg. # **NFPA 101** LSC K0155	**12/08/2015**	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	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	TL/kfd	12/29/2015	35482	12/17/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 11/4/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9OML

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**

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(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 **11/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Carol Bode, HFE NE II 12/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 24, 2015

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

RE: Project Number S5429026

Dear Ms. Borreson:

On November 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 15, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 5, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 5, 2016 (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
Health Regulation Division
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 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: 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 ______	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to effectively respond to individual grievances, related loud noises made by R43 during the overnight hours, for 1 of 1 residents (R40) reviewed with expressed concerns of loud noise levels within the facility. Findings include: R40's admission Minimum Data Set (MDS) dated 7/28/15, identified his cognition intact, no problems with his mood, or behaviors. R40 had a diagnosis of anxiety, manic depressive and	F 166	F166 Gundersen Tweeten Care Center will continue to be prompt in their efforts to resolve grievances the resident may have, including those with respect to the behavior of other residents. Grievance for Resident # 40 was resolved by 11/5/15. Staff will continue to report resident complaints/grievances to the charge nurse, case manager, SSD, or DON depending on the concern or issue. Residents are invited to the monthly Resident Council meetings and asked for any concerns or grievances. All	12/15/15

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

Electronically Signed — 12/04/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	11/05/2015

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

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F 166	Continued From page 1 dementia. When observed and interviewed on 11/03/15, at 10:38 a.m. R40 said he has a problem in this room. R40 said his roommate "stays awake and calls for mama all night." I told management about it four weeks ago and nothing had been done. I talked to social services (SS)-E and registered nurse (RN)-F about it and they said they would do what they could. I said I wanted to move to another room and was told there are no open rooms to move into. No one has asked if it has improved. An interview on 11/04/15, at 8:37 a.m. SS-E said the process for grievances is if it is verbal and brought up at care conference we talk about it at that time. SS-E said she knew about R40's concern with his roommate talking at night but she hasn't received any written grievances. SS-E said if a concern is received it goes to the affected department. That department will address it and than it comes back to the resident council meeting. SS-E than said that she doesn't document some complaints. SS-E said she did not fill out a grievance form on R40's behalf because R40 had not complained more then one time. SS-E was offered a different room or something for sleep but he chose neither option so SS-E thought it was no longer a concern. An interview on 11/04/15, at 1:17 p.m. the director of nurses (DON) said RN-F who is the care manager and she reviews grievances form residents. She said she has not heard anything about R40's grievance. The DON also said she doesn't think it is a grievance because he did not go to the administrator like the policy says he should have. During an interview with RN-F at 11/05/15, at 9:15	F 166	grievances received at Resident Council are documented and given to the Department Head to address and resolve. The Grievance Procedure for Residents/Advocates Policy has been reviewed and updated as needed. All residents receive a copy of the grievance procedure upon admission and are reminded of the right to voice grievances at monthly council meetings. IDT to monitor at weekly care plan conference meetings to ensure resolutions are timely. All staff were re-educated on this process of handling complaints/grievances on December 8th, 2015.	

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F 166	Continued From page 2	F 166		

a.m. said she knew about R40's grievance. RN-F said they (SS-E and RN-F) talked to R40 and he said it was better but she thinks it is worse again now that the roommate is back from the hospital. RN-F said they don't have any open rooms a the time. RN-F said SS-E does most of the documentation regarding resident complaints. She said she doesn't know if the DON knows about it. RN-F said we normally don't make a big deal about it. Our policy is if you are not happy, you can move. RN-F said she knew this issue wasn't resolved as R40 kept talking about it with her. We have a grievance form but we normally don't fill the form out. She agreed there is no documentation in progress note.

An interview on 11/05/15, at 9:37 a.m. nursing assistant (NA)-A said she knew about R40 not sleeping because of his roommate. She said when R40 mentions it, she always tells the nurse. She said the nurse will tell her to lay him down more often during the day.

During an interview on 11/05/15, at 9:38 a.m. NA-G said R40 tells her about being woken up in the night by his roommate. She said that the nurses talk about and have said to lie him down more frequently. NA-G said she has not heard of any other plan for R40.

An interview on 11/05/15, at 11:42 a.m. the administrator said they discuss grievances at care conferences, stand up meetings, department meetings or resident council to address grievances.

R40's sleep assessment dated 10/20/15, read, "How many times does resident awaken in the night?" The answer was two to four times.

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F 166	Continued From page 3 A facility policy for persons being served shall have the right to voice grievances. Included all complaints will be documented and given to the Director of Nurses or the Department Head/Supervisor of the area involving the grievance. The Department Head/Supervisor will conduct an investigation of the matter to determine its validity. If the Department Head/Supervisor either does not have a satisfactory answer for you or does not answer you concern within seven days, report to the Administrator in person, in writing or by phone concerning your issue. The Administrator will investigate and respond to you within seven days.	F 166		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a recliner was assessed as a restraint for 1 of 1 resident (R39) who utilized a recliner for sleep. Findings Include: R39's quarterly Minimum Data Set dated 8/25/15 indicated severe cognitive impairment and R39 was steady at all times with moving from a seated to standing position, walking, turning around, moving on/off the toilet, and surface to surface	F 221	F221 Gundersen Tweeten Care Center will continue to ensure our residents are free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident□s medical symptoms. Resident # 39 was assessed for use of recliner and care plan updated according to results. All residents currently using a recliner were reassessed for recliner use to rule out it being a restraint. Prior to any resident using a recliner they will be assessed if it	12/15/15

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F 221	Continued From page 4 transfers. On 11/4/15 at 2:36 a.m. a continuous observation was started of R39. R39 was asleep in a manual recliner located in the public day area of the secure Woodland unit. R39 remained sleeping in the recliner until 4:20 a.m. when licensed practical nurse (LPN)-B awakened R39. Once awake R39 was able to push against the recliner to move the back of the recliner to an upright position and push her feet against the foot rest to move the foot rest. LPN-B assisted R39 to the bathroom to complete morning cares after the completion of morning cares LPN-B assisted R39 to an electric recliner which used a remote control for positioning. LPN-B used the remote control to recline the chair. LPN-B then placed the remote control in an outside pocket on the right side of the recliner which R39 could not reach. At 5:32 a.m. R39 was observed to be sleeping in the recliner. At 5:39 a.m. R39 began to move self in recliner and with her feet hanging over side of recliner foot rest. At 5:54 a.m. R39 was intermittently moving around in the recliner, talking to herself, with her knees bent. At 6:10 a.m. R39 was observed to be moving her legs, pushing her feet on the raised leg rest of the recliner, moving her torso and sitting up and down stating, "I want to go too." R39 is unable to get out of the chair due to the leg rest raised. At 6:19 a.m. R39 continued to attempt to get out of the chair noted her to push off recliner with legs and arms. R39's legs were hanging off the side of the raised leg rest. At 6:25 a.m. R39 was attempting to push off on the recliner, pushing down on the recliner arms. At 6:32 a.m. R39 was observed attempting to climb out of the recliner. LPN-B ran to R39's side and used the remote control to return the chair to the upright position.	F 221	would be considered a restraint. IDT will evaluate recliner use quarterly with MDS cycle to ensure proper assessments have been done. Nursing staff were re-educated on the right to be free from restraints and the process for assessing recliners as a restraint on December 8, 2015.	

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F 221	Continued From page 5 With minimal assistance R39 was able to stand up and walk independently throughout the unit. On 11/4/15 at 5:56 a.m. LPN-B stated R39 normally sleeps in a recliner in the day room, "She would fall out of her bed. At home she would sleep on the floor. Once she is settled into the recliner she will sleep pretty well. She had a room on her own and she wouldn't go into her room. It seems safer to have her out here and keep a close eye on her." Trained medication aide (TMA)-C added, "It's nice on nights to peek in on her and get to her sooner." LPN-B reviewed R39's care plan and stated, "It doesn't look like it is care planned" when asked about the recliner used as a restraint and located near the nurses station. On 11/4/15 at 8:39 a.m. registered nurse (RN)-D, a manager, stated R39 slept in the blue manual recliner and that she could sometimes independently get out of the chair on her own adding, "If staff see her trying to get out they should help her up otherwise it will cause her distress." On 11/5/15 at 9:37 a.m. nursing assistant (NA)-E stated, "If she [R39] starts wiggly that's our cue to get her up. If the blue recliner is sitting up she can get up on her own." On 11/5/15 at 12:07 p.m. RN-D stated, "She might not be care planned for sleeping in the recliner, she slept on the floor at home. Therapy would assess her, I don't know what our policy is on that. She will put her feet between the foot rest and the arm rest and push herself up. If she was trying to get up for long time I wouldn't want to say that it is a restraint all the time. If she was	F 221		

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F 221	Continued From page 6 struggling a good amount of time then yes it would be a restraint, ten or five minutes." On 11/4/15 at 10:05 a.m. physical therapist assistant-D stated nursing would complete assessments regarding sleeping in recliners. On 11/5/15 at 1:55 p.m. the director of nursing (DON) stated, "We don't have a recliner assessment. It would be an observation. If they could normally get out of it [recliner] without help and can't." The noted observations of R39 were read to the DON and she responded with, "At that point it would be considered a restraint." The DON added the recliner was not care planned. R39's care plan dated 12/4/13 reads, "At times, [R39] may lower herself to the floor and sleep on the floor, consistent with her preferences and routine for many years. If [R39] prefers to sleep on floor, ensure that she is warm enough; do not awaken or attempt to put back to bed, until she herself awakens." Facility policy, Physical Restraint, dated 1/20/06, reads; "Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to one's body. Physical restraints include any article, device or garment used primarily to modify resident behavior by interfering with free movement of the resident or normal functioning of a portion of the body, and which the resident is unable to remove easily, confinement in a locked room....Resident's will be assessed for safety risks and abilities on admission, re-admission, with a significant change, and quarterly with reassessment as needed should a change in condition alter the risks."	F 221		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan according to the physician orders for 1 of 3 residents (R33) reviewed for nutrition; failed to revise the care plan to include risk of bruising for 1 of 3 residents (R33) reviewed for skin conditions and failed to revise the care plan to include the use of a foot board for 1 of 3 residents (R33) reviewed for restraints. In addition the facility failed to update a care plan after physical therapy recommended changes for 1 of 1 resident (R44) reviewed for positioning.	F 280	F280 Gundersen Tweeten Care Center will continue to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident□s needs, and, to the extent practicable, the participation of the resident, the resident□s family or the residents legal representative; and	12/15/15

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F 280	Continued From page 8 Findings include: LACK OF PHYSICIAN ORDERS INCLUDED IN R33'S CARE PLAN: R33's quarterly Minimum Data Set (MDS) dated 8/18/15, identified R33 had diagnoses of Alzheimer's, dementia, had severe cognitive impairment, required extensive assistance from staff to eat, mechanical altered diet and therapeutic diet. R33's physician order report dated 10/5/15 through 11/5/15, indicated order start date diet: mechanical soft, carbohydrate controlled, supplements with meals, nectar thickened liquids, may have regular water in lidded cup in room 30 minutes post meals after offered oral cares. On 11/04/2015, at 9:25 a.m., nursing assistant (NA)-D was observed to assist R33 with breakfast which included nectar thickened liquids of juice, water and milk, oatmeal, mighty shake supplement, ground sausage and toast. On 11/04/2015, 9:50 a.m., a lidded cup with regular consistency water was observed in R33's room on a tray table. R33's care plan, dated 5/11/15, indicated poor fluid intake with meals with interventions of fluids monitored and recorded each meal, fluids offered between meals and at structured activities. Varied food intakes with interventions of eat at grace table with staff to feed at meals, food dislikes are recorded in kitchen, food intakes are monitored and recorded each meal and offer carbohydrate controlled mechanically altered diet. However, the care plan failed to include supplements with meals and nectar thickened liquids, may have regular water in lidded cup on room 30 minutes	F 280	periodically reviewed and revised by a team of qualified persons after each assessment. Resident # 33□s care plan has been updated to reflect the correct diet order, risk of bruising, and use of foot board. Resident # 44□s care plan has been updated to reflect transferring and ambulating according to therapy□s most recent recommendations after working with Resident #44. Case managers will continue to ensure all other residents in the facility will have up to date care plans. All residents will be reviewed for comprehensive care plans as their next RAI review comes up during the next quarter, on all new admissions, and with significant changes. Order changes will be logged and reviewed weekly with IDT meetings. QA nurse will do chart audits one week following care plan review dates and report results to quarterly QA meeting.	

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F 280	Continued From page 9 post meals after offered oral cares. On 11/04/2015, at 9:52 a.m., registered nurse (RN)-A verified R33's care plan failed to include nectar thickened liquids, may have regular water in lidded cup in room 30 minutes post meals after offered oral cares. On 11/5/15, at 4:53 p.m., dietary manager director (DMD)-C verified R33's physician order for supplements with meals and nectar thickened liquids. DMD-C verified R33's care plan failed to include supplements with meals and nectar thickened liquids. On 11/05/2015, at 3:05 p.m., director of nursing verified R33's physician order dated 10/14/15, and verified R33's care plan failed to include nectar thickened liquids, may have regular water in lidded cup on room 30 minutes post meals after offered oral cares and she would expect the information to be included on R33's care plan. LACK OF CARE PLAN INTERVENTION FOR RISK OF BRUISING: R33 was observed on 11/04/2015, at 8:39 a.m., and had a bruise on the side of left hand and on top of left forearm. During observation on 11/05/2015, at 9:55 a.m., RN-A confirmed R33 had a bruise on the side of left hand and on top of left forearm. RN-A stated I wander if bruising from EZ stand mechanical lift use, because of where the bruises are located. R33's resident progress notes dated 10/12/15 through 10/15/15, identified R33 had prior bruising noted below umbilicus of unknown origin and on top of penis.	F 280		

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R33's care plan, dated 5/11/15, indicated at risk for pressure ulcers related to impaired bed mobility. Report any signs of skin breakdown (sore, tender, red or broken areas). R33's care plan failed to include risk of bruising.

During interview on 11/05/2015, at 9:55 a.m., RN-A verified R33's progress notes identified R33 has had previous bruising. RN-A verified R33's care plan failed to include the risk of bruising and stated the risk of bruising should be care planned.

During interview on 11/05/2015, at 3:05 p.m., DON verified R33's care plan failed to include the risk of bruising and stated she would expect the risk of bruising to be care planned.

LACK OF CARE PLAN INTERVENTION OF FOOD BOARD IN WHEELCHAIR: R33 was observed on 11/3/15, at 9:29 a.m., a foot board was in place on R33's wheelchair.

On 11/4/15, at 8:39 a.m., NA-D was observed to place footrests onto R33's wheelchair and then strapped a foot board in place onto R33's footrests.

R33's care plan problem date 5/28/15, indicated limited physical mobility, chair fast all or most of time related to physical limitations, depression with interventions of make sure reclined when not at meals and unsupervised, make sure foot rests elevated to prevent falling forward. R33's care plan failed to include the use of a foot board.

During interview on 11/05/2015, at 3:05 p.m., DON verified R33's care plan failed to include the use of a foot board and stated she would expect

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F 280	Continued From page 11 R33's care plan to include the foot board. When asked for a policy for revision of the care plan, the facility provided an untitled copy of listed regulations, which addressed F280 and indicated care plans are revised as necessary to address the current needs of each resident. R44's care plan dated 1/12/15, identified limited activity/mobility/transfers with impaired balance/weakness. Interventions included, "offer to ambulate with resident on household tolerating at this time up to 50 ft [FEET] with nursing staff bid (twice daily) and when she appears restless, consider offering a walk. Resident will transfer/ambulate with 1 staff assist as needed." R44's care plan indicated R44, with assistance would ambulate with proper use of a walker and two staff assist. PT-Therapist Progress and Discharge Summary dated 10/14/15 included the following discharge instructions, "Discharge to memory care unit with instructions for dc [discharge] of walking program, use of EZ stand for transfers." Quarterly Minimum Data Set (MDS) dated 7/21/15 indicated R44 was a one person physical assist with walking in room and corridor. Quarterly MDS dated 10/20/15 indicated R44 did not ambulate during the seven day look back period. On 11/4/15 at 8:33 a.m. registered nurse (RN)-D, a manager, stated, R44 uses the EZ stand because her knees will buckle. Therapy has worked with her for a while. She has been working with physical therapy since 9/16/15. On 10/14/15 R44 changed to the use of the EZ	F 280		

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	245429	A. BUILDING _____ B. WING _____	11/05/2015

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F 280	Continued From page 12 stand. RN-D said, "I'm gonna say that's the way the care plan was done before I came. I haven't changed that in her care plan." On 11/5/15 at 1:51 p.m. the director of nursing stated, "RN-D and RN-F are new to the care plan process for the last four months. The care is updated quarterly or as changes occur." A facility policy on care planning was requested but not provided.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting cares as directed by the care plan for 1 of 1 resident (R13) who required assistance with toileting and failed to ensure the use of a tab alarm and provide toileting cares as directed by the care plan for 1 of 1 resident (R33) who required assistance with toileting and had limited mobility. In addition the facility failed to provide transfer assistance as directed by the care plan for 1 of 1 resident (R44) who required assistance with transfers. Findings include: LACK OF OFFERING TOILET PER CARE PLAN AND LACK OF USE OF CARE PLANNED TAB	F 282	F282 Gundersen Tweeten Care Center will continue to ensure the services provided or arranged by the facility will be provided by a qualified person in accordance with each resident□s written plan of care. NA-C has been reeducated on the need to provide toileting cares as directed by the care plan for the resident. NA-D has been reeducated on not double padding incontinent products as directed by the plan of care for the resident. NA-E was reeducated on the need to transfer the resident according to the plan of care. All nursing staff was reeducated on the need to follow the residents□ plan of care in regards to the care of the resident on	12/15/15

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F 282	Continued From page 13 ALARM WHILE IN WHEELCHAIR TO PREVENT FALLS: R13's care plan, dated 09/08/2015, indicated limited in ability to toilet self-related to dementia with interventions of check for incontinence every two hours and offer to assist to the bathroom. Establish routine for toileting. Use bathroom/commode during waking hours and commode at night for toileting. During observation of morning cares on 11/04/2015, at 7:31 a.m., nursing assistant (NA)-C had washed R13, changed R13's incontinent product and had assisted to dress R13. NA-C then transferred R13 into a wheelchair, combed R13's hair, shaved R13 and assisted R13 with eye glasses. NA-C then assisted R13 out of R13's room. NA-C failed to offer the toilet to R13. During interview on 11/4/15, at 8:59 a.m., NA-C verified had not offered R13 the toilet. During interview on 11/05/2015, at 2:48 p.m., director of nursing (DON) stated she would expect toileting to be provided according to R13's care plan. R33's care plan, problem start date 5/28/15, indicated limited in physical mobility, chair fast all or most of the time related to physical limitations and depression with intervention of do not double brief, use night time brief day and night. Problem start date, 5/11/15, at risk for falling related to unsteady balance with intervention of place alarm on resident when sitting in wheelchair. In addition, the care sheet dated 10/13/15, indicated use night brief at all times, do not	F 282	December 8, 2015. This will be monitored by QA Nurse doing random audits of nursing assistant cares as compared to the residents□ care plans monthly x6 months.	

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F 282	Continued From page 14 double pad R33. On 11/04/2015, at 8:39 a.m., nursing assistant (NA)-D was observed to double pad R33 with incontinent products. In addition, on 11/4/15, at 9:49 a.m., R33 was observed sitting in wheelchair with a tab alarm hanging on the back of the wheelchair. The tab alarm was not attached to R33. During interview on 11/4/15, at 8:57 a.m., NA-D verified had double padded R33 with incontinent products. NA-D further stated R33 has a lot of wetness and was trained to double pad R33. NA-D verified R33's care sheet read do not double pad. During interview on 11/4/15, at 9:49 a.m., NA-D verified the tab alarm was not attached to R33. During interview on 11/05/2015, at 3:05 p.m., DON stated she would expect staff to follow R33's care plan regarding the tab alarm to be in place when in wheelchair. DON stated the care sheets the nursing assistants follow coincides with the resident's care plan. DON verified R33's care sheet read do not double pad in regards to incontinent product. In addition, the DON stated no residents should be double padded in regards to the use of incontinent products. A facility policy regarding care plan implementation was requested, but was not provided. LACK OF USE OF EZ STAND WHILE RECEIVING CARES: R44's care plan dated 10/15/15, indicated R44	F 282		

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F 282	Continued From page 15 required an assist of one and use of the EZ stand for transfers. R44 was transferred on 11/4/15 at 7:41 a.m. by nursing assistant (NA)-E using an easy stand from the recliner in the day area to R44's wheelchair. NA-E propelled R44 to her room. NA-E applied a gait belt snuggly around R44's upper torso region. R44 was pushed up to the sink where with extensive assistance from NA-E R44 was pulled up to the sink. NA-E repeatedly directed R44 to hold on to the front lip of the sink to hold herself up. R44 kept grabbing for the knobs of the faucet and pulling on the sink to hold herself up. NA-E repositioned R44's gait belt, pinching R44's upper torso region. NA-E then extensively assisted R44 to sit on the commode. R44 was once again extensively assisted to a standing position, pulling on the sink, grabbing the faucet handles and faucet to stay standing. NA-E continued to assist R44 with her morning cares. Following R44's morning cares, NA-E stated it was a normal routine for R44 to stand at the sink to have her cares completed. NA-E indicated it would be new to her if R44's transfer routine changed. NA-E then reviewed R44's care plan, confirming R44 was an assist of one with the EZ stand. Physical Therapy Communication Note, dated 10/14/15 recommended use of EZ stand for transfers. A facility policy regarding care plan implementation was requested, but was not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		12/15/15

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F 309	Continued From page 16 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 observation, interview and document review, the facility failed to provide necessary care and services related to monitoring of bruises for 2 of 3 residents (R53 & R33) reviewed for non-pressure related skin conditions. Findings include: R53's resident admission record, dated 9/9/15, indicated that the resident had diagnoses of: moderate protein-calorie malnutrition; deficiency of other specified B group vitamins; vitamin D deficiency; thrombocytopenia (a disorder of the blood which can cause bleeding in to the tissues, bruising, and slow blood clotting after injury). R53's care plan, dated 9/9/15, stated that nursing staff were to conduct a systematic skin inspection on a daily basis. It further directed nursing staff to inspect the skin for sites of concern when performing activities of daily living including toileting and weekly bathing. During an observation on 11/3/15 at 2:13 p.m., R53 was seen to have several sites of bruising of varying sizes on both forearms.	F 309	F309 Gundersen Tweeten Care Center will continue to ensure that each resident receives and is provided with 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. Resident #53 passed away on 11/30/15. A bruising event form was initiated prior to surveyors leaving the building for R53 & R33 and monitored by nursing until healed. Case Managers will review all care plans and update any residents at risk for bruising. All staff was reeducated on the policy and procedure for notifying the charge nurse of bruising immediately upon finding on December 8, 2015. This will be monitored by a weekly skin inspection to be completed on bath days.	

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F 309	Continued From page 17 During record review of R53, no documentation was evident to indicate that R53 had any bruising on either forearm: the care plan lacked any documentation which stated that the resident was susceptible to bruising; the interdisciplinary notes lacked any indication of any bruising on R53's forearms; a document titled, "Tweeten Skin Integrity Condition Report," dated 11/2/15, had no mention of any bruising for R53; a document with the same title but dated 10/27/15 had no mention of any bruising. When interviewed on 11/4/15 at 9:11 a.m., nursing assistant (NA)-B stated that she was not aware that R53 had any bruising on his forearms. She stated that if a resident were to develop any bruising she would notify the nurse. When interviewed on 11/5/15 at 8:49 a.m., registered nurse (RN)-A stated that she was not aware of any bruising on R53's bilateral forearms. She stated that after the resident finished breakfast she would assess the resident. When interviewed on 11/5/15 at 10:28 a.m., registered nurse (RN)-A verified that R53 had bruising on both of his forearms. She stated that the resident was in the hospital on 10/15/15 and attributed the bruising to the hospital stay. RN-A stated there was no documentation on the bruising and that staff had not been monitoring the bruising on R53. RN-A stated that the nursing staff would begin to monitor R53's bruising on his forearms. When interviewed on 11/5/15 at 12:07 p.m., the director of nursing (DON) stated that the nursing assistants should have notified the nursing staff that R53 had bruising on both of his arms.	F 309		

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F 309	Continued From page 18 When asked for a policy on developing a care plan for problems such as bruising, the facility provided a copy of the state regulations which high-lighted the title "Comprehensive resident care plans (no date on copy)." It stated that a comprehensive care plan was to be developed for each resident using the results of the comprehensive assessment. It stated that each resident care plan should include measurable objectives and timetables to meet all resident needs identified in the comprehensive assessment. It stated that all services to be provided should be included in each resident's plan of care. It stated that the comprehensive care plan should describe the services furnished to attain the resident's highest well-being. R33's quarterly Minimum Data Set (MDS) dated 8/18/15, identified R33 had diagnoses of Alzheimer's, dementia, had severe cognitive impairment and required extensive assist with activities of daily living. R33's care plan, dated 5/11/15, indicated at risk for pressure ulcers related to impaired bed mobility. Report any signs of skin breakdown (sore, tender, red or broken areas). R33's care plan failed to address bruising. On 11/04/2015, at 8:39 a.m., during observation of R33's morning cares provided by nursing assistant (NA)-D and nursing assistant (NA)-C, R33 was observed to have a bruise on the side of R33's left hand and on the top of R33's left forearm. During observation on 11/05/2015, at 9:55 a.m., RN-A confirmed R33 had a bruise on the side of left hand and on top of left forearm. RN-A stated I	F 309		

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F 309	Continued From page 19	F 309		

wander if bruising from EZ stand mechanical lift use, because of where the bruises are located. RN-A reviewed R33's record and confirmed there was no documentation regarding the bruises located on R33's side of left hand and on the top of R33's left forearm. RN-A stated the nursing assistants are to inform a nurse when a resident has bruising, the nurse then measures the bruises and documents in the resident record under events regarding the bruising. The nurse then notifies the family, the physician and the case manager. The nurse makes a progress note in the resident's record, relays information to the next shift and adds to 24 hour report. In addition, RN-A stated we monitor bruising by documenting on the treatment section of the residents record, usually once a day until resolved as a nursing order.

During interview on 11/05/2015, at 3:05 p.m., when queried regarding system reporting bruising, the director of nursing stated nursing assistants should notify the nurse when bruising is observed with a resident.

The facility policy Accident and Incident Reporting, dated 7/15/13, indicated it is the policy of Gunderson Tweeten Care Center to use a systemic approach to preventing accidents as follows: identification of hazards, including inadequate supervision, and resident's risk of potentially avoidable accidents in the resident environment; evaluation and analysis of hazards and risks; implement intervention of interventions, including adequate supervision and assistive devices, to reduce individual risk related to hazards in the environment; and monitoring for effectiveness and modification of intervention when necessary.

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral cares for 1 of 1 resident (R13) who required assistance with personal hygiene. Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/6/15, identified R13 had severe cognitive impairment and required extensive assistance from staff to complete personal hygiene. During observation of morning cares on 11/04/2015, at 7:31 a.m., nursing assistant (NA)-C had washed R13, changed R13's incontinent product and had assisted to dress R13. NA-C then transferred R13 into a wheelchair, combed R13's hair, shaved R13 and assisted R13 with eye glasses. NA-C then assisted R13 out of R13's room. NA-C failed to provide oral cares. R13's care plan, dated 09/08/2015, indicated limited ability to maintain grooming and hygiene related to dementia with interventions of provide all three cues to limited assist for oral cares, has own teeth.	F 312	F312 Gundersen Tweeten Care Center will continue to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. NA-C has been reeducated on the need to provide oral cares as part of providing AM ADL□s for residents. All other nursing staff was reeducated on providing oral cares as well on December 8, 2015. This will be monitored by QA Nurse doing random audits of nursing assistant cares as compared to the residents□ care plans monthly x6 months.	12/15/15

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F 312	Continued From page 21 During interview on 11/4/15, at 8:59 a.m., NA-C verified had not provided oral cares for R13. During interview on 11/05/2015, at 2:48 p.m., director of nursing stated she would expect oral cares to be provided. The facility policy Oral Hygiene, undated, indicated offer oral hygiene before breakfast, after each meal and at bedtime.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a safe transfer technique for 1 of 2 residents (R44) observed for transfers. Findings Include: R44 was transferred on 11/4/15 at 7:41 a.m. by nursing assistant (NA)-E using an EZ stand from the recliner in the day area to R44's wheelchair. NA-E then propelled R44 to her room. NA-E applied a gait belt snuggly around R44's upper torso region. R44 was pushed up to the sink where with an extensive assistant from NA-E R44	F 323	F323 Gundersen Tweeten Care Center will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. NA-E was reeducated on the need to transfer the resident according to the plan of care. All nursing staff was reeducated on the need to follow the residents plan of care in regards to the care of the resident on December 8, 2015. This will be monitored by QA Nurse doing random audits of nursing assistant cares as	12/15/15

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F 323	Continued From page 22 was pulled up to the sink. NA-E repeatedly directed R44 to hold on to the front lip of the sink to hold herself up. R44 kept grabbing for the knobs of the faucet and pulling on the sink to hold herself up. NA-E repositioned R44's gait belt, pinching R44's upper torso region. NA-E then extensively assisted R44 to sit on the commode. R44 was once again extensively assisted to a standing position, pulling on the sink, grabbing the faucet handles and faucet to stay standing. NA-E continued to assist R44 with her morning cares. Following R44's morning cares, NA-E stated it was a normal routine for R44 to stand at the sink to have her cares completed. On 11/4/15 at 8:33 a.m. registered nurse (RN)-D, a manager, stated; "[R44] does very well with the sink. We do that with [another residents name] too. All the residents pull on them [reference to the sink to hold on to when standing]." RN-D was asked if the sinks were a safe alternative to a grab bar for a resident to use for standing and support when standing and she said, "I'm gonna say I think so." On 11/5/15 at 9:24 a.m. the maintenance worker was questioned if the sink was a safe tool to use for residents to help them stand and use for support and he stated, "The sink is not a grab bar, but they have used them to pull themselves up, they won't hurt anything. I don't know what the manufacturer recommends. I think that is why they have the curved faucet to grab onto." On 11/5/15 at 1:49 a.m. the director of nursing stated, "As far as I know it is safe [using the sink as a transfer assist], it has been [routine] on the Woodlands, the goal is to get them to do it for themselves."	F 323	compared to the residents care plans monthly x6 months.	

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F 323	Continued From page 23 R44's care plan dated 1/12/15 indicated R44 required an assist of one with daily cares and will transfer self with staff assistance and staff providing step by step cues. Facility policy, Safe Patient Handling, dated 7/1/08, reads: "This policy is to ensure that staff use appropriate techniques in transferring the residents of the facility to avoid back injury to staff and ensure safety of residents...1. PIVOT with 1, Resident can bear weight on one or both feet consistently, and can lean forward, reach and follow simple directions, and can maintain a sitting position of 90 degrees without support."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor weights and reassess for significant weight loss for 1 of 3 residents (R33) who had been reviewed for nutritional status.	F 325	F325 Gundersen Tweeten Care Center will continue to ensure that a resident- (1) maintains acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident□s	12/15/15

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F 325	Continued From page 24 Findings Include: R33 was observed on 11/04/2015, at 9:25 a.m., while nursing assistant (NA)-D assisted R33 with breakfast. Breakfast which included nectar thickened liquids of juice, water and milk, oatmeal, mighty shake supplement, ground sausage and toast. R33 had stated I am done, take me back to my room. R33 had eaten 95 percent of oatmeal, 50 percent of sausage, 100 percent of milk and water, 50 percent of juice, 0 percent of mighty shake supplement (the carton had not been opened) and 0 percent of toast. On 11/05/2015, at 8:29 a.m., R33 was sitting in wheelchair in the dining room. R33 had eaten 100 percent of food and fluids. R33's quarterly Minimum Data Set (MDS) dated 8/18/15, identified R33 had diagnoses of Alzheimer's, dementia, had severe cognitive impairment, required extensive assistance from staff to eat, mechanical altered diet and therapeutic diet, weight 209 and no weight loss. Review of R33's weights was documented as follows: 11/5/15: 191 pounds (lbs) 11/3/15; 172 lbs 10/14/15: 198 lbs 9/1/15: 210 lbs 8/18/15: 209 lbs 7/8/15: 208 lbs 5/11/15: 212 lbs (date of admission to facility) A total of 21 lbs since admission and is a significant loss of 10 percent (%) in 6 months. R33's Tweeten Medical Nutritional Therapy	F 325	clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem based on a resident□s comprehensive assessment. Resident #33 was reweighed; provider notified of results and Registered Dietician evaluated results. Policies and Procedures reviewed and updated as needed. All nursing staff will be retrained on scales and proper weighing techniques; importance of determining which scale is appropriate for each resident and being consistent with using that scale; use of Monthly Weight Form as guideline for baseline weights; need to reweigh resident according to policy and reporting discrepancies to RD. This will be monitored by RD after getting Monthly Weight Form from Case Managers by 15th of each month; review and reassess as needed.	

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F 325	Continued From page 25 Re-Assessment, dated 8/25/15, indicated weight stable, varied intakes of 0% to 100% for breakfast, 25% to 100% for lunch and 1% to 74% for supper, totally dependent for eating, nutrition intervention: continue previous. R33's care plan, dated 5/11/15, indicated weight 209 pounds, will be encouraged to remain within DWB (dry weight basis) range of 200-210 pounds with intervention of weigh monthly or per physician orders. Poor fluid intake with meals with interventions of fluids monitored and recorded each meal, fluids offered between meals and at structured activities. Varied food intakes with interventions of eat at grace table with staff to feed at meals, food dislikes are recorded in kitchen, food intakes are monitored and recorded each meal and offer carbohydrate controlled mechanically altered diet. R33's resident progress note, dated 10/14/2015, documented by the dietary manager director (DMD)-C read she had spoken to R33's family member (FM)-A related to start of a new drug metformin related to diabetes. Family often assisted R33 at meals and have noticed a decrease in intakes. Upon review, R33's intakes at breakfast and lunch have decreased over the past four days but supper is unchanged. R33's weight does show a significant change/decrease at one month of 21 pounds and 10%. Reweigh has been requested and RDN [registered dietician nutritionist] to verify loss or inaccurate weight. Will add diabetic chocolate shake at 240 cubic centimeters for three meals daily. Continue to monitor weights and intakes and adjust nutrition as needed. Review of R33's recorded intake of supplements (diabetic chocolate shake) for breakfast, lunch	F 325		

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and supper identified from 10/14/15 through 11/5/15 with 76 to 100 percent intake of the supplements at breakfast meal for these four days only (10/28, 10/30, 11/02 and 11/5).

On 11/5/15, at 2:31 p.m., DMD-C was questioned regarding R33's supplement intake, weight loss and if reweigh had been done DMD-C stated staff should be opening the carton of supplement and pouring the supplement into a glass at meals. DMD-C reviewed R33's intake of supplements and stated R33 usually drinking supplement at breakfast, but not so much other meals. DMD-C stated FM-A wants supplements at meal time, so if R33 does not eat well R33 should drink the supplement. DMD-C stated she had reviewed R33's weight last on 10/14/15, and had spoken with FM-A regarding decreased intake, significant change weight noticed and had requested reweigh for R33. DMD-C stated weight on 11/3/15 was 172, which is off, we will have to reweigh. When queried regarding how soon reweighs should be done the DMD-C stated reweighs should be done within a week. In addition, DMD-C stated if the computer weight looks out of normal the resident should be automatically reweigh, but the computer system flags after the fact and not when the weight is put in, that is why reweighs are getting missed. In addition, the DMD-C stated R33's reweigh on 11/3/15, did not include which scale was used and last month one weight was obtained using a Hoyer mechanical lift and then three weights were obtained sitting. DMD-C verified system problem with weighing.

On 11/05/2015, at 3:23 p.m., DMD-C stated she had not notified R33's physician regarding weight loss and do not know if anyone else had notified the physician. The protocol regarding significant

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weight loss is to notify the residents case manager, but had not done this. In addition, DMD-C stated she had requested R33's reweigh after talking with surveyor.

On 11/05/2015, at 3:28 p.m., registered nurse (RN)-D stated she had not been notified of any weight loss for R33. RN-D stated to be honest weights are something we have been struggling with and working on. RN-D said the weights should be taken with the same scale each time and normally all weights are obtained on bath days using the bath chair. RN-D verified R33's weights were fluctuating and show a weight loss. RN-A stated sometimes I will not know of weight loss until quite a drop with weight. RN-A stated our policy for reweigh is to reweigh at the time if more than a five pound difference in previous weight and the same shift is to reweigh the resident. RN-A stated she did not know why R33 was not reweigh with over five pound loss.

On 11/5/15, at 4:53 p.m., DMD-C stated she had staff reweigh R33, weight was 191 pounds which is down from admission.

The facility policy Tracking Weight Changes, dated 10/31/08, indicated a copy of weight records will be forwarded to the appropriate professional each month to weight team leader, registered dietician/dietary manager (RD/DTR) or appropriate person. The RD/DTR will review monthly weights and calculate significant change over one, three and six months. A copy of all significant weight losses and gains will be given to the care team for appropriate review and documentation. The care team will review and document on all significant weight changes, with appropriate referrals to the RD/DTR. The

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F 325	Continued From page 28 RD/DTR will review all significant weight losses and referrals and take action as necessary (including follow up documentation). All individuals with significant weight changes will be re-weighed to assure accuracy of the weight prior to reporting this to the staff, physician, or family. The individual, family (or legal guardian), physician and RD/DTR will be notified of any individual with an unplanned significant weight change of 5% in one month, 7.5% in three months, or 10% on six months. The facility is responsible for obtaining correct weights on a regular basis, and for keeping accurate records. This includes having adequate weight scales, bed scales, lift scales, and/or wheel chair scales as needed. The facility Weight Change Policy, dated 3/12/07, indicated when there is a weight change of five pounds or greater in a residents weight nursing will reweigh the resident. If the initial weight change is accurate nursing will notify the Dietician/Dietary Manager. The Dietician/Dietary Manager will then assess the resident and determine if the weight change is significant. If the change is not significant the Dietician/Dietary Manager will continue to monitor successive weights. If noted to be significant Dietician/Dietary Manager will perform a comprehensive reassessment of resident and evaluate possible causes. Recommendations will be made and the Physician will be notified per director of nursing.	F 325		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		12/15/15

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F 431	Continued From page 29 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly secure medication from unauthorized access and prevent aversion of medications for two medication rooms. This had the potential to affect all residents living in the facility who receive	F 431	F431 Gundersen Tweeten Care Center will continue to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The system for narcotic	

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F 431	Continued From page 30 narcotics. Findings include: LACK OF SOUND SYSTEM FOR NARCOTIC STORAGE TO PREVENT AVERSION: During the onsite visit on 11/2/15 at 5:06 p.m., registered nurse (RN)-B gave a tour of the medication room. In this room contained a locked cabinet which housed narcotics to be destroyed in the future. In this cabinet contained one bottle of liquid oxycodone (class two narcotic) which did not contain the amount of liquid which had been charted the last time it had been used. RN-B stated that the medication had been used for a resident who expired in October 2015. The bottle of liquid Oxycodone was placed in a plastic bag. A document titled, "Controlled Drug record for Tweeten Health Services (no date)," indicated the dates and times this medication had been given. The controlled drug record described the physician order: Oxycodone HCL-20 mg (milligrams) /ml (milliliters), give 0.25 ml sublingually (under the tongue) every 2 hours as needed for shortness of breath. A note dated 10/16/15 had been taped to the controlled drug record; it stated that the liquid in the bottle should have been measured at 18.25 ml (milliliters) but the count at 10:00 p.m. shift change indicated 15.50 ml (milliliters). The writer of the note stated there was spilled liquid oxycodone in the plastic bag. The writer stated they were unsure why this occurred. It advised that whoever administered the medication in the future to keep an eye on the seal to prevent further spillage. On 10/16/15 at 11:30 p.m., the record indicated a dose of 0.25 ml had been given to the patient; on 10/17/15 at 7:45 a.m., the record indicated that 0.25 ml had been given to the resident; on 10/17/15 at 10:40 a.m. the record indicated that 0.25 ml had been given	F 431	storage was reviewed and Policies and Procedures updated as needed. Licensed nursing staff was reeducated on December 8, 2015 in regards to the need to secure medications from confused residents; need to secure Controlled Substances according to policy and need to ensure medication refrigerators are locked at all times when not in use. This will be monitored by QA nurse doing random audits weekly of medication refrigerators and ensuring all medications are properly secured. Two nurses will now document accurate counts of any controlled substances removed from medication cart prior to destruction. DON or designee and Consulting Pharmacist will destroy Controlled Substances monthly and monitor compliance of accurate counts.	

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to the resident. The controlled drug record indicated that the remaining liquid in the bottle was 14.75 milliliters (ml). When the bottle was reviewed with RN-B, there was 12 ml of liquid in the bottle. RN-B stated that every single nurse in the facility had access to this locked cabinet. RN-B stated that she did not know why there was missing amount of liquid Oxycodone in the bottle. RN-B stated, "I don't know what to tell you." RN-B stated this was the only location in the facility where discontinued narcotic medications were stored in preparation of being destroyed. RN-B stated that these narcotics were not counted at the end of each shift. RN-B stated that all nurses have access to these narcotics and can access them with a key at any time.

When interviewed on 11/2/15 at 5:48 p.m. registered nurse (RN)-B stated that the nursing staff does not count expired narcotics which are to be held until they are destroyed in the locked cabinet. RN-B described that when a narcotic is to be destroyed the nurse will take the controlled drug record sheet out of the narcotic book; the nurse then takes this sheet along with the expired narcotic and stores it in the locked cabinet. There was only one nurse that does this. RN-B reiterated that no one verifies the actual amount of the narcotic once it ends up in the locked cabinet before it is to be destroyed. RN-B stated, "I don't ever count (narcotic medication) again."

When interviewed on 11/2/15 at 5:56 p.m., the director of nursing (DON) stated that she and the consultant pharmacist destroy the discontinued narcotics on a monthly basis. She stated that she and the pharmacist take the expired narcotics out of the cabinet. The DON stated that she does keep the sheet titled, Controlled Drug Record For

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Tweeten Health Services, which was the only record of how much was administered to the resident. The DON has this piece of paper scanned in to the resident's permanent medical record. The DON stated that she does compare the sheet with the actual amount of medication prior to destroying the medication.

When interviewed on 11/2/15 at 7:21 p.m., the director of nursing (DON) stated that she would be notified if there was a discrepancy in the count of a medication and the actual amount. The DON verified that there was 12 ml (milliliters) of the discontinued liquid Oxycodone medication in the locked cabinet. The DON stated that only one nurse will put any newly discontinued narcotic medication in the locked cabinet at any time. When asked what would happen if a narcotic medication along with its accompanying Controlled Drug Record sheet were to be taken out of the locked cabinet, the DON stated she would have no way of knowing if the narcotics had been taken. The DON stated that the discontinued medication was only identified by its accompanying Controlled Drug Record sheet. Regarding the discrepancy in the actual count and the Controlled Drug Record of the liquid Oxycodone, the DON stated that she had not had time yet to look in to that to comment on that.

When interviewed on 11/14/15 at 9:38 a.m., the consultant pharmacist (Ph)-B stated that to ensure to there would be a lessened chance for diversion, the system should have two nurses verify an expired narcotic medication prior to being placed in the locked cabinet. He stated that as of right now, only one nurse was performing this task and it should be done by two nurses.

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F 431	Continued From page 33 The facility policy titled, Medication Storage in the Facility (February 2015), stated that medication storage conditions are monitored on a monthly basis by the pharmacist and corrective action taken if problems are identified. The facility policy titled, Medication Storage in the Facility: Controlled Substance Storage (February 2015), stated that controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. Any discrepancy in controlled substance counts was to be reported to the director of nursing immediately. The director or designee was to investigate and make every reasonable effort to reconcile all reported discrepancies. The director of nursing was to document irreconcilable discrepancies in a report to the administrator. The consultant pharmacist or designee was to routinely monitor controlled substance storage (of discontinued controlled substances), records and expiration dates during routine medication storage inspections. LACK OF SECURING MEDICATIONS FROM CONFUSED RESIDENTS AND POTENTIAL ACCESS/AVERSION BY UNAUTHORIZED PERSONS: During the initial facility tour on 11/2/15 at 1:31 p.m. in the woodlands unit (secure unit where residents with severe cognitive impairment reside) the medication refrigerator was found to be unlocked. The refrigerator is located in the kitchenette area. The kitchenette area is behind a counter with a counter height latching half door. During constant observation of the kitchenette area from 1:31 p.m. through 2:53 p.m. (one hour and 22 minutes) the half door was observed to be left open and unlocked with no staff in the	F 431		

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immediate area six times. During this time R39 (a confused resident) was observed to go into the kitchenette area behind the half door twice. The medication refrigerator contained insulin pens, biscodyl suppositories, and influenza vaccine solution. At 1:51 p.m. registered nurse (RN)-A stated that the medication refrigerator was normally unlocked. The medication refrigerator remained unlocked until 4:03 p.m. when it was brought to the attention of the director of nursing (DON). The DON stated, "There are never residents back here [behind half door]." The DON then locked the medication refrigerator. However, R39 had previously been observed to be alone in the room with the unlocked medication refrigerator.

On 11/2/15 at 2:53 p.m. on the floor near the medication cart (parked near the Woodlands unit main door) a yellow medication tablet was found on the floor. The yellow tablet had a "m35" marking on one side. The tablet was pointed out to licensed practical nurse (LPN)-A. LPN-A was unsure how long the pill was on the floor.

On 11/2/15 at 4:07 p.m. another yellow pill with "m35" markings on one side was found on the floor underneath the window in the dining area of the Woodland unit. At 4:12 p.m. LPN-A stated, "It is very strange that's the same as before." The yellow pill was identified to be chlorthalidone 25 mg (diuretic drug used to treat hypertension). One resident, R52, was identified on the Woodland unit to be prescribed chlorthalidone. R52's physician order read, "chlorthalidone 25 mg 1 tablet once in the morning."

On 11/2/15 at 7:34 p.m. in the Woodlands unit medication was observed to be dropped off by a

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staff person. The staff person laid the medication on the card on the desk near the computer behind the half door. She was able to do this without opening the half door. The staff person immediately left the unit without talking to any staff and the medication was not secured as no staff were present in the area at this time. Upon closer review it was discovered the medication card contained 30 half tabs of Ativan 0.5 mg (anti-anxiety medication that is a controlled substance.) At 7:52 p.m. (18 minutes later) licensed practical nurse (LPN)-A found the medication card on the desk and stated that sometimes it was typical to find meds on the desk and sometimes they will flag her down.

On 11/4/15 at 10:01 a.m. the facility's contract pharmacist stated he reviews medication storage including medication carts and refrigerators on a quarterly basis and added that he has talked to the facility about the Woodlands unit refrigerator being unlocked. Registered pharmacist was informed of the open medication refrigerator and the ativan medications that were set on the cart and left unattended for 18 minutes. Pharmacist said, "[Ativan] is a controlled substance, at a lot of places it's under double locks. It shouldn't be left sitting out. There should be communication when it's handed off. It shouldn't be left out and should be secured in the cart."

On 11/5/15 at 2:00 p.m. the director of nursing stated the Ativan should be locked at all times when not in use. "Ativan should be handed off and put in the cart and handed off."

Facility policy Medication Storage in the Facility, dated February 2015, reads: "Medications and biologicals are stored safely, securely, and

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	245429	A. BUILDING _____ B. WING _____	11/05/2015

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 431	Continued From page 36 properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications....B...Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must 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	F 441		12/15/15

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 _____	11/05/2015

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 441	Continued From page 37 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices during the provision of personal hygiene for 2 of 5 residents (R13, R33) observed receiving cares. Findings include: R13 was observed on 11/04/2015, at 7:31 a.m., nursing assistant (NA)-C had washed R13's peri area and buttocks with a wash cloth, removed gloves and applied clean gloves. In addition, NA-C had laid the soiled washcloth used to cleanse R13's peri area and buttocks on the top of R13's night stand. After providing cares for R13 NA-C then removed the soiled wash cloth off of the top of R13's night stand, placed the washcloth in to a plastic bag and walked out of R13's room. NA-C had failed to wash hands after providing peri cares and failed to sanitize the top of R13's night stand after removing the soiled wash cloth. During interview on 11/4/15, at 8:59 a.m., NA-C verified she had not washed hands after providing peri cares. In addition, NA-C verified she had laid a soiled wash cloth used to cleanse R13's peri	F 441	F441 Gundersen Tweeten Care Center will continue to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. NA-C and NA-D were reeducated on proper infection control practices when providing cares to residents on use of gloves and hand washing. All other nursing staff was reeducated on proper infection control practices when providing cares to residents on December 8, 2015. Infection control nurse to monitor by doing random audits weekly of nursing staff x6 months and reporting results to quarterly QA meeting.	

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F 441	Continued From page 38 area and buttocks on top of R13's night stand and had not sanitized the top of R13's night stand after removing the soiled wash cloth. During interview on 11/05/2015, at 2:48 p.m., director of nursing (DON) stated she would expect staff to wash hands after providing peri cares. In addition, the DON stated she would expect the nightstand to be sanitized after a wash cloth used to provide peri cares was laid on the top of the night stand. R33 was observed on 11/04/2015, at 8:39 a.m., when NA-D donned gloves and removed R33's wet incontinent product. NA-D then (with the same soiled gloves left on) opened R33's cupboard, picked up a container of disposable wipes, cleansed R33's buttocks (with visible bowel movement), then with stool soiled gloves moved a commode and assisted R33 to sit down onto the commode using an EZ stand mechanical lift. NA-D then removed the soiled gloves and assisted to give R33 a drink of water before washed hands with soap and water. Then when R33 was done using the commode NA-D donned gloves, assisted R33 off of the commode using an EZ stand mechanical lift and cleansed R33's buttocks (with visible bowel movement) using a disposable wipe. NA-D continued to wear the stool soiled gloves and placed the container of disposable wipes back into a cupboard, applied a clean incontinent product onto R33, pulled up R33's pants and transferred R33 into a wheelchair using the EZ stand mechanical lift, placed leg rests and a foot board onto R33's wheelchair, changed R33's shirt, applied deodorant under R33's arms, placed a blanket on R33's lap and brushed R33's hair. NA-D then removed the stool soiled gloves.	F 441		

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	245429	A. BUILDING _____ B. WING _____	11/05/2015

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

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F 441	Continued From page 39 During interview on 11/4/15, at 8:57 a.m., nursing assistant (NA)-D verified she had not removed the stool soiled gloves and washed hands after removing R33's wet incontinent product and cleansing R33's buttocks. During interview on 11/05/2015, at 3:05 p.m., DON stated she would expect staff to remove gloves and wash hands after changing a wet incontinent product and providing peri cares. The facility policy Infection Control, dated 2010, indicated change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and wash hands immediately to avoid transfer of microorganisms to other resident or environments. The facility policy Perineal Care, undated, indicated general infection control guidelines 1. Observe (standard) universal precautions or other infection control standards as approved by appropriate facility committee. 2. Wash your hands before and after all procedures. Wear gloves when appropriate.	F 441		

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	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2015**

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

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K 000	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 email to:	K 000	EPOC	

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

Electronically Signed | 12/04/2015

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**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 50 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 12:30 PM on 11/04/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the	K 154	K 154 Gundersen Tweeten Care Center will continue to ensure that when a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. On 11/4/15 a single plan was put in place for the fire sprinkler system out of service. All staff was educated on this on December 8, 2015.	12/8/15

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	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2015**

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K 154	Continued From page 3 Facility Maintenance Director (CG) at the time of discovery.	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 12:30 PM on 11/04/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (CG) at the time of discovery.	K 155	K155 Gundersen Tweeten Care Center will continue to ensure that when a required fire alarm system is out of service for more than 4 hours in a 24-hour 4period, the authority having jurisdiction is notified, and the building is is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. On 11/4/15 a single plan was put in place for the fire alarm system out of service. All staff was educated on this on December 8, 2015.	12/8/15

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
November 24, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5338026

Dear Ms. Borreson:

The above facility was surveyed on November 2, 2015 through November 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00285	A. BUILDING: _____ B. WING _____	11/05/2015

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 2, 3, 4 & 5, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 510	Continued From page 2	2 510		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a recliner was assessed as a restraint for 1 of 1 resident (R39) who utilized a recliner for sleep. Findings Include: R39's quarterly Minimum Data Set dated 8/25/15 indicated severe cognitive impairment and R39 was steady at all times with moving from a seated to standing position, walking, turning around, moving on/off the toilet, and surface to surface transfers. On 11/4/15 at 2:36 a.m. a continuous observation was started of R39. R39 was asleep in a manual recliner located in the public day area of the secure Woodland unit. R39 remained sleeping in the recliner until 4:20 a.m. when licensed practical nurse (LPN)-B awakened R39. Once awake R39 was able to push against the recliner to move the back of the recliner to an upright position and push her feet against the foot rest to move the foot rest. LPN-B assisted R39 to the bathroom to complete morning cares after the completion of morning cares LPN-B assisted R39 to an electric recliner which used a remote control for positioning. LPN-B used the remote control to recline the chair. LPN-B then placed the remote	2 510	Corrected	12/15/15

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	00285	A. BUILDING: _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTEI	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) COMPLETE DATE
2 510	Continued From page 3 control in an outside pocket on the right side of the recliner which R39 could not reach. At 5:32 a.m. R39 was observed to be sleeping in the recliner. At 5:39 a.m. R39 began to move self in recliner and with her feet hanging over side of recliner foot rest. At 5:54 a.m. R39 was intermittently moving around in the recliner, talking to herself, with her knees bent. At 6:10 a.m. R39 was observed to be moving her legs, pushing her feet on the raised leg rest of the recliner, moving her torso and sitting up and down stating, "I want to go too." R39 is unable to get out of the chair due to the leg rest raised. At 6:19 a.m. R39 continued to attempt to get out of the chair noted her to push off recliner with legs and arms. R39's legs were hanging off the side of the raised leg rest. At 6:25 a.m. R39 was attempting to push off on the recliner, pushing down on the recliner arms. At 6:32 a.m. R39 was observed attempting to climb out of the recliner. LPN-B ran to R39's side and used the remote control to return the chair to the upright position. With minimal assistance R39 was able to stand up and walk independently throughout the unit. On 11/4/15 at 5:56 a.m. LPN-B stated R39 normally sleeps in a recliner in the day room, "She would fall out of her bed. At home she would sleep on the floor. Once she is settled into the recliner she will sleep pretty well. She had a room on her own and she wouldn't go into her room. It seems safer to have her out here and keep a close eye on her." Trained medication aide (TMA)-C added, "It's nice on nights to peek in on her and get to her sooner." LPN-B reviewed R39's care plan and stated, "It doesn't look like it is care planned" when asked about the recliner used as a restraint and located near the nurses station.	2 510		

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2 510	Continued From page 4 On 11/4/15 at 8:39 a.m. registered nurse (RN)-D, a manager, stated R39 slept in the blue manual recliner and that she could sometimes independently get out of the chair on her own adding, "If staff see her trying to get out they should help her up otherwise it will cause her distress." On 11/5/15 at 9:37 a.m. nursing assistant (NA)-E stated, "If she [R39] starts wiggly that's our cue to get her up. If the blue recliner is sitting up she can get up on her own." On 11/5/15 at 12:07 p.m. RN-D stated, "She might not be care planned for sleeping in the recliner, she slept on the floor at home. Therapy would assess her, I don't know what our policy is on that. She will put her feet between the foot rest and the arm rest and push herself up. If she was trying to get up for long time I wouldn't want to say that it is a restraint all the time. If she was struggling a good amount of time then yes it would be a restraint, ten or five minutes." On 11/4/15 at 10:05 a.m. physical therapist assistant-D stated nursing would complete assessments regarding sleeping in recliners. On 11/5/15 at 1:55 p.m. the director of nursing (DON) stated, "We don't have a recliner assessment. It would be an observation. If they could normally get out of it [recliner] without help and can't." The noted observations of R39 were read to the DON and she responded with, "At that point it would be considered a restraint." The DON added the recliner was not care planned. R39's care plan dated 12/4/13 reads, "At times, [R39] may lower herself to the floor and sleep on the floor, consistent with her preferences and	2 510		

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2 510	Continued From page 5 routine for many years. If [R39] prefers to sleep on floor, ensure that she is warm enough; do not awaken or attempt to put back to bed, until she herself awakens." Facility policy, Physical Restraint, dated 1/20/06, reads; "Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to one's body. Physical restraints include any article, device or garment used primarily to modify resident behavior by interfering with free movement of the resident or normal functioning of a portion of the body, and which the resident is unable to remove easily, confinement in a locked room....Resident's will be assessed for safety risks and abilities on admission, re-admission, with a significant change, and quarterly with reassessment as needed should a change in condition alter the risks." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident restraint usage data to ensure residents are not restrained without proper assessments and monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 510		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		12/15/15

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2 565	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting cares as directed by the care plan for 1 of 1 resident (R13) who required assistance with toileting and failed to ensure the use of a tab alarm and provide toileting cares as directed by the care plan for 1 of 1 resident (R33) who required assistance with toileting and had limited mobility. In addition the facility failed to provide transfer assistance as directed by the care plan for 1 of 1 resident (R44) who required assistance with transfers. Findings include: LACK OF OFFERING TOILET PER CARE PLAN AND LACK OF USE OF CARE PLANNED TAB ALARM WHILE IN WHEELCHAIR TO PREVENT FALLS: R13's care plan, dated 09/08/2015, indicated limited in ability to toilet self-related to dementia with interventions of check for incontinence every two hours and offer to assist to the bathroom. Establish routine for toileting. Use bathroom/commode during waking hours and commode at night for toileting. During observation of morning cares on 11/04/2015, at 7:31 a.m., nursing assistant (NA)-C had washed R13, changed R13's incontinent product and had assisted to dress R13. NA-C then transferred R13 into a wheelchair, combed R13's hair, shaved R13 and assisted R13 with eye glasses. NA-C then assisted R13 out of R13's room. NA-C failed to offer the toilet to R13. During interview on 11/4/15, at 8:59 a.m., NA-C	2 565	Corrected	

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2 565	Continued From page 7 verified had not offered R13 the toilet. During interview on 11/05/2015, at 2:48 p.m., director of nursing (DON) stated she would expect toileting to be provided according to R13's care plan. R33's care plan, problem start date 5/28/15, indicated limited in physical mobility, chair fast all or most of the time related to physical limitations and depression with intervention of do not double brief, use night time brief day and night. Problem start date, 5/11/15, at risk for falling related to unsteady balance with intervention of place alarm on resident when sitting in wheelchair. In addition, the care sheet dated 10/13/15, indicated use night brief at all times, do not double pad R33. On 11/04/2015, at 8:39 a.m., nursing assistant (NA)-D was observed to double pad R33 with incontinent products. In addition, on 11/4/15, at 9:49 a.m., R33 was observed sitting in wheelchair with a tab alarm hanging on the back of the wheelchair. The tab alarm was not attached to R33. During interview on 11/4/15, at 8:57 a.m., NA-D verified had double padded R33 with incontinent products. NA-D further stated R33 has a lot of wetness and was trained to double pad R33. NA-D verified R33's care sheet read do not double pad. During interview on 11/4/15, at 9:49 a.m., NA-D verified the tab alarm was not attached to R33. During interview on 11/05/2015, at 3:05 p.m.,	2 565		

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2 565	Continued From page 8 DON stated she would expect staff to follow R33's care plan regarding the tab alarm to be in place when in wheelchair. DON stated the care sheets the nursing assistants follow coincides with the resident's care plan. DON verified R33's care sheet read do not double pad in regards to incontinent product. In addition, the DON stated no residents should be double padded in regards to the use of incontinent products. A facility policy regarding care plan implementation was requested, but was not provided. LACK OF USE OF EZ STAND WHILE RECEIVING CARES: R44's care plan dated 10/15/15, indicated R44 required an assist of one and use of the EZ stand for transfers. R44 was transferred on 11/4/15 at 7:41 a.m. by nursing assistant (NA)-E using an easy stand from the recliner in the day area to R44's wheelchair. NA-E propelled R44 to her room. NA-E applied a gait belt snuggly around R44's upper torso region. R44 was pushed up to the sink where with extensive assistance from NA-E R44 was pulled up to the sink. NA-E repeatedly directed R44 to hold on to the front lip of the sink to hold herself up. R44 kept grabbing for the knobs of the faucet and pulling on the sink to hold herself up. NA-E repositioned R44's gait belt, pinching R44's upper torso region. NA-E then extensively assisted R44 to sit on the commode. R44 was once again extensively assisted to a standing position, pulling on the sink, grabbing the faucet handles and faucet to stay standing. NA-E continued to assist R44 with her morning cares. Following R44's morning cares, NA-E	2 565		

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2 565	Continued From page 9 stated it was a normal routine for R44 to stand at the sink to have her cares completed. NA-E indicated it would be new to her if R44's transfer routine changed. NA-E then reviewed R44's care plan, confirming R44 was an assist of one with the EZ stand. Physical Therapy Communication Note, dated 10/14/15 recommended use of EZ stand for transfers. A facility policy regarding care plan implementation was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident care plans to ensure they are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570		12/15/15

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2 570	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan according to the physician orders for 1 of 3 residents (R33) reviewed for nutrition; failed to revise the care plan to include risk of bruising for 1 of 3 residents (R33) reviewed for skin conditions and failed to revise the care plan to include the use of a foot board for 1 of 3 residents (R33) reviewed for restraints. In addition the facility failed to update a care plan after physical therapy recommended changes for 1 of 1 resident (R44) reviewed for positioning. Findings include: LACK OF PHYSICIAN ORDERS INCLUDED IN R33'S CARE PLAN: R33's quarterly Minimum Data Set (MDS) dated 8/18/15, identified R33 had diagnoses of Alzheimer's, dementia, had severe cognitive impairment, required extensive assistance from staff to eat, mechanical altered diet and therapeutic diet. R33's physician order report dated 10/5/15 through 11/5/15, indicated order start date diet: mechanical soft, carbohydrate controlled, supplements with meals, nectar thickened liquids, may have regular water in lidded cup in room 30 minutes post meals after offered oral cares. On 11/04/2015, at 9:25 a.m., nursing assistant (NA)-D was observed to assist R33 with breakfast which included nectar thickened liquids of juice, water and milk, oatmeal, mighty shake supplement, ground sausage and toast. On 11/04/2015, 9:50 a.m., a lidded cup with	2 570	Corrected	

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2 570	Continued From page 11 regular consistency water was observed in R33's room on a tray table. R33's care plan, dated 5/11/15, indicated poor fluid intake with meals with interventions of fluids monitored and recorded each meal, fluids offered between meals and at structured activities. Varied food intakes with interventions of eat at grace table with staff to feed at meals, food dislikes are recorded in kitchen, food intakes are monitored and recorded each meal and offer carbohydrate controlled mechanically altered diet. However, the care plan failed to include supplements with meals and nectar thickened liquids, may have regular water in lidded cup on room 30 minutes post meals after offered oral cares. On 11/04/2015, at 9:52 a.m., registered nurse (RN)-A verified R33's care plan failed to include nectar thickened liquids, may have regular water in lidded cup in room 30 minutes post meals after offered oral cares. On 11/5/15, at 4:53 p.m., dietary manager director (DMD)-C verified R33's physician order for supplements with meals and nectar thickened liquids. DMD-C verified R33's care plan failed to include supplements with meals and nectar thickened liquids. On 11/05/2015, at 3:05 p.m., director of nursing verified R33's physician order dated 10/14/15, and verified R33's care plan failed to include nectar thickened liquids, may have regular water in lidded cup on room 30 minutes post meals after offered oral cares and she would expect the information to be included on R33's care plan. LACK OF CARE PLAN INTERVENTION FOR RISK OF BRUISING:	2 570		

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2 570	Continued From page 12 R33 was observed on 11/04/2015, at 8:39 a.m., and had a bruise on the side of left hand and on top of left forearm. During observation on 11/05/2015, at 9:55 a.m., RN-A confirmed R33 had a bruise on the side of left hand and on top of left forearm. RN-A stated I wander if bruising from EZ stand mechanical lift use, because of where the bruises are located. R33's resident progress notes dated 10/12/15 through 10/15/15, identified R33 had prior bruising noted below umbilicus of unknown origin and on top of penis. R33's care plan, dated 5/11/15, indicated at risk for pressure ulcers related to impaired bed mobility. Report any signs of skin breakdown (sore, tender, red or broken areas). R33's care plan failed to include risk of bruising. During interview on 11/05/2015, at 9:55 a.m., RN-A verified R33's progress notes identified R33 has had previous bruising. RN-A verified R33's care plan failed to include the risk of bruising and stated the risk of bruising should be care planned. During interview on 11/05/2015, at 3:05 p.m., DON verified R33's care plan failed to include the risk of bruising and stated she would expect the risk of bruising to be care planned. LACK OF CARE PLAN INTERVENTION OF FOOD BOARD IN WHEELCHAIR: R33 was observed on 11/3/15, at 9:29 a.m., a foot board was in place on R33's wheelchair. On 11/4/15, at 8:39 a.m., NA-D was observed to place footrests onto R33's wheelchair and then strapped a foot board in place onto R33's	2 570		

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2 570	Continued From page 13 footrests. R33's care plan problem date 5/28/15, indicated limited physical mobility, chair fast all or most of time related to physical limitations, depression with interventions of make sure reclined when not at meals and unsupervised, make sure foot rests elevated to prevent falling forward. R33's care plan failed to include the use of a foot board. During interview on 11/05/2015, at 3:05 p.m., DON verified R33's care plan failed to include the use of a foot board and stated she would expect R33's care plan to include the foot board. When asked for a policy for revision of the care plan, the facility provided an untitled copy of listed regulations, which addressed F280 and indicated care plans are revised as necessary to address the current needs of each resident. R44's care plan dated 1/12/15, identified limited activity/mobility/transfers with impaired balance/weakness. Interventions included, "offer to ambulate with resident on household tolerating at this time up to 50 ft [FEET] with nursing staff bid (twice daily) and when she appears restless, consider offering a walk. Resident will transfer/ambulate with 1 staff assist as needed." R44's care plan indicated R44, with assistance would ambulate with proper use of a walker and two staff assist. PT-Therapist Progress and Discharge Summary dated 10/14/15 included the following discharge instructions, "Discharge to memory care unit with instructions for dc [discharge] of walking program, use of EZ stand for transfers." Quarterly Minimum Data Set (MDS) dated	2 570		

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2 570	Continued From page 14 7/21/15 indicated R44 was a one person physical assist with walking in room and corridor. Quarterly MDS dated 10/20/15 indicated R44 did not ambulate during the seven day look back period. On 11/4/15 at 8:33 a.m. registered nurse (RN)-D, a manager, stated, R44 uses the EZ stand because her knees will buckle. Therapy has worked with her for a while. She has been working with physical therapy since 9/16/15. On 10/14/15 R44 changed to the use of the EZ stand. RN-D said, "I'm gonna say that's the way the care plan was done before I came. I haven't changed that in her care plan." On 11/5/15 at 1:51 p.m. the director of nursing stated, "RN-D and RN-F are new to the care plan process for the last four months. The care is updated quarterly or as changes occur." A facility policy on care planning was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident care plan to ensure their accuracy of care plans. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on	2 830		12/15/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTEI	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) COMPLETE DATE
2 830	Continued From page 15 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary care and services related to monitoring of bruises for 2 of 3 residents (R53 & R33) reviewed for non-pressure related skin conditions. Findings include: R53's resident admission record, dated 9/9/15, indicated that the resident had diagnoses of: moderate protein-calorie malnutrition; deficiency of other specified B group vitamins; vitamin D deficiency; thrombocytopenia (a disorder of the blood which can cause bleeding in to the tissues, bruising, and slow blood clotting after injury). R53's care plan, dated 9/9/15, stated that nursing staff were to conduct a systematic skin inspection on a daily basis. It further directed nursing staff to inspect the skin for sites of concern when performing activities of daily living including toileting and weekly bathing. During an observation on 11/3/15 at 2:13 p.m., R53 was seen to have several sites of bruising of varying sizes on both forearms.	2 830	Corrected	

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2 830	Continued From page 16 During record review of R53, no documentation was evident to indicate that R53 had any bruising on either forearm: the care plan lacked any documentation which stated that the resident was susceptible to bruising; the interdisciplinary notes lacked any indication of any bruising on R53's forearms; a document titled, "Tweeten Skin Integrity Condition Report," dated 11/2/15, had no mention of any bruising for R53; a document with the same title but dated 10/27/15 had no mention of any bruising. When interviewed on 11/4/15 at 9:11 a.m., nursing assistant (NA)-B stated that she was not aware that R53 had any bruising on his forearms. She stated that if a resident were to develop any bruising she would notify the nurse. When interviewed on 11/5/15 at 8:49 a.m., registered nurse (RN)-A stated that she was not aware of any bruising on R53's bilateral forearms. She stated that after the resident finished breakfast she would assess the resident. When interviewed on 11/5/15 at 10:28 a.m., registered nurse (RN)-A verified that R53 had bruising on both of his forearms. She stated that the resident was in the hospital on 10/15/15 and attributed the bruising to the hospital stay. RN-A stated there was no documentation on the bruising and that staff had not been monitoring the bruising on R53. RN-A stated that the nursing staff would begin to monitor R53's bruising on his forearms. When interviewed on 11/5/15 at 12:07 p.m., the director of nursing (DON) stated that the nursing assistants should have notified the nursing staff that R53 had bruising on both of his arms.	2 830		

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2 830	Continued From page 17 When asked for a policy on developing a care plan for problems such as bruising, the facility provided a copy of the state regulations which high-lighted the title "Comprehensive resident care plans (no date on copy)." It stated that a comprehensive care plan was to be developed for each resident using the results of the comprehensive assessment. It stated that each resident care plan should include measurable objectives and timetables to meet all resident needs identified in the comprehensive assessment. It stated that all services to be provided should be included in each resident's plan of care. It stated that the comprehensive care plan should describe the services furnished to attain the resident's highest well-being. R33's quarterly Minimum Data Set (MDS) dated 8/18/15, identified R33 had diagnoses of Alzheimer's, dementia, had severe cognitive impairment and required extensive assist with activities of daily living. R33's care plan, dated 5/11/15, indicated at risk for pressure ulcers related to impaired bed mobility. Report any signs of skin breakdown (sore, tender, red or broken areas). R33's care plan failed to address bruising. On 11/04/2015, at 8:39 a.m., during observation of R33's morning cares provided by nursing assistant (NA)-D and nursing assistant (NA)-C, R33 was observed to have a bruise on the side of R33's left hand and on the top of R33's left forearm. During observation on 11/05/2015, at 9:55 a.m., RN-A confirmed R33 had a bruise on the side of left hand and on top of left forearm. RN-A stated I	2 830		

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2 830	Continued From page 18 wander if bruising from EZ stand mechanical lift use, because of where the bruises are located. RN-A reviewed R33's record and confirmed there was no documentation regarding the bruises located on R33's side of left hand and on the top of R33's left forearm. RN-A stated the nursing assistants are to inform a nurse when a resident has bruising, the nurse then measures the bruises and documents in the resident record under events regarding the bruising. The nurse then notifies the family, the physician and the case manager. The nurse makes a progress note in the resident's record, relays information to the next shift and adds to 24 hour report. In addition, RN-A stated we monitor bruising by documenting on the treatment section of the residents record, usually once a day until resolved as a nursing order. During interview on 11/05/2015, at 3:05 p.m., when queried regarding system reporting bruising, the director of nursing stated nursing assistants should notify the nurse when bruising is observed with a resident. The facility policy Accident and Incident Reporting, dated 7/15/13, indicated it is the policy of Gunderson Tweeten Care Center to use a systemic approach to preventing accidents as follows: identification of hazards, including inadequate supervision, and resident's risk of potentially avoidable accidents in the resident environment; evaluation and analysis of hazards and risks; implement intervention of interventions, including adequate supervision and assistive devices, to reduce individual risk related to hazards in the environment; and monitoring for effectiveness and modification of intervention when necessary.	2 830		

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2 830	Continued From page 19 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident care to ensure an residents receive good care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		12/15/15

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21390	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices during the provision of personal hygiene for 2 of 5 residents (R13, R33) observed receiving cares. Findings include: R13 was observed on 11/04/2015, at 7:31 a.m., nursing assistant (NA)-C had washed R13's peri area and buttocks with a wash cloth, removed gloves and applied clean gloves. In addition, NA-C had laid the soiled washcloth used to cleanse R13's peri area and buttocks on the top of R13's night stand. After providing cares for R13 NA-C then removed the soiled wash cloth off of the top of R13's night stand, placed the washcloth in to a plastic bag and walked out of R13's room. NA-C had failed to wash hands after providing peri cares and failed to sanitize the top of R13's night stand after removing the soiled wash cloth. During interview on 11/4/15, at 8:59 a.m., NA-C verified she had not washed hands after providing peri cares. In addition, NA-C verified she had laid a soiled wash cloth used to cleanse R13's peri area and buttocks on top of R13's night stand and had not sanitized the top of R13's night stand after removing the soiled wash cloth. During interview on 11/05/2015, at 2:48 p.m., director of nursing (DON) stated she would expect staff to wash hands after providing peri cares. In addition, the DON stated she would expect the nightstand to be sanitized after a wash cloth used to provide peri cares was laid on the	21390	Corrected	

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21390	Continued From page 21 top of the night stand. R33 was observed on 11/04/2015, at 8:39 a.m., when NA-D donned gloves and removed R33's wet incontinent product. NA-D then (with the same soiled gloves left on) opened R33's cupboard, picked up a container of disposable wipes, cleansed R33's buttocks (with visible bowel movement), then with stool soiled gloves moved a commode and assisted R33 to sit down onto the commode using an EZ stand mechanical lift. NA-D then removed the soiled gloves and assisted to give R33 a drink of water before washed hands with soap and water. Then when R33 was done using the commode NA-D donned gloves, assisted R33 off of the commode using an EZ stand mechanical lift and cleansed R33's buttocks (with visible bowel movement) using a disposable wipe. NA-D continued to wear the stool soiled gloves and placed the container of disposable wipes back into a cupboard, applied a clean incontinent product onto R33, pulled up R33's pants and transferred R33 into a wheelchair using the EZ stand mechanical lift, placed leg rests and a foot board onto R33's wheelchair, changed R33's shirt, applied deodorant under R33's arms, placed a blanket on R33's lap and brushed R33's hair. NA-D then removed the stool soiled gloves. During interview on 11/4/15, at 8:57 a.m., nursing assistant (NA)-D verified she had not removed the stool soiled gloves and washed hands after removing R33's wet incontinent product and cleansing R33's buttocks. During interview on 11/05/2015, at 3:05 p.m., DON stated she would expect staff to remove gloves and wash hands after changing a wet incontinent product and providing peri cares.	21390		

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21390	Continued From page 22 The facility policy Infection Control, dated 2010, indicated change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and wash hands immediately to avoid transfer of microorganisms to other resident or environments. The facility policy Perineal Care, undated, indicated general infection control guidelines 1. Observe (standard) universal precautions or other infection control standards as approved by appropriate facility committee. 2. Wash your hands before and after all procedures. Wear gloves when appropriate. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident care to ensure infections control practices are being followed by staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the	21630		12/15/15

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21630	Continued From page 23 pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly secure narcotic medication while waiting for destruction for 1 of 1 narcotic medications located in the medication room. This had the potential to affect all residents living in the facility who receive narcotics. Findings include: LACK OF SOUND SYSTEM FOR NARCOTIC STORAGE TO PREVENT AVERSION: During the onsite visit on 11/2/15 at 5:06 p.m., registered nurse (RN)-B gave a tour of the medication room. In this room contained a locked cabinet which housed narcotics to be destroyed in the future. In this cabinet contained one bottle of liquid oxycodone (class two narcotic) which did not contain the amount of liquid which had been charted the last time it had been used. RN-B stated that the medication had been used for a	21630	Corrected	

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resident who expired in October 2015. The bottle of liquid Oxycodone was placed in a plastic bag. A document titled, "Controlled Drug record for Tweeten Health Services (no date)," indicated the dates and times this medication had been given. The controlled drug record described the physician order: Oxycodone HCL-20 mg (milligrams) /ml (milliliters), give 0.25 ml sublingually (under the tongue) every 2 hours as needed for shortness of breath. A note dated 10/16/15 had been taped to the controlled drug record; it stated that the liquid in the bottle should have been measured at 18.25 ml (milliliters) but the count at 10:00 p.m. shift change indicated 15.50 ml (milliliters). The writer of the note stated there was spilled liquid oxycodone in the plastic bag. The writer stated they were unsure why this occurred. It advised that whoever administered the medication in the future to keep an eye on the seal to prevent further spillage. On 10/16/15 at 11:30 p.m., the record indicated a dose of 0.25 ml had been given to the patient; on 10/17/15 at 7:45 a.m., the record indicated that 0.25 ml had been given to the resident; on 10/17/15 at 10:40 a.m. the record indicated that 0.25 ml had been given to the resident. The controlled drug record indicated that the remaining liquid in the bottle was 14.75 milliliters (ml). When the bottle was reviewed with RN-B, there was 12 ml of liquid in the bottle. RN-B stated that every single nurse in the facility had access to this locked cabinet. RN-B stated that she did not know why there was missing amount of liquid Oxycodone in the bottle. RN-B stated, "I don't know what to tell you." RN-B stated this was the only location in the facility where discontinued narcotic medications were stored in preparation of being destroyed. RN-B stated that these narcotics were not counted at the end of each shift. RN-B stated that all nurses have access to these narcotics and can access

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21630	Continued From page 25 them with a key at any time. When interviewed on 11/2/15 at 5:48 p.m. registered nurse (RN)-B stated that the nursing staff does not count expired narcotics which are to be held until they are destroyed in the locked cabinet. RN-B described that when a narcotic is to be destroyed the nurse will take the controlled drug record sheet out of the narcotic book; the nurse then takes this sheet along with the expired narcotic and stores it in the locked cabinet. There was only one nurse that does this. RN-B reiterated that no one verifies the actual amount of the narcotic once it ends up in the locked cabinet before it is to be destroyed. RN-B stated, "I don't ever count (narcotic medication) again." When interviewed on 11/2/15 at 5:56 p.m., the director of nursing (DON) stated that she and the consultant pharmacist destroy the discontinued narcotics on a monthly basis. She stated that she and the pharmacist take the expired narcotics out of the cabinet. The DON stated that she does keep the sheet titled, Controlled Drug Record For Tweeten Health Services, which was the only record of how much was administered to the resident. The DON has this piece of paper scanned in to the resident's permanent medical record. The DON stated that she does compare the sheet with the actual amount of medication prior to destroying the medication. When interviewed on 11/2/15 at 7:21 p.m., the director of nursing (DON) stated that she would be notified if there was a discrepancy in the count of a medication and the actual amount. The DON verified that there was 12 ml (milliliters) of the discontinued liquid Oxycodone medication in the locked cabinet. The DON stated that only one nurse will put any newly discontinued narcotic	21630		

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medication in the locked cabinet at any time. When asked what would happen if a narcotic medication along with its accompanying Controlled Drug Record sheet were to be taken out of the locked cabinet, the DON stated she would have no way of knowing if the narcotics had been taken. The DON stated that the discontinued medication was only identified by its accompanying Controlled Drug Record sheet. Regarding the discrepancy in the actual count and the Controlled Drug Record of the liquid Oxycodone, the DON stated that she had not had time yet to look in to that to comment on that.

When interviewed on 11/14/15 at 9:38 a.m., the consultant pharmacist (Ph)-B stated that to ensure to there would be a lessened chance for diversion, the system should have two nurses verify an expired narcotic medication prior to being placed in the locked cabinet. He stated that as of right now, only one nurse was performing this task and it should be done by two nurses.

The facility policy titled, Medication Storage in the Facility (February 2015), stated that medication storage conditions are monitored on a monthly basis by the pharmacist and corrective action taken if problems are identified.

The facility policy titled, Medication Storage in the Facility: Controlled Substance Storage (February 2015), stated that controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. Any discrepancy in controlled substance counts was to be reported to the director of nursing immediately. The director or designee was to investigate and make every reasonable effort to reconcile all reported

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21630	Continued From page 27 discrepancies. The director of nursing was to document irreconcilable discrepancies in a report to the administrator. The consultant pharmacist or designee was to routinely monitor controlled substance storage (of discontinued controlled substances), records and expiration dates during routine medication storage inspections. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident narcotics upon discharge to ensure accountability of narcotics and to ensure refrigerators are locked appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a safe transfer technique for 1 of 2 residents (R44) observed for transfers. Findings Include: R44 was transferred on 11/4/15 at 7:41 a.m. by nursing assistant (NA)-E using an EZ stand from the recliner in the day area to R44's wheelchair. NA-E then propelled R44 to her room. NA-E applied a gait belt snuggly around R44's upper	21665	Corrected	12/15/15

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(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) COMPLETE DATE
21665	Continued From page 28 torso region. R44 was pushed up to the sink where with an extensive assistant from NA-E R44 was pulled up to the sink. NA-E repeatedly directed R44 to hold on to the front lip of the sink to hold herself up. R44 kept grabbing for the knobs of the faucet and pulling on the sink to hold herself up. NA-E repositioned R44's gait belt, pinching R44's upper torso region. NA-E then extensively assisted R44 to sit on the commode. R44 was once again extensively assisted to a standing position, pulling on the sink, grabbing the faucet handles and faucet to stay standing. NA-E continued to assist R44 with her morning cares. Following R44's morning cares, NA-E stated it was a normal routine for R44 to stand at the sink to have her cares completed. On 11/4/15 at 8:33 a.m. registered nurse (RN)-D, a manager, stated; "[R44] does very well with the sink. We do that with [another residents name] too. All the residents pull on them [reference to the sink to hold on to when standing]." RN-D was asked if the sinks were a safe alternative to a grab bar for a resident to use for standing and support when standing and she said, "I'm gonna say I think so." On 11/5/15 at 9:24 a.m. the maintenance worker was questioned if the sink was a safe tool to use for residents to help them stand and use for support and he stated, "The sink is not a grab bar, but they have used them to pull themselves up, they won't hurt anything. I don't know what the manufacturer recommends. I think that is why they have the curved faucet to grab onto." On 11/5/15 at 1:49 a.m. the director of nursing stated, "As far as I know it is safe [using the sink as a transfer assist], it has been [routine] on the Woodlands, the goal is to get them to do it for	21665		

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	00285	A. BUILDING: _____ B. WING _____	11/05/2015

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21665	Continued From page 29 themselves." R44's care plan dated 1/12/15 indicated R44 required an assist of one with daily cares and will transfer self with staff assistance and staff providing step by step cues. Facility policy, Safe Patient Handling, dated 7/1/08, reads: "This policy is to ensure that staff use appropriate techniques in transferring the residents of the facility to avoid back injury to staff and ensure safety of residents...1. PIVOT with 1, Resident can bear weight on one or both feet consistently, and can lean forward, reach and follow simple directions, and can maintain a sitting position of 90 degrees without support." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident environment to ensure the environment is free from unsafe hazards. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as	21880		12/15/15

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21880	Continued From page 30 well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to effectively respond to individual grievances, related loud noises made by R43 during the overnight hours, for 1 of 1 residents (R40) reviewed with expressed concerns of loud noise levels within the facility.	21880	Corrected	

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21880	Continued From page 31 Findings include: R40's admission Minimum Data Set (MDS) dated 7/28/15, identified his cognition intact, no problems with his mood, or behaviors. R40 had a diagnosis of anxiety, manic depressive and dementia. When observed and interviewed on 11/03/15, at 10:38 a.m. R40 said he has a problem in this room. R40 said his roommate "stays awake and calls for mama all night." I told management about it four weeks ago and nothing had been done. I talked to social services (SS)-E and registered nurse (RN)-F about it and they said they would do what they could. I said I wanted to move to another room and was told there are no open rooms to move into. No one has asked if it has improved. An interview on 11/04/15, at 8:37 a.m. SS-E said the process for grievances is if it is verbal and brought up at care conference we talk about it at that time. SS-E said she knew about R40's concern with his roommate talking at night but she hasn't received any written grievances. SS-E said if a concern is received it goes to the affected department. That department will address it and than it comes back to the resident council meeting. SS-E than said that she doesn't document some complaints. SS-E said she did not fill out a grievance form on R40's behalf because R40 had not complained more then one time. SS-E was offered a different room or something for sleep but he chose neither option so SS-E thought it was no longer a concern. An interview on 11/04/15, at 1:17 p.m. the director of nurses (DON) said RN-F who is the care manager and she reviews grievances form residents. She said she has not heard anything	21880		

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21880	Continued From page 32	21880		

about R40's grievance. The DON also said she doesn't think it is a grievance because he did not go to the administrator like the policy says he should have.

During an interview with RN-F at 11/05/15, at 9:15 a.m. said she knew about R40's grievance. RN-F said they (SS-E and RN-F) talked to R40 and he said it was better but she thinks it is worse again now that the roommate is back from the hospital. RN-F said they don't have any open rooms a the time. RN-F said SS-E does most of the documentation regarding resident complaints. She said she doesn't know if the DON knows about it. RN-F said we normally don't make a big deal about it. Our policy is if you are not happy, you can move. RN-F said she knew this issue wasn't resolved as R40 kept talking about it with her. We have a grievance form but we normally don't fill the form out. She agreed there is no documentation in progress note.

An interview on 11/05/15, at 9:37 a.m. nursing assistant (NA)-A said she knew about R40 not sleeping because of his roommate. She said when R40 mentions it, she always tells the nurse. She said the nurse will tell her to lay him down more often during the day.

During an interview on 11/05/15, at 9:38 a.m. NA-G said R40 tells her about being woken up in the night by his roommate. She said that the nurses talk about and have said to lie him down more frequently. NA-G said she has not heard of any other plan for R40.

An interview on 11/05/15, at 11:42 a.m. the administrator said they discuss grievances at care conferences, stand up meetings, department meetings or resident council to address

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21880	Continued From page 33 grievances. R40's sleep assessment dated 10/20/15, read, "How many times does resident awaken in the night?" The answer was two to four times. A facility policy for persons being served shall have the right to voice grievances. Included all complaints will be documented and given to the Director of Nurses or the Department Head/Supervisor of the area involving the grievance. The Department Head/Supervisor will conduct an investigation of the matter to determine its validity. If the Department Head/Supervisor either does not have a satisfactory answer for you or does not answer you concern within seven days, report to the Administrator in person, in writing or by phone concerning your issue. The Administrator will investigate and respond to you within seven days. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident grievance process to ensure their complaints are being heard, and the residents are getting timely resolution. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		