DEPARTMENT OF HEA					CENTERS FOR ME	DICARE & MEDIC	AID SERVICES
					AND TRANSMITTAL		D: 90ML
1. MEDICARE/MEDICAID PRO		3. NAME AND AI			FE SURVEY AGENCY	4. TYPE OF ACTIO	Facility ID: 00285 N: 7 (L8)
(L1) 245429					CARE CENTER	1. Initial	2. Recertification
2.STATE VENDOR OR MEDICA	AID NO.	(L4) 125 5TH AV		HEAST	a o 55054	3. Termination	4. CHOW
(L2) 068252700		(L5) SPRING GR	ROVE, MN		(L6) 55974	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE	E OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)	8. Full Survey After	Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA		F
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 	2/18/2015 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF 11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR ENDI	NG DATE: (L35)
0 Unaccredited 1 TJ	(L10)	03 SNF/NF/Distilet	07 X-Ray 08 OPT/SP	12 RHC	16 HOSPICE	09/30	
2 AOA 3 Ot		01011	00 01 1/01	121010			
11. LTC PERIOD OF CERTIFICA	ATION	10.THE FACILITY	Y IS CERTIFIED	AS:			
From (a):		X A. In Complia	nce With		And/Or Approved Waivers O	f The Following Requireme	ents:
To (b):		Ŭ	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	_ `	
12. Total Facility Beds	50 (L18)		cceptable POC		4. 7-Day RN (Rural S	 7. Medical Dire NF)8. Patient Room 	
			-		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	50 (L17)	B. Not in Con Requirem	npliance with Pro ents and/or Appli	gram ed Waivers:	* Code: A	(L12)	
14. LTC CERTIFIED BED BREA	KDOWN				15. FACILITY MEETS		
18 SNF 18/19 S	INF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
50							
(L37) (L38	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY I	REMARKS (IF APPLIC	ABLE SHOW LTC C	ANCELLATION	N DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Gary Nederhoff,	Unit Supervisor	1	2/29/2015	(L19)	K <u>amala Fiske-Downing</u>	, Enforcement Speci	ialist 12/29/2015 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIC	GIBILITY		IPLIANCE WIT	H CIVIL		ancial Solvency (HCFA-257	
 Facility is Eligibl 	e to Participate	KIGI	HTS ACT:		 Ownersnip/Contr Both of the Abov 	rol Interest Disclosure Stmt ve :	(HCFA-1513)
2. Facility is not El	igible (L21)						
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	4: (L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 0		
02/01/1987					01-Merger, Closure		Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg 03-Risk of Involuntary Terminat		Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS			04-Other Reason for Withdrawa	<u>OTHER</u>	n Status Change
	A. Suspensio	n of Admissions:	(L44)			00-Active	r Status Change
(L27)) B. Rescind S	spension Date:	(211)				
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVA	L DATE			
	(L32)			(L33)	DETERMINATION APP	PROVAL	



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,

Kumala Fiske Downing

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



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 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,

Kumalu Fiske Downing

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	(1) Provider / Supplier / CLIA / Identification Number (Y2) Multiple Construction 245429 A. Building B. Wing		(Y3) Date of Revisit 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			Correction Completed 12/15/2015	ID Prefix	-		Correction Completed 12/15/2015		ID Prefix			Correction Completed 12/15/2015
	483.10(f)(2)				483.13(a)				Reg. # LSC	483.20(d)(3), 4		
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii))	Correction Completed 12/15/2015		F0309 483.25		Correction Completed 12/15/2015		Reg. #	F0312 483.25(a)(3)		Correction Completed 12/15/2015
ID Prefix Reg. # LSC			Correction Completed 12/15/2015	ID Prefix Reg. # LSC	F0325 483.25(i)		Correction Completed 12/15/2015			_F0431 483.60(b), (d)		Correction Completed 12/15/2015
	192.65		Correction Completed 12/15/2015									
Reg. #									D //			
Reviewed I	By F	Reviewed	Ву	Date:	Signatu	re of Sur	veyor:				Date:	
State Agen Reviewed I CMS RO		<u>GPN/kfc</u> Reviewed		12/29/201 Date:		re of Sur	101 veyor:	.60			Date:	12/18/2015
Followup	to Survey Com 11/5/2	-	:							Summary of the Facility?	YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number(Y2) Multiple Construction A. Building B. Wing245429B. Wing			IN BUILDING 01	(Y3) Date of Revisit 12/17/2015			
Name of Facility				Street Address, City, State, Zip Code				
ΤV	VEETEN 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		Correction Completed 12/08/2015	ID Prefix		Correction Completed 12/08/2015	ID Prefix		Correction Completed
-	NFPA 101		-	NFPA 101		Reg. #		
LSC	K0154		LSC	K0155				
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		-	Reg. #			Dec. #		
LSC			LSC			LSC		
		Correction			Correction			Correction
15 5 <i>(</i> '		Completed			Completed			Completed
ID Prefix		-						
Reg. # LSC			Reg. # LSC			Reg. # LSC		<u> </u>
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		-	ID Prefix			ID Prefix		
Reg. # LSC			Reg. # LSC			Reg. # LSC		
Reg. #			– <i>– –</i>					
LSC			LSC			LSC		
Reviewed B	By Reviewed	Ву	Date:	Signature of Sur	veyor:	1	Date:	
State Agen	cy TL/kfd		12/29/201	5	35	482	12	/17/2015
Reviewed E CMS RO	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Date:	
Followup t	o Survey Completed or 11/4/2015	1:		Check for any Unco Uncorrected Defic				NO

DEPARTMENT OF HI						DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: 90ML		
	PART I -				TE SURVEY AGENCY	Facility ID: 00285		
1. MEDICARE/MEDICAID P	ROVIDER NO.	3. NAME AND AL			CARE CENTER	4. TYPE OF ACTION: $\underline{2}$ (L8)		
(L1) 245429 2.STATE VENDOR OR MEDI		(L4) 125 5TH AV			CARE CENTER	1. Initial 2. Recertification		
(L2) 068252700	ICAID NO.	(L5) SPRING GF			(L6) 55974	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHAN	IGE OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY	11/05/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATU	US: (L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/II	D 15 ASC	FISCAL YEAR ENDING DATE: (L35)		
	TJC 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11. LTC PERIOD OF CERTIF	ICATION	10.THE FACILIT	Y IS CERTIFIED	AS:		1		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):		Program R	equirements		2. Technical Personnel	6. Scope of Services Limit		
	50 (1.19)	-	e Based On:		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director		
12.Total Facility Beds	50 (L18)	1. A	cceptable POC		5. Life Safety Code	VF)8. Patient Room Size 9. Beds/Room		
13.Total Certified Beds	50 (L17)	X B. Not in Cor	npliance with Pro	gram		—		
		Requirem	ents and/or Appli	ed waivers	: * Code: B *	(L12)		
14. LTC CERTIFIED BED BR	EAKDOWN				15. FACILITY MEETS			
18 SNF 18/1	9 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
	50							
(L37) (I	L38) (L39)	(L42)	(L43)					
16. STATE SURVEY AGENC	CY REMARKS (IF APPLICA	ABLE SHOW LTC C	ANCELLATION	NDATE):				
17. SURVEYOR SIGNATUR	E	Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:		
Carol Bode, H	FF NF II	1	2/07/2015		Kanala Fieles Describer	Enforcement Specialist 12/09/2015		
				(L19)	Kamala Fiske-Downing,	(L20)		
	PART II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF E	LIGIBILITY		IPLIANCE WIT	H CIVIL		ancial Solvency (HCFA-2572)		
 Facility is Elig 	gible to Participate	RIGI	HTS ACT:		2. Ownership/Contr 3. Both of the Abov	ol Interest Disclosure Stmt (HCFA-1513) e :		
2. Facility is not								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> 00	INVOLUNTARY		
02/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs			
25. LTC EXTENSION DATE	E: 27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	T ()		04-Other Reason for withdrawai	07-Provider Status Change 00-Active		
(L	.27) B. Rescind Su	spension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY			30. REMARKS			
20. TERMINATION DATE.	27		c. nuulli 110.					
	(L28)	03001		(L31)				
	(120)			(131)	-			
31. RO RECEIPT OF CMS-15	39 32	2. DETERMINATION	N OF APPROVAL	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



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.

Tweeten Lutheran Health Care Center November 24, 2015 Page 2

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

Tweeten Lutheran Health Care Center November 24, 2015 Page 4

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

Tweeten Lutheran Health Care Center November 24, 2015 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala Fiske Downing

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

Enclosure

cc: Licensing and Certification File

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	DATE SURVEY COMPLETED
		245429	B. WING		11/05/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
TWEETE	N LUTHERAN HEAL	TH CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 000		
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 166 SS=D	on-site revisit of yo validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with T TO PROMPT EFFORTS TO ANCES	F 166		12/15/15
	facility to resolve g	right to prompt efforts by the rievances the resident may se with respect to the behavior			
	by: Based on observa review, the facility f individual grievance by R43 during the o residents (R40) rev concerns of loud no Findings include: R40's admission M 7/28/15, identified f problems with his r	NT is not met as evidenced tion, interview and document ailed to effectively respond to es, related loud noises made overnight hours, for 1 of 1 viewed with expressed bise levels within the facility.		F166 Gundersen Tweeten Care Center will continue to be prompt in their effor to resolve grievances the resident may have, including those with respect to the behavior of other residents. Grievance 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 any concerns or grievances. All	ts ne for 5.

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.

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245429	B. WING				
	PROVIDER OR SUPPLIER	210120		STR	REET ADDRESS, CITY, STATE, ZIP CODE	11/0	05/2015
	N LUTHERAN HEAL	TH CARE CENTER		125	5TH AVENUE SOUTHEAST RING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 166	dementia. When of 11/03/15, at 10:38 problem in this roo "stays awake and of management about had been done. I t and registered nurs said they would do wanted to move to there are no open in has asked if it has An interview on 11/ the process for grie brought up at care that time. SS-E sa concern with his ro she hasn't received said if a concern is affected department address it and thar council meeting. S document some con not fill out a grievant because R40 had to time. SS-E was off something for slee so SS-E thought it An interview on 11/ of nurses (DON) sa manager and she to residents. She sait about R40's grievant doesn't think it is a	bserved and interviewed on a.m. R40 said he has a m. R40 said his roommate calls for mama all night." I told it it four weeks ago and nothing alked to social services (SS)-E se (RN)-F about it and they what they could. I said I another room and was told rooms to move into. No one	F 16		grievances received at Resident (are documented and given to the Department Head to address and The Grievance Procedure for Residents/Advocates Policy has b reviewed and updated as needed residents receive a copy of the gr procedure upon admission and at reminded of the right to voice grie at monthly council meetings. IDT monitor at weekly care plan confe meetings to ensure resolutions ar All staff were re-educated on this of handling complaints/grievances December 8th, 2015.	resolve. Deen . All ievance re vances to orence e timely. process	

If continuation sheet Page 2 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER/LIDING (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245429 B. WING 11105/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 125 STREET ADDRESS. CITY, STATE, ZIP CODE 125 STREET ADDRESS. CITY, STATE, ZIP CODE (PAI_ID TAG ISJUMMARY STATEMENT OF DEFICIENCIES PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTION THE APPROPRIATE DEFICIENCY WITH EACH TO PORTORIATION) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLET (M3) CRASS-REFERENCED TO THE APPROPRIATE DEFICIENCY (M3) CRASS-REFERENCED TO THE APPROPRIATE (M3) CRASS-REFERENCED TO THE APPROPRIATE (M3) CRASS-REFERENCED TO THE APPROPRIATE DEFICIENCY (M3) CRASS-REFERENCED TO THE APPROPRIATE (M4) CRASS-REFERENCED TO THE APPROPR			AND HUMAN SERVICES				FORM	12/07/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE TWEETEN LUTHERAN HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (x4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LS: IDENTIFYING INFORMATION) PROVIDER'S FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) (x5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) (x5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT CORRECTION DEFICIENCY) (x5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT THE DEFICIENCY) (x5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT CORRECTION DEFICIENCY) (x5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT CORRECTIVE DEFICIENCY) F 166 A.m. N-F said SE does MOST OT THE MOST AT ACTION THE APPROPRIATE DEFICIENCY) F 166 MILL	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ECONSTRUCTION	(X3) DATE	E SURVEY
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 REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMETER DATE F 166 Continued From page 2 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 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 SS-E does most of the documentation in grees form to the appy, 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 wabout 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. NA-G said R40 tells her about being woken up in			245429	B. WING _			11/(05/2015
TWEETEN LUTHERAN HEALTH CARE CENTER SPRING GROVE, MN 55974 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECIDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C/04PLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 166 Continued From page 2 a.m. said she knew about R40's grievance. RN-F said it was better but she thinks it is worse again now that the roommate is back from the hospital. 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 she corres of the documentation regarding resident complaints. She said she doesn't know if the DON knows 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	NAME OF F	PROVIDER OR SUPPLIER						
PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) converter DATE F 166 Continued From page 2 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 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	TWEETE	EN LUTHERAN HEALT	TH CARE CENTER					
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 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. 	F 166	a.m. said she knew said they (SS-E and said it was better by now that the roomn RN-F said they don time. RN-F said SS documentation rega She said she doesr about it. RN-F said deal about it. Our p you can move. RN wasn't resolved as her. We have a gri don't fill the form ou documentation in p An interview on 11// assistant (NA)-A sa sleeping because of when R40 mentions She said the nurse more often during t During an interview NA-G said R40 tells the night by his roo nurses talk about a more frequently. N any other plan for F An interview on 11// administrator said t care conferences, s meetings or resider grievances. R40's sleep assess "How many times d	 about R40's grievance. RN-F d RN-F) talked to R40 and he ut she thinks it is worse again nate is back from the hospital. In thave any open rooms a the S-E does most of the arding resident complaints. In thow if the DON knows d we normally don't make a big policy is if you are not happy, N-F said she knew this issue R40 kept talking about it with ievance form but we normally ut. She agreed there is no progress note. 705/15, at 9:37 a.m. nursing aid she knew about R40 not of his roommate. She said s it, she always tells the nurse. will tell her to lay him down the day. <i>Y</i> on 11/05/15, at 9:38 a.m. s her about being woken up in mmate. She said that the und have said to lie him down IA-G said she has not heard of R40. 705/15, at 11:42 a.m. the they discuss grievances at stand up meetings, department nt council to address 		56			

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		AND HUMAN SERVICES			FOI	ED: 12/07/2015 RM APPROVED IO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY	
		245429	B. WING	i		11/05/2015	
NAME OF I	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/00/2010	
TWEETE	N LUTHERAN HEALT	TH CARE CENTER			25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 166	Continued From pa	ige 3	F	166			
F 221 SS=D	have the right to vo complaints will be o Director of Nurses of Head/Supervisor of grievance. The De conduct an investig determine its validit Head/Supervisor ei satisfactory answer you concern within Administrator in per concerning your iss investigate and res 483.13(a) RIGHT T PHYSICAL RESTR The resident has th physical restraints i discipline or conver treat the resident's This REQUIREMEN by: Based on observat review, the facility fassessed as a resti who utilized a reclin Findings Include: R39's quarterly Min indicated severe co was steady at all tir to standing position	the area involving the partment Head/Supervisor will ation of the matter to y. If the Department ther does not have a for you or does not answer seven days, report to the rson, in writing or by phone sue. The Administrator will pond to you within seven days. O BE FREE FROM AINTS he right to be free from any mposed for purposes of hience, and not required to medical symptoms. NT is not met as evidenced tion, interview, and document ailed to ensure a recliner was raint for 1 of 1 resident (R39)	F2	221	F221 Gundersen Tweeten Care Center will continue to ensure our residents are free from any physical restraints impose for purposes of discipline or conveniend and not required to treat the resident s medical symptoms. Resident # 39 was assessed for use of recliner and care pl 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	ed e, an	

Facility ID: 00285

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						<u>. 0938-039</u>		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED		
		245429	B. WING _		11/	05/2015		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
TWEETE	N LUTHERAN HEALT	H CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 221	Continued From pa	ge 4	F 22	1				
	transfers.			would be considered a res				
	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			evaluate recliner use quar cycle to ensure proper ass				
				been done. Nursing staff				
				re-educated on the right to	be free from			
		ure Woodland unit. R39 remained sleeping in recliner until 4:20 a.m. when licensed ctical nurse (LPN)-B awakened R39. Once ike R39 was able to push against the recliner		restraints and the process				
				recliners as a restraint on 2015.	December 8,			
				2013.				
	to move the back of	f the recliner to an upright						
		er feet against the foot rest to						
		LPN-B assisted R39 to the ete morning cares after the						
		ing cares LPN-B assisted R39						
	to an electric recline	er which used a remote control						
		I-B used the remote control to						
		PN-B then placed the remote e pocket on the right side of						
		R39 could not reach. At 5:32						
		rved to be sleeping in the						
		n. R39 began to move self in						
		er feet hanging over side of t 5:54 a.m. R39 was						
		g around in the recliner,						
		ith her knees bent. At 6:10						
		rved to be moving her legs,						
		the raised leg rest of the						
		r torso and sitting up and nt to go too." R39 is unable to						
		due to the leg rest raised. At						
		inued to attempt to get out of						
		to push off recliner with legs gs were hanging off the side of						
		At 6:25 a.m. R39 was						
		off on the recliner, pushing						
	down on the recline	r arms. At 6:32 a.m. R39 was						
		g to climb out of the recliner. side and used the remote						
	LEIN-DIAILU H39'S		1	1		1		

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		AND HUMAN SERVICES				FORM	12/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245429	B. WING			11/	05/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	up and walk independent On 11/4/15 at 5:56 normally sleeps in a "She would fall out sleep on the floor. Or recliner she will sleep on her own and she seems safer to hav close eye on her." T (TMA)-C added, "It" her and get to her s R39's care plan and is care planned" wh used as a restraint station. On 11/4/15 at 8:39 a manager, stated I recliner and that shi independently get or adding, "If staff see should help her up distress." On 11/5/15 at 9:37 stated, "If she [R39 get her up. If the bling get up on her own." On 11/5/15 at 12:07 might not be care p recliner, she slept of would assess her, I on that. She will put and the arm rest art trying to get up for I	tance R39 was able to stand endently throughout the unit. a.m. LPN-B stated R39 a recliner in the day room, of her bed. At home she would Once she is settled into the ep pretty well. She had a room e wouldn't go into her room. It re her out here and keep a Trained medication aide 's nice on nights to peek in on sconer." LPN-B reviewed d stated, "It doesn't look like it nen asked about the recliner and located near the nurses a.m. registered nurse (RN)-D, R39 slept in the blue manual e could sometimes but of the chair on her own e her trying to get out they otherwise it will cause her a.m. nursing assistant (NA)-E] starts wiggly that's our cue to ue recliner is sitting up she can	F	221			

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		AND HUMAN SERVICES				FORM	12/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245429	B. WING			11/(05/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TWEETE	N LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	would be a restraint On 11/4/15 at 10:05 assistant-D stated r assessments regar On 11/5/15 at 1:55 ((DON) stated, "We assessment. It wou could normally get of and can't." The note read to the DON an point it would be co DON added the reo R39's care plan dat [R39] may lower he the floor, consistent routine for many ye on floor, ensure tha awaken or attempt herself awakens." Facility policy, Phys reads; "Physical res method or physical material, or equipm one's body. Physical device or garment of resident behavior b movement of the rea a portion of the bod unable to remove e roomResident's v risks and abilities of with a significant ch reassessment as n	mount of time then yes it t, ten or five minutes." 5 a.m. physical therapist nursing would complete ding sleeping in recliners. p.m. the director of nursing don't have a recliner ld be an observation. If they out of it [recliner] without help ed observations of R39 were nd she responded with, "At that onsidered a restraint." The cliner was not care planned. ted 12/4/13 reads, "At times, erself to the floor and sleep on t with her preferences and ears. If [R39] prefers to sleep at she is warm enough; do not to put back to bed, until she sical Restraint, dated 1/20/06, straints are any manual or mechanical device, tent attached or adjacent to al restraints include any article, used primarily to modify y interfering with free esident or normal functioning of dy, and which the resident is easily, confinement in a locked will be assessed for safety n admission, re-admission, nange, and quarterly with eeded should a change in	F 2	221	DEFICIENCY)		
		eeded should a change in					

Facility ID: 00285

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		IDENTITION TON NONDER.	A. BUILD	ING .		0010	
		245429	B. WING			11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 25 5TH AVENUE SOUTHEAST		
TWEETE	N LUTHERAN HEALT	H CARE CENTER			PRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 SS=D	PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in planni changes in care and A comprehensive c within 7 days after t comprehensive asses interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ng care and treatment or	F 2	80			12/15/15
	by: Based on observat review, the facility fa according to the ph residents (R33) rev revise the care plar 1 of 3 residents (R3 conditions and faile include the use of a (R33) reviewed for facility failed to upd therapy recommend	NT is not met as evidenced ion, interview and record ailed to revise the care plan ysician orders for 1 of 3 iewed for nutrition; failed to to include risk of bruising for 3) reviewed for skin d to revise the care plan to a foot board for 1 of 3 residents restraints. In addition the ate a care plan after physical ded changes for 1 of 1 ewed for positioning.			F280 Gundersen Tweeten Care Ce will continue to develop a comprehe care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes attending physician, a registered nu with responsibility for the resident, a other appropriate staff in disciplines determined by the resident s need to the extent practicable, the particip of the resident, the resident s fami the residents legal representative; a	the trse and s as s, and, pation ly or	

Facility ID: 00285

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NO.	APPROVE 0938-039
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245429	B. WING _			05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	TH CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	Findings include: LACK OF PHYSICI R33'S CARE PLAN R33's quarterly Min 8/18/15, identified F Alzheimer's, demer impairment, require staff to eat, mechar therapeutic diet. R33's physician orc through 11/5/15, inc mechanical soft, ca supplements with n may have regular w minutes post meals On 11/04/2015, at 9 (NA)-D was observ breakfast which inc of juice, water and supplement, ground On 11/04/2015, 9:5 regular consistency room on a tray table R33's care plan, da fluid intake with me monitored and reco between meals and food intakes with in table with staff to fe recorded in kitchen and recorded each controlled mechanii care plan failed to in meals and nectar th	AN ORDERS INCLUDED IN I: imum Data Set (MDS) dated R33 had diagnoses of htia, had severe cognitive ed extensive assistance from hical altered diet and der report dated 10/5/15 dicated order start date diet: urbohydrate controlled, heals, nectar thickened liquids, vater in lidded cup in room 30 a fiter offered oral cares. D:25 a.m., nursing assistant ed to assist R33 with luded nectar thickened liquids milk, oatmeal, mighty shake d sausage and toast. 0 a.m., a lidded cup with water was observed in R33's	F 28	periodically reviewed and revise team of qualified persons after assessment. Resident # 33 s of has been updated to reflect the diet order, risk of bruising, and board. Resident # 44 s care pl been updated to reflect transfer ambulating according to therap recent recommendations after w with Resident #44. Case manage continue to ensure all other res the facility will have up to date of All residents will be reviewed for comprehensive care plans as th RAI review comes up during the quarter, on all new admissions, significant changes. Order char logged and reviewed weekly wir meetings. QA nurse will do char one week following care plan re and report results to quarterly of meeting.	each care plan correct use of foot an has ring and y s most working gers will dents in are plans. r heir next and with nges will be h IDT int audits eview dates	

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		AND HUMAN SERVICES				FORM	12/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245429	B. WING _			11/(05/2015
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	TH CARE CENTER			25 5TH AVENUE SOUTHEAST PRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa post meals after off	-	F 2	80			
	(RN)-A verified R33 nectar thickened lig	9:52 a.m., registered nurse 3's care plan failed to include quids, may have regular water m 30 minutes post meals after					
	director (DMD)-C veri for supplements with liquids. DMD-C veri	p.m., dietary manager erified R33's physician order th meals and nectar thickened ified R33's care plan failed to ts with meals and nectar					
	verified R33's physi and verified R33's of nectar thickened liq in lidded cup on roo after offered oral ca	3:05 p.m., director of nursing ician order dated 10/14/15, care plan failed to include quids, may have regular water om 30 minutes post meals ares and she would expect the icluded on R33's care plan.					
	RISK OF BRUISING R33 was observed	LAN INTERVENTION FOR G: on 11/04/2015, at 8:39 a.m., n the side of left hand and on					
	RN-A confirmed R3 left hand and on top wander if bruising f	on 11/05/2015, at 9:55 a.m., 33 had a bruise on the side of p of left forearm. RN-A stated I rom EZ stand mechanical lift here the bruises are located.					
	through 10/15/15, ic	gress notes dated 10/12/15 dentified R33 had prior w umbilicus of unknown origin					

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		AND HUMAN SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		COM	IPLETED
		245429	B. WING			11/	05/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TWEETE	N LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 10	F 2	280			
	for pressure ulcers mobility. Report any	ted 5/11/15, indicated at risk related to impaired bed y signs of skin breakdown r broken areas). R33's care e risk of bruising.					
	RN-A verified R33's has had previous be care plan failed to in	11/05/2015, at 9:55 a.m., progress notes identified R33 ruising. RN-A verified R33's nclude the risk of bruising and uising should be care planned.					
	DON verified R33's	11/05/2015, at 3:05 p.m., care plan failed to include the stated she would expect the e care planned.					
	FOOD BOARD IN V	AN INTERVENTION OF WHEELCHAIR: R33 was 5, at 9:29 a.m., a foot board 3's wheelchair.					
	place footrests onto	a.m., NA-D was observed to R33's wheelchair and then and in place onto R33's					
	limited physical mol time related to phys with interventions o at meals and unsup elevated to prevent	blem date 5/28/15, indicated bility, chair fast all or most of sical limitations, depression f make sure reclined when not pervised, make sure foot rests falling forward. R33's care e the use of a foot board.					
	DON verified R33's	11/05/2015, at 3:05 p.m., care plan failed to include the and stated she would expect					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/07/2015 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	0938-0391 E SURVEY PLETED
		245429	B. WING			11/(05/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	When asked for a p plan, the facility pro regulations, which a care plans are revis the current needs of R44's care plan dat activity/mobility/tran balance/weakness. to ambulate with re- at this time up to 50 bid (twice daily) and consider offering a transfer/ambulate wit two staff assist. PT-Therapist Progr dated 10/14/15 incli instructions, "Disch instructions for dc [use of EZ stand for Quarterly Minimum 7/21/15 indicated R assist with walking Quarterly MDS date not ambulate during period. On 11/4/15 at 8:33 a manager, stated, because her knees worked with her for working with physic	nclude the foot board. policy for revision of the care vided an untitled copy of listed addressed F280 and indicated sed as necessary to address f each resident. ed 1/12/15, identified limited sfers with impaired Interventions included, "offer sident on household tolerating 0 ft [FEET] with nursing staff d when she appears restless, walk. Resident will vith 1 staff assist as needed." icated R44, with assistance h proper use of a walker and ess and Discharge Summary uded the following discharge arge to memory care unit with discharge] of walking program,	F 2	280			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		245429	B. WING _		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 280 F 282 SS=D	stand. RN-D said, " the care plan was d changed that in her On 11/5/15 at 1:51 stated, "RN-D and I process for the last updated quarterly o A facility policy on c but not provided.	I'm gonna say that's the way lone before I came. I haven't care plan." p.m. the director of nursing RN-F are new to the care plan four months. The care is r as changes occur." are planning was requested RVICES BY QUALIFIED	F 28			12/15/15
	must be provided b accordance with ea care.	led or arranged by the facility y qualified persons in ch resident's written plan of NT is not met as evidenced				
	Based on observat review, the facility fa as directed by the of (R13) who required failed to ensure the provide toileting car plan for 1 of 1 resid assistance with toile In addition the facili assistance as direc resident (R44) who transfers. Findings include: LACK OF OFFERIN	ion, interview and document ailed to provide toileting cares care plan for 1 of 1 resident assistance with toileting and use of a tab alarm and res as directed by the care ent (R33) who required eting and had limited mobility. ty failed to provide transfer ted by the care plan for 1 of 1 required assistance with		F282 Gundersen Tweeten Care will continue to ensure the servic provided or arranged by the facil provided by a qualified person in accordance with each resident plan of care. NA-C has been ree on the need to provide toileting of directed by the care plan for the NA-D has been reeducated on n padding incontinent products as by the plan of care for the reside was reeducated on the need to t the resident according to the pla All nursing staff was reeducated need to follow the residents pla in regards to the care of the reside	es ty will be s written ducated ares as resident. ot double directed nt. NA-E ransfer n of care. on the n of care	

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ATEMENT OF		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-03 E SURVEY PLETED
DILANOI	CONNECTION	IDENTIFICATION NOWBER.				001	
		245429	B. WING _			11/0	05/2015
AME OF PRO	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 25 5TH AVENUE SOUTHEAST		
WEETEN	LUTHERAN HEALT	H CARE CENTER			PRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETI DATE
AFRiiwtyEbc D1(1irRwaao Dv Ddec Riroabsuo Ir	ALLS: A13's care plan, dat mited in ability to to vith interventions of wo hours and offer Establish routine for pathroom/commode commode at night for During observation of 1/04/2015, at 7:31 NA)-C had washed noontinent product R13. NA-C then tran vheelchair, combec assisted R13 with ey assisted R13 out of offer the toilet to R1 During interview on verified had not offe During interview on lirector of nursing (expect toileting to be care plan. R33's care plan, pro- ndicated limited in p or most of the time of and depression with prief, use night time of resident when sit an addition, the care	 WHEELCHAIR TO PREVENT ted 09/08/2015, indicated bilet self-related to dementia check for incontinence every to assist to the bathroom. toileting. Use e during waking hours and or toileting. of morning cares on a.m., nursing assistant R13, changed R13's and had assisted to dress hsferred R13 into a I R13's hair, shaved R13 and ye glasses. NA-C then R13's room. NA-C failed to 3. 11/4/15, at 8:59 a.m., NA-C red R13 the toilet. 11/05/2015, at 2:48 p.m., DON) stated she would e provided according to R13's bolem start date 5/28/15, obysical mobility, chair fast all related to physical limitations of intervention of do not double brief day and night. Problem at risk for falling related to ith intervention of place alarm 	F 28	82	December 8, 2015. This will be more by QA Nurse doing random audits of nursing assistant cares as compare the residents care plans monthly months.	of ed to	

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		AND HUMAN SERVICES				FORM	APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI			0938-0391 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245429	B. WING			11//	05/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	JJ/201J
тжеете	N LUTHERAN HEALT			1	25 5TH AVENUE SOUTHEAST		
		H CARE CENTER		S	SPRING GROVE, MN 55974		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
E 202			– – –	~~~			
F 282	Continued From pa	ge 14	F 2	82			
	double pad R33.						
		3:39 a.m., nursing assistant					
		ed to double pad R33 with					
	incontinent products	S.					
	In addition, on 11/4/	/15, at 9:49 a.m., R33 was					
		wheelchair with a tab alarm					
	hanging on the bac alarm was not attac	k of the wheelchair. The tab					
	alarin was not allac						
		11/4/15, at 8:57 a.m., NA-D					
		padded R33 with incontinent her stated R33 has a lot of					
		ained to double pad R33.					
	NA-D verified R33's	s care sheet read do not					
	double pad.						
	During interview on	11/4/15, at 9:49 a.m., NA-D					
		m was not attached to R33.					
	During interview or						
		11/05/2015, at 3:05 p.m., ould expect staff to follow					
		jarding the tab alarm to be in					
	place when in whee	elchair. DON stated the care					
		assistants follow coincides					
		care plan. DON verified R33's not double pad in regards to					
		. In addition, the DON stated					
		be double padded in regards					
	to the use of incont	inent products.					
	A facility policy rega	arding care plan					
	implementation was	s requested, but was not					
	provided.						
	LACK OF USE OF RECEIVING CARE						
		-					
	R44's care plan dat	ed 10/15/15, indicated R44					

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		& MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245429	B. WING		11/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALI	TH CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ige 15	F 282	2		
	required an assist of for transfers.	of one and use of the EZ stand				
	nursing assistant (N from the recliner in wheelchair. NA-E p NA-E applied a gain upper torso region. sink where with ext R44 was pulled up directed R44 to hole to hold herself up. If knobs of the faucet herself up. NA-E re pinching R44's upp extensively assisted R44 was once again standing position, p the faucet handles NA-E continued to cares. Following R4 stated it was a norr the sink to have he indicated it would b routine changed. N	d on 11/4/15 at 7:41 a.m. by NA)-E using an easy stand the day area to R44's propelled R44 to her room. t belt snuggly around R44's R44 was pushed up to the ensive assistance from NA-E to the sink. NA-E repeatedly d on to the front lip of the sink R44 kept grabbing for the and pulling on the sink to hold positioned R44's gait belt, er torso region. NA-E then d R44 to sit on the commode. In extensively assisted to a bulling on the sink, grabbing and faucet to stay standing. assist R44 with her morning 44's morning cares, NA-E nal routine for R44 to stand at r cares completed. NA-E e new to her if R44's transfer A-E then reviewed R44's care 14 was an assist of one with				
		Communication Note, dated nded use of EZ stand for				
F 309	A facility policy rega implementation was provided. 483.25 PROVIDE 0	s requested, but was not	F 309			12/15/15

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		AND HUMAN SERVICES				FORM	APPROVED
	<u>SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION		0938-0391 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			ECONSTRUCTION		PLETED
				-			
		245429	B. WING			11/0	05/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST PRING GROVE, MN 55974		
				3			0(5)
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
			1				
F 309	Continued From pa	ge 16	F 3	09			
		receive and the facility must					
		ary care and services to attain nest practicable physical,					
	mental, and psycho	social well-being, in					
	accordance with the and plan of care.	e comprehensive assessment					
	and plan of care.						
		VT is not met as evidenced					
	by:	IT IS NOT THET AS EVIDENCED					
	Based on observat	ion, interview and document			F309 Gundersen Tweeten Care Ce		
		ailed to provide necessary			will continue to ensure that each res	sident	
		elated to monitoring of bruises (R53 & R33) reviewed for			receives and is provided with the necessary care and services to atta	ain or	
	non-pressure relate				maintain the highest practicable phy	ysical,	
	The dia are the short of				mental, and psychosocial well-being		
	Findings include:				accordance with the comprehensive assessment and plan of care. Resid		
		ission record, dated 9/9/15,			#53 passed away on 11/30/15. A br	uising	
		esident had diagnoses of:			event form was initiated prior to sur		
		alorie malnutrition; deficiency group vitamins; vitamin D			leaving the building for R53 & R33 a monitored by nursing until healed.		
		pocytopenia (a disorder of the			Managers will review all care plans		
		use bleeding in to the tissues,			update any residents at risk for brui		
	bruising, and slow t	blood clotting after injury).			All staff was reeducated on the polic procedure for notifying the charge r		
		ted 9/9/15, stated that nursing			of bruising immediately upon finding	g on	
		ct a systematic skin inspection			December 8, 2015. This will be more	nitored	
		urther directed nursing staff to sites of concern when			by a weekly skin inspection to be completed on bath days.		
	performing activities	s of daily living including					
	toileting and weekly	bathing.					
	During an observati	ion on 11/3/15 at 2:13 p.m.,					
	R53 was seen to ha	ave several sites of bruising of					
	varying sizes on bo	th forearms.					

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ATEMENT	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ID PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	PLETED
		245429	B. WING			11/	05/2015
IAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
WEETE	N LUTHERAN HEAL	TH CARE CENTER			25 5TH AVENUE SOUTHEAST PRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 309	Continued From pa	age 17	F3	309			
		ew of R53, no documentation	_				
		cate that R53 had any bruising					
		the care plan lacked any ich stated that the resident was					
		sing; the interdisciplinary notes					
		on of any bruising on R53's					
		ient titled, "Tweeten Skin Report," dated 11/2/15, had no					
		ising for R53; a document with					
	the same title but o	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					
		d any bruising on his forearms.					
	bruising she would	resident were to develop any notify the nurse.					
	When interviewed	on 11/5/15 at 8:49 a.m.,					
	registered nurse (F	RN)-A stated that she was not					
		ing on R53's bilateral forearms. er the resident finished					
		Id assess the resident.					
	When interviewed	on 11/5/15 at 10:28 a.m.,					
	registered nurse (F	RN)-A verified that R53 had					
		his forearms. She stated that					
		the hospital on 10/15/15 and ing to the hospital stay. RN-A					
		o documentation on the					
		taff had not been monitoring					
		3. RN-A stated that the nursing o 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					
		have notified the nursing staff ing on both of his arms.					

		AND HUMAN SERVICES				FORM	APPROVED	
						MB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A BOILDI	110				
		245429	B. WING			11/0	05/2015	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
TWEETEN LUTHERAN HEALTH CARE CENTER				25 5TH AVENUE SOUTHEAST				
				S	SPRING GROVE, MN 55974			
(X4) ID PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	~	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD			
TAG			TAG	~	CROSS-REFERENCED TO THE APPROP		DATE	
					DEFICIENCY)			
E 200		10	– – –	~~				
F 309	Continued From pa	ge 18	F 3	09				
	When asked for a r	oolicy on developing a care						
		uch as bruising, the facility						
		the state regulations which						
		"Comprehensive resident						
		on copy)." It stated that a e plan was to be developed for						
	each resident using							
	comprehensive ass	essment. It stated that each						
		should include measurable						
	objectives and time needs identified in t	tables to meet all resident						
		ed that all services to be						
		included in each resident's						
		ed that the comprehensive						
		escribe the services furnished						
		nt's highest well-being. imum Data Set (MDS) dated						
		R33 had diagnoses of						
		ntia, had severe cognitive						
		uired extensive assist with						
	activities of daily livi	ing.						
	B33's care plan da	ted 5/11/15, indicated at risk						
		related to impaired bed						
		y signs of skin breakdown						
		r broken areas). R33's care						
	plan failed to addre	ss bruising.						
	On 11/04/2015 at 8	3:39 a.m., during observation						
		ares provided by nursing						
	assistant (NA)-D ar	nd nursing assistant (NA)-C,						
		to have a bruise on the side of						
	R33's left hand and forearm.	on the top of R33's left						
		on 11/05/2015, at 9:55 a.m.,						
		3 had a bruise on the side of						
	left hand and on top	o of left forearm. RN-A stated I						

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		AND HUMAN SERVICES				FORM	12/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245429	B. WING	i		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	EN LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	wander if bruising fr use, because of wh RN-A reviewed R33 was no documental located on R33's sid of R33's left forearn assistants are to inf has bruising, the nu bruises and docum under events regard then notifies the fan case manager. The in the resident's rec next shift and adds RN-A stated we mo on the treatment se usually once a day order. During interview on when queried regar bruising, the directo assistants should n is observed with a r The facility policy Ad Reporting, dated 7/ of Gunderson Twee systemic approach follows: identificatio inadequate supervis potentially avoidable environment; evalua and risks; implement including adequate devices, to reduce in hazards in the envir	rom EZ stand mechanical lift nere the bruises are located. B's record and confirmed there tion regarding the bruises de of left hand and on the top m. RN-A stated the nursing form a nurse when a resident urse then measures the ents in the resident record ding the bruising. The nurse mily, the physician and the e nurse makes a progress note cord, relays information to the to 24 hour report. In addition, onitor bruising by documenting ection of the residents record, until resolved as a nursing of nursing stated nursing otify the nurse when bruising	F	309			

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		AND HUMAN SERVICES			FC	RM	12/07/2015 APPROVED 0938-0391
-	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	245429					11/(05/2015
NAME OF	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	TWEETEN LUTHERAN HEALTH CARE CENTER				25 5TH AVENUE SOUTHEAST PRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 312 SS=D	483.25(a)(3) ADL C DEPENDENT RES	ARE PROVIDED FOR	FЗ	312			12/15/15
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal					
	by: Based on observat review the facility fa of 1 resident (R13) personal hygiene. Findings include: R13's quarterly Min 10/6/15, identified F impairment and rec from staff to comple During observation 11/04/2015, at 7:31 (NA)-C had washed incontinent product R13. NA-C then tra wheelchair, combed assisted R13 with e assisted R13 out of provide oral cares. R13's care plan, da limited ability to ma related to dementia	NT is not met as evidenced tion, interview and document ailed to provide oral cares for 1 who required assistance with and assistance with and a severe cognitive quired extensive assistance ete personal hygiene. of morning cares on a.m., nursing assistant d R13, changed R13's and had assisted to dress nsferred R13 into a d R13's hair, shaved R13 and eye glasses. NA-C then i R13's room. NA-C failed to atted 09/08/2015, indicated intain grooming and hygiene with interventions of provide ited assist for oral cares, has			F312 Gundersen Tweeten Care Cente will continue to ensure that a resident v 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 provid oral cares as part of providing AM ADL for residents. All other nursing staff was reeducated on providing oral cares as of 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.	/ho o s s well	

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-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			. 0938-039 E SURVEY IPLETED	
		245429	B. WING		11/	11/05/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/	05/2015	
TWEETEN LUTHERAN HEALTH CARE CENTER							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 312 F 323 SS=D	During interview on verified had not pro During interview on director of nursing s cares to be provide The facility policy O indicated offer oral each meal and at b 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	11/4/15, at 8:59 a.m., NA-C vided oral cares for R13. 11/05/2015, at 2:48 p.m., stated she would expect oral d. ral Hygiene, undated, hygiene before breakfast, after edtime. FACCIDENT	F 3			12/15/15	
	by: Based on observat review the facility fa technique for 1 of 2 transfers. Findings Include: R44 was transferre nursing assistant (N the recliner in the d NA-E then propelle applied a gait belt s torso region. R44 w	NT is not met as evidenced ion, interview, and document iled to provide a safe transfer residents (R44) observed for d on 11/4/15 at 7:41 a.m. by NA)-E using an EZ stand from ay area to R44's wheelchair. d R44 to her room. NA-E nuggly around R44's upper ras pushed up to the sink nsive assistant from NA-E R44		F323 Gundersen Tweeten Care will continue to ensure that the re environment remains as free of a hazards as is possible; and each receives adequate supervision at assistance devices to prevent ac NA-E was reeducated on the nee transfer the resident according to of care. All nursing staff was ree on the need to follow the resident of care in regards to the care of t resident on December 8, 2015. be monitored by QA Nurse doing audits of nursing assistant cares	sident ccident resident d cidents. d to the plan ducated is plan ne This will random		

Facility ID: 00285

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					PLICTION	0		0938-039	
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST		(X3) DATE SURVEY COMPLETED			
		245429	B. WING				11/0	05/2015	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP (CODE			
TWEETE	N LUTHERAN HEALT	H CARE CENTER			VENUE SOUTHEAST GROVE, MN 55974				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION OSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETIO DATE	
F 323	was pulled up to the directed R44 to hold to hold herself up. F knobs of the faucet herself up. NA-E re pinching R44's upp extensively assisted R44 was once agai standing position, p the faucet handles NA-E continued to a cares. Following R4 stated it was a norm the sink to have her On 11/4/15 at 8:33 a manager, stated; sink. We do that wit too. All the resident the sink to hold on t asked if the sinks w grab bar for a resid support when stand say I think so." On 11/5/15 at 9:24 a was questioned if th for residents to help support and he stat bar, but they have u up, they won't hurt a manufacturer recom they have the curve On 11/5/15 at 1:49 a stated, "As far as I	e sink. NA-E repeatedly d on to the front lip of the sink R44 kept grabbing for the and pulling on the sink to hold positioned R44's gait belt, er torso region. NA-E then d R44 to sit on the commode. n extensively assisted to a ulling on the sink, grabbing and faucet to stay standing. assist R44 with her morning I4's morning cares, NA-E nal routine for R44 to stand at r cares completed. a.m. registered nurse (RN)-D, "[R44] does very well with the th [another residents name] s pull on them [reference to to when standing]." RN-D was vere a safe alternative to a ent to use for standing and ling and she said, "I'm gonna a.m. the maintenance worker he sink was a safe tool to use o them stand and use for ed, "The sink is not a grab used them to pull themselves anything. I don't know what the nmends. I think that is why ed faucet to grab onto." a.m. the director of nursing know it is safe [using the sink], it has been [routine] on the	F 3	comp	ared to the residents nly x6 months.	care pl	ans		

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		AND HUMAN SERVICES			FORM	12/07/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245429	B. WING		11/0	05/2015
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER		25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 23	F 323			
F 325 SS=D	required an assist of transfer self with sta providing step by sta Facility policy, Safe 7/1/08, reads: "This use appropriate teo residents of the fac and ensure safety of Resident can bear consistently, and ca follow simple direct sitting position of 90 483.25(i) MAINTAIN UNLESS UNAVOID Based on a resident assessment, the fa resident - (1) Maintains accept status, such as boo unless the resident demonstrates that the (2) Receives a ther nutritional problem. This REQUIREMENT by: Based on observative review, the facility for weights and reassed	Patient Handling, dated policy is to ensure that staff hniques in transferring the ility to avoid back injury to staff of residents1. PIVOT with 1, weight on one or both feet an lean forward, reach and ions, and can maintain a 0 degrees without support." N NUTRITION STATUS DABLE tt's comprehensive cility must ensure that a btable parameters of nutritional ly weight and protein levels, 's clinical condition this is not possible; and apeutic diet when there is a NT is not met as evidenced tion, interview and document ailed to consistently monitor tess for significant weight loss (R33) who had been reviewed	F 325	F325 Gundersen Tweeten Care Ce will continue to ensure that a resider maintains acceptable parameters of nutritional status, such as body weig and protein levels; unless the resider	nt- (1) f ght	12/15/15

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		AND HUMAN SERVICES				FORM	12/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245429					11/0	05/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	TWEETEN LUTHERAN HEALTH CARE CENTER				25 5TH AVENUE SOUTHEAST PRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 24	FS	325			
	while nursing assist breakfast. Breakfast thickened liquids of oatmeal, mighty sha sausage and toast. take me back to my percent of oatmeal, percent of milk and percent of milk and percent of mighty shad not been opened On 11/05/2015, at 8 wheelchair in the di percent of food and R33's quarterly Min 8/18/15, identified F Alzheimer's, demer impairment, require staff to eat, mechar therapeutic diet, we Review of R33's we follows: 11/5/15: 191 pound 11/3/15; 172 lbs 10/14/15: 198 lbs 9/1/15: 209 lbs 7/8/15: 208 lbs 5/11/15: 212 lbs (da A total of 21 lbs sin significant loss of 1	imum Data Set (MDS) dated R33 had diagnoses of htia, had severe cognitive ed extensive assistance from hical altered diet and hight 209 and no weight loss.			clinical condition demonstrates that not possible; and (2) receives a therapeutic diet when there is a nut problem based on a resident s comprehensive assessment. Resid #33 was reweighed; provider notifier results and Registered Dietician ever results. Policies and Procedures reviewed and updated as needed. nursing staff will be retrained on sca and proper weighing techniques; importance of determining which sc appropriate for each resident and b consistent with using that scale; use Monthly Weight Form as guideline to baseline weights; need to reweigh resident according to policy and rep discrepancies to RD. This will be monitored by RD after getting Mont Weight Form from Case Managers 15th of each month; review and rea as needed.	ritional dent ed of aluated All ales cale is e of for porting hly by	
		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/07/2015 APPROVED : 0938-0391
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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245429	B. WING			11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
TWEETE	N LUTHERAN HEALT	H CARE CENTER			I25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	stable, varied intake breakfast, 25% to 1 for supper, totally d intervention: continu R33's care plan, da 209 pounds, will be DWB (dry weight ba with intervention of physician orders. P interventions of fluid each meal, fluids of structured activities interventions of eat feed at meals, food kitchen, food intake each meal and offe mechanically altere R33's resident prog documented by the (DMD)-C read she member (FM)-A reli- metformin related to assisted R33 at me decrease in intakes at breakfast and lur past four days but s weight does show a at one month of 21 has been requested dietician nutritionist weight. Will add dia cubic centimeters for	ated 8/25/15, indicated weight es of 0% to 100% for 00% for lunch and 1% to 74% ependent for eating, nutrition ue previous. ted 5/11/15, indicated weight encouraged to remain within asis) range of 200-210 pounds weigh monthly or per oor fluid intake with meals with ds monitored and recorded ifered between meals and at . Varied food intakes with at grace table with staff to dislikes are recorded in es are monitored and recorded r carbohydrate controlled	F	325			
	nutrition as needed Review of R33's red						

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		. 0938-039 E SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:			<u></u>	CON	IPLETED	
		245429	B. WING			11/	05/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	E		
TWEETE	N LUTHERAN HEAL	TH CARE CENTER	125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 325	Continued From pa	age 26	F3	325				
	and supper identified 11/5/15 with 76 to supplements at break brea	ed from 10/14/15 through 100 percent intake of the eakfast meal for these four 0/30, 11/02 and 11/5).						
	regarding R33's su and if reweigh had should be opening pouring the supple DMD-C reviewed F and stated R33 use breakfast, but not s stated FM-A wants if R33 does not eat supplement. DMD- R33's weight last o with FM-A regarding	p.m., DMD-C was questioned applement intake, weight loss been done DMD-C stated staff the carton of supplement and ment into a glass at meals. R33's intake of supplements ually drinking supplement at so much other meals. DMD-C supplements at meal time, so t well R33 should drink the C stated she had reviewed in 10/14/15, and had spoken ing decreased intake, significant iced and had requested						
	reweigh for R33. D was 172, which is o When queried rega should be done the should be done wit DMD-C stated if th normal the residen reweigh, but the co	MD-C stated weight on 11/3/15 off, we will have to reweigh. arding how soon reweighs b DMD-C stated reweighs hin a week. In addition, e computer weight looks out of t should be automatically omputer system flags after the						
	reweighs are gettin DMD-C stated R33 include which scale weight was obtaine and then three wei	the weight is put in, that is why ng missed. In addition, the 3's reweigh on 11/3/15, did not e was used and last month one ed using a Hoyer mechanical lift ghts were obtained sitting. stem problem with weighing.						
	had not notified R3 loss and do not kno	3:23 p.m., DMD-C stated she 3's physician regarding weight ow if anyone else had notified protocol regarding significant						

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		AND HUMAN SERVICES				FORM	12/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245429	B. WING			11/(05/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	EN LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	weight loss is to not manager, but had n DMD-C stated she after talking with su On 11/05/2015, at 3 (RN)-D stated she f weight loss for R33 weights are someth with and working or should be taken wit and normally all we days using the bath weights were fluctu. RN-A stated someti loss until quite a dro our policy for reweig more than a five po weight and the sam resident. RN-A state was not reweigh with On 11/5/15, at 4:53 staff reweigh R33, v is down from admiss The facility policy Tr dated 10/31/08, ind records will be forw professional each n registered dietician/ appropriate person. monthly weights an over one, three and significant weight lo to the care team for documentation. The document on all sig	tify the residents case not done this. In addition, had requested R33's reweigh reveyor. 3:28 p.m., registered nurse had not been notified of any . RN-D stated to be honest ning we have been struggling n. RN-D said the weights the same scale each time ights are obtained on bath n chair. RN-D verified R33's ating and show a weight loss. imes I will not know of weight op with weight. RN-A stated gh is to reweigh at the time if ound difference in previous ne shift is to reweigh the ed she did not know why R33 th over five pound loss. p.m., DMD-C stated she had weight was 191 pounds which	F 3	325			

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TATEMENT	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>0938-039</u> E SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		G	`́CO№	IPLETED
		245429	B. WING		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL	TH CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 325	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.		F 32	5		
F 431 SS=D	indicated when the pounds or greater will reweigh the res change is accurate Dietician/Dietary M Manager will then a determine if the we the change is not s Manager will contin weights. If noted to Manager will perfor reassessment of re causes. Recomme Physician will be not 483.60(b), (d), (e)	Change Policy, dated 3/12/07, re is a weight change of five in a residents weight nursing sident. If the initial weight anager. The Dietician/Dietary assess the resident and eight change is significant. If significant the Dietician/Dietary nue to monitor successive be significant Dietician/Dietary rm a comprehensive esident and evaluate possible indations will be made and the otified per director of nursing. DRUG RECORDS, RUGS & BIOLOGICALS	F 43	1		12/15/15

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STATEMENT	T OF DEFICIENCIES DF CORRECTION	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		X3) DATE SU COMPLE	JRVEY	
		245429	B. WING		11/05/2	2015	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CC	(X5) DMPLETIC DATE	
F 431	controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accorda professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and perm have access to the The facility must pri- permanently affixe controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr	sufficient detail to enable an tion; and determines that drug er and that an account of all maintained and periodically als used in the facility must be nce with currently accepted oles, and include the sory and cautionary he expiration date when a State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to e keys. rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and 5 and other drugs subject to in the facility uses single unit ibution systems in which the ninimal and a missing dose can	F 431				
	by: Based on observa review, the facility medication from un prevent aversion o medication rooms.	NT is not met as evidenced tion, interview and document failed to properly secure nauthorized access and f medications for two This had the potential to affect in the facility who receive		F431 Gundersen Tweeten Care 6 will continue to store all drugs and biologicals in locked compartmen proper temperature controls, and only authorized personnel to have to the keys. The system for narco	ts under permit access		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245429	B. WING		11/0	05/2015
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WEETE	N LUTHERAN HEALT	H CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 431	STORAGE TO PRI During the onsite vir registered nurse (R medication room. In cabinet which hous the future. In this ca- liquid oxycodone (c not contain the amo charted the last tim stated that the medi- resident who expire of liquid Oxycodone A document titled, " Tweeten Health Se dates and times thi The controlled drug physician order: Ox (milligrams) /ml (mi sublingually (under needed for shortne 10/16/15 had been record; it stated that have been measure the count at 10:00 p 15.50 ml (milliliters) there was spilled lice bag. The writer state occurred. It advised the medication in th seal to prevent furth 11:30 p.m., the record	ge 30 SYSTEM FOR NARCOTIC EVENT AVERSION: sit on 11/2/15 at 5:06 p.m., N)-B gave a tour of the n this room contained a locked ed narcotics to be destroyed in abinet contained one bottle of lass two narcotic) which did ount of liquid which had been e it had been used. RN-B lication had been used for a ed in October 2015. The bottle e was placed in a plastic bag. Controlled Drug record for rvices (no date)," indicated the s medication had been given. record described the sycodone HCL-20 mg lliliters), give 0.25 ml the tongue) every 2 hours as ss of breath. A note dated taped to the controlled drug t the liquid in the bottle should ed at 18.25 ml (milliliters) but o.m. shift change indicated build oxycodone in the plastic red they were unsure why this d that whoever administered he future to keep an eye on the her spillage. On 10/16/15 at ord indicated a dose of 0.25 ml he patient; on 10/17/15 at 7:45	F 43 ⁻	storage was reviewed and Policie Procedures updated as needed. Licensed nursing staff was reedu December 8, 2015 in regards to t to secure medications from confu- residents; need to secure Control Substances according to policy at to ensure medication refrigerators locked at all times when not in us will be monitored by QA nurse do random audits weekly of medicati refrigerators and ensuring all med are properly secured. Two nurses document accurate counts of any controlled substances removed fr medication cart prior to destructio or designee and Consulting Phan will destroy Controlled Substance monthly and monitor compliance accurate counts.	cated on he need sed led nd need s are e. This ing on dications will now om n. DON macist s	

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLF CO	ONSTRUCTION		<u>3 NO. 0938-</u> 3) date surve	
	OF CORRECTION	IDENTIFICATION NUMBER:				(**	COMPLETED	
		245429	B. WING				11/05/201	5
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP (CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER		125 5 SPR				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		ÉTIO
F 431	indicated that the rewas 14.75 milliliters reviewed with RN-E the bottle. RN-B stat the facility had acce RN-B stated that sh missing amount of RN-B stated, "I don stated this was the where discontinued stored in preparatio stated that these nat the end of each shift have access to these them with a key at a When interviewed of registered nurse (R staff does not count to be held until they cabinet. RN-B desc to be destroyed the drug record sheet of nurse then takes th narcotic and stores was only one nurse reiterated that no on of the narcotic once cabinet before it is t "I don't ever count (When interviewed of director of nursing (consultant pharmaon narcotics on a mon	controlled drug record maining liquid in the bottle (ml). When the bottle was a, there was 12 ml of liquid in the that every single nurse in ess to this locked cabinet. The did not know why there was liquid Oxycodone in the bottle. It know what to tell you." RN-B only location in the facility narcotic medications were n of being destroyed. RN-B arcotics were not counted at ft. RN-B stated that all nurses any time. The stated that the nursing texpired narcotics which are are destroyed in the locked ribed that when a narcotic is nurse will take the controlled but of the narcotic book; the is sheet along with the expired it in the locked cabinet. There that does this. RN-B ne verifies the actual amount e it ends up in the locked to be destroyed. RN-B stated, narcotic medication) again."		31				

If continuation sheet Page 32 of 40

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245429	B. WING		11	/05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		/05/2015
TWEETE	N LUTHERAN HEAL	TH CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SP CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 431	record of how much resident. The DON scanned in to the re record. The DON s the sheet with the a prior to destroying the When interviewed of director of nursing be notified if there we of a medication and verified that there we discontinued liquid locked cabinet. The nurse will put any n medication in the lock When asked what we medication along we Controlled Drug Re out of the locked cat would have no way had been taken. The discontinued medic accompanying Com Regarding the disc and the Controlled Oxycodone, the DO time yet to look in the When interviewed of consultant pharmace ensure to there wood diversion, the syster verify an expired na being placed in the as of right now, only	rvices, which was the only h was administered to the has this piece of paper esident's permanent medical tated that she does compare actual amount of medication		31		

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		0938-039 E SURVEY	
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:				СОМ	IPLETED	
		245429	B. WING			11/	05/2015	
NAME OF I	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
TWEETE	N LUTHERAN HEAL	TH CARE CENTER	125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 431	Continued From pa	-	F4	31				
	Facility (February 2 storage conditions	itled, Medication Storage in the 2015), stated that medication are monitored on a monthly nacist and corrective action are identified.						
	Facility: Controlled 2015), stated that of subject to special h record keeping in t federal, state and of regulations. Any di substance counts director of nursing designee was to in	itled, Medication Storage in the Substance Storage (February controlled substances are handling, storage, disposal and he facility in accordance with other applicable laws and screpancy in controlled was to be reported to the immediately. The director or vestigate and make every						
	discrepancies. The document irrecond to the administrato designee was to ro substance storage substances), recor routine medication	o reconcile all reported e director of nursing was to ilable discrepancies in a report r. The consultant pharmacist or putinely monitor controlled (of discontinued controlled ds and expiration dates during storage inspections. ING MEDICATIONS FROM						
	ACCESS/AVERSIC PERSONS: During the initial fa	DENTS AND POTENTIAL ON BY UNAUTHORIZED cility tour on 11/2/15 at 1:31 nds unit (secure unit where						
	residents with seve reside) the medica be unlocked. The r kitchenette area. T	ere cognitive impairment tion refrigerator was found to refrigerator is located in the he kitchenette area is behind a nter height latching half door.						
	During constant ob area from 1:31 p.m and 22 minutes) th	bservation of the kitchenette h. through 2:53 p.m. (one hour he half door was observed to be cked with no staff in the						

Facility ID: 00285

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
				NG			
	PROVIDER OR SUPPLIER	245429	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		/05/2015	
	EN LUTHERAN HEALT	H CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 431	confused resident) kitchenette area be medication refrigera biscodyl suppositor solution. At 1:51 p.r stated that the med normally unlocked. remained unlocked brought to the atten (DON). The DON s residents back here then locked the me R39 had previously the room with the u refrigerator. On 11/2/15 at 2:53 medication cart (pa main door) a yellow on the floor. The ye marking on one sid to licensed practica unsure how long the On 11/2/15 at 4:07 "m35" markings on floor underneath the the Woodland unit. is very strange that yellow pill was ident mg (diuretic drug us One resident, R52, Woodland unit to be R52's physician orc 1 tablet once in the	times. During this time R39 (a was observed to go into the hind the half door twice. The ator contained insulin pens, ies, and influenza vaccine m. registered nurse (RN)-A ication refrigerator was The medication refrigerator until 4:03 p.m. when it was tion of the director of nursing tated, "There are never e [behind half door]." The DON dication refrigerator. However, been observed to be alone in nlocked medication p.m. on the floor near the rked near the Woodlands unit medication tablet was found llow tablet had a "m35" e. The tablet was pointed out I nurse (LPN)-A. LPN-A was e pill was on the floor. p.m. another yellow pill with one side was found on the e window in the dining area of At 4:12 p.m. LPN-A stated, "It s the same as before." The tified to be chlorthalidone 25 sed to treat hypertension). was identified on the e prescribed chlorthalidone. ler read, "chlorthalidone 25 mg	F 43	31			

Facility ID: 00285

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		CO	MPLETED	
		245429	B. WING			11	/05/2015	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 125 5TH AVENUE SOUTHEAST			E		
TWEETE	N LUTHERAN HEALT	H CARE CENTER			PRING GROVE, MN 55974			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
F 431	on the card on the of behind the half doo without opening the immediately left the staff and the medic staff were present in closer review it was card contained 30 h (anti-anxiety medica substance.) At 7:52 licensed practical n medication card on sometimes it was ty and sometimes the On 11/4/15 at 10:01 pharmacist stated h including medicatio quarterly basis and the facility about the being unlocked. Re informed of the ope the ativan medicatio and left unattended said, "[Ativan] is a of places it's under left sitting out. Ther when it's handed of should be secured in On 11/5/15 at 2:00 stated the Ativan sh when not in use. "A and put in the cart a Facility policy Medic	aff person laid the medication desk near the computer r. She was able to do this half door. The staff person unit without talking to any ation was not secured as no in the area at this time. Upon discovered the medication half tabs of Ativan 0.5 mg ation that is a controlled p.m. (18 minutes later) urse (LPN)-A found the the desk and stated that pical to find meds on the desk y will flag her down. a.m. the facility's contract he reviews medication storage in carts and refrigerators on a added that he has talked to be Woodlands unit refrigerator gistered pharmacist was n medication refrigerator and ons that were set on the cart for 18 minutes. Pharmacist controlled substance, at a lot double locks. It shouldn't be e should be communication f. It shouldn't be left out and in the cart."	F 4	.31				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY
		245429	B. WING		11/05/201	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
IWEETE	N LUTHERAN HEAL	H CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 431 F 441 SS=D	properly, following in recommendations of medication supply in nursing personnel, members lawfully a medicationsBM medication supplies attended by person 483.65 INFECTION	-	F 4			12/15/15
	Infection Control Pr safe, sanitary and o to help prevent the of disease and infe (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in	I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective ifections.				
	determines that a reprevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus	ion Control Program esident needs isolation to of infection, the facility must				

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		AND HUMAN SERVICES			FORM /	12/07/201 APPROVEI 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		245429	B. WING		11/0	5/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
TWEETE	N LUTHERAN HEAL	TH CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	hand washing is ind professional practic (c) Linens Personnel must ha transport linens so infection. This REQUIREMEN by: Based on observa review, the facility f infection control pra personal hygiene for observed receiving Findings include: R13 was observed nursing assistant (f area and buttocks of gloves and applied NA-C had laid the s cleanse R13's peri of R13's night stand R13 NA-C then rem of the top of R13's washcloth in to a pl R13's room. NA-C providing peri cares of R13's night stand wash cloth. During interview on verified she had no peri cares. In additi	dicated by accepted ce. ndle, store, process and as to prevent the spread of NT is not met as evidenced tion, interview and document failed to ensure proper actices during the provision of or 2 of 5 residents (R13, R33)	F 441	F441 Gundersen Tweeten Care C will continue to establish and maint Infection Control Program designer provide a safe, sanitary and comfo environment and to help prevent th development and transmission of c and infection. NA-C and NA-D were reeducated on proper infection corn practices when providing cares to residents on use of gloves and har washing. All other nursing staff wa reeducated on proper infection corn practices when providing cares to residents on December 8, 2015. In control nurse to monitor by doing ra audits weekly of nursing staff x6 m and reporting results to quarterly C meeting.	ain an d to rtable le disease e ttrol nd ls ttrol nfection andom onths		

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						0. 0938-039
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245429	B. WING _			/05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
TWEETE	EN LUTHERAN HEAL	TH CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 441	area and buttocks had not sanitized th after removing the During interview or director of nursing expect staff to was cares. In addition, expect the nightsta cloth used to provid top of the night sta R33 was observed when NA-D donne- wet incontinent pro- same soiled gloves cupboard, picked u wipes, cleansed R3 bowel movement), moved a commode lift. NA-D then rem assisted to give R3 washed hands with R33 was done usin gloves, assisted R3 an EZ stand mech- buttocks (with visited disposable wipes to clean incontinent pro- stool soiled gloves disposable wipes to clean incontinent pro- R33's pants and tra- wheelchair using th placed leg rests ar	on top of R13's night stand and ne top of R13's night stand soiled wash cloth. n 11/05/2015, at 2:48 p.m., (DON) stated she would h hands after providing peri the DON stated she would and to be sanitized after a wash de peri cares was laid on the		41		

Facility ID: 00285

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245429	B. WING			11/(05/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TWEETE	N LUTHERAN HEALT	H CARE CENTER			125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 39	F4	141			
	assistant (NA)-D ve the stool soiled glov	11/4/15, at 8:57 a.m., nursing erified she had not removed yes and washed hands after t incontinent product and ttocks.					
	DON stated she wo gloves and wash ha	11/05/2015, at 3:05 p.m., ould expect staff to remove ands after changing a wet and providing peri cares.					
	indicated change gl procedures on the s with material that m concentration of mi- promptly after use, non-contaminated i surfaces and wash	croorganisms. Remove gloves					
	indicated general in Observe (standard) infection control sta appropriate facility of	erineal Care, undated, fection control guidelines 1. universal precautions or other ndards as approved by committee. 2. Wash your fter all procedures. Wear oriate.					

Facility ID: 00285

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		AND HUMAN SERVICES		Ŧ	-5429024	FORM	: 12/04/2015 1APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION 11 - MAIN BUILDING 01		TE SURVEY MPLETED
		245429	B. WING			11	/04/2015
	PROVIDER OR SUPPLIER			12	REET ADDRESS, CITY, STATE, ZIP CODE		
				S	PRING GROVE, MN 55974 PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
к'000	INITIAL COMMEN	TS	K	000			
9	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS COMPLIANCE.					н.,
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departn Fire Marshal Division Tweeten Lutheran not in substantial c requirements for particular Medicare/Medicaid 483.70(a), Life Safi edition of National	articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					
	Safety Deficiencies Health Care Fire In State Fire Marshal 444 Cedar St., Suit	nspections Division te 145		5	EPOC		
	St Paul, MN 55101 By email to:	-5145, or			2		
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 12/04/2015
Electror	nically Signed						12/04/2013

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	12/04/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245429	B. WING		11/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER		125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
К 000	Marian.Whitney@s <mailto:marian.whit Angela.Kappenmar <mailto:angela.kap THE PLAN OF COU DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre Tweeten Lutheran I building with a partic constructed at 2 diff building was constru- determined to be or 1967, addition was that was determine construction. Becau the 1 addition are of</mailto:angela.kap </mailto:marian.whit 	tate.mn.us itney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. Health Care Center is a 1-story ial basement. The building was ferent times. The original ructed in 1965 and was f Type II(222) construction. In constructed to the South Wing d to be of Type II(222) use the original building and of the same type of	K 00			
	facility was surveyed The building is fully fire alarm system we detection and space	ed for existing buildings, the ed as one building. I sprinklered. The facility has a with full corridor smoke les open to the corridors that is matic fire department			2	

States -

Facility ID: 00285

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPL			0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245429	B. WING			11/0	4/2015
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTER			25 5TH AVENUE SOUTHEAST		
				S	PRING GROVE, MN 55974		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST. BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	1	(X5) COMPLETION DATE
K 000	Continued From pa	qe 2	ĸ	000			
		apacity of 50 beds and had a					
	•••••					2	
K 154	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD		154			12/8/15
K 154 SS=D		utomatic sprinkler system is		104			12/0/10
	out of service for m period, the authority	ore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire					
	watch system is pro unprotected by the	ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1					
	Where a required a out of service for m period, the authority and the building is a watch system is pro-	s not met as evidenced by: automatic sprinkler system is ore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1			K 154 Gundersen Tweeten Care Cent will continue to ensure that when a required automatic sprinkler system is of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building evacuated or an approved fire watch system is provided for all parties left	out	
	on 11/04/2015, obs reviewed revealed	veen 09:00 AM and 12:30 PM ervation and documentation that there was not a single service plan for the fire			unprotected by the shutdown until the sprinkler system has been returned to service. On 11/4/15 a single plan was in place for the fire sprinkler system of service. All staff was educated on this December 8, 2015.	it of	
	This deficient pract	ice was confirmed by the					

Facility ID: 00285

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PRINTED: 12/04/2015

		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
			245429	B, WING			11/0	04/2015
	IAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
1	WEETE	N LUTHERAN HEAL	TH CARE CENTER			25 5TH AVENUE SOUTHEAST		
					s	PRING GROVE, MN 55974		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
	K 154	Continued From pa Facility Maintenand discovery.	age 3 ce Director (CG) at the time of	К 1	54			
	K 155 SS=D	NFPA 101 LIFE SA	FETY CODE STANDARD	K 1	55			12/8/15
		service for more th the authority having building is evacuat provided for all par	ire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been . 9.6.1.8					
		Where a required service for more th the authority havin building is evacuat provided for all par	is not met as evidenced by: fire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been a. 9.6.1.8			K155 Gundersen Tweeten Care (will continue to ensure that when a required fire alarm system is out of service for more than 4 hours in a 4period, the authority having juriso notified, and the building is is evad or an approved fire watch is provid all parties left unprotected by the	a of 24-hour diction is cuated	
		on 11/04/2015, obs reviewed revealed	ween 09:00 AM and 12:30 PM servation and documentation that there was not a single service plan for the fire alarm			shutdown until the fire alarm syste been returned to service. On 11/4 single plan was put in place for the alarm system out of service. All st educated on this on December 8,	/15 a e fire aff was	
			tice was confirmed by the ce Director (CG) at the time of					

Event ID: 90ML21

Facility ID: 00285

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PRINTED: 12/04/2015



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Tweeten Lutheran Health Care Center November 24, 2015 Page 2

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 Riske. Downing

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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00285	B. WING		11/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TWEETE	N LUTHERAN HEALT	H CARE CENTEE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all a rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	that may result from orders provided tha the Department with	n non-compliance with these t a written request is made to hin 15 days of receipt of a				
	You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES PRING GROVE, MN 55974 SUMMARY STATEMENT OF DEFICIENCIES PRECIDE OF CONSERVENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Initial Comments 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					

Electronically Signed

If continuation sheet 1 of 34

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00285	B. WING			05/0015
	PROVIDER OR SUPPLIER		DRESS, CITY, ST			05/2015
		125 5TH	AVENUE SOUT			
WEELE	IN LUTHERAN HEAL	SPRING	GROVE, MN 5	5974		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLE DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On November 2, 3 Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far la Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." Fo are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	, 4 & 5, 2015, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed. nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is nary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state teement, "This Rule is not met ollowing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00285	B. WING		11/05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
TWEETE	N LUTHERAN HEAL		AVENUE SO GROVE, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
2 510	Continued From pa	age 2	2 510		
2 510	MN Rule 4658.030	0 Subp. 2 Use of Restraints	2 510		12/15/1
	must be free from a restraints imposed	from restraints. Residents any physical or chemical for purposes of discipline or not required to treat the symptoms.			
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document failed to ensure a recliner was raint for 1 of 1 resident (R39) her for sleep.		Corrected	
	Findings Include:				
	indicated severe co was steady at all tir to standing position	nimum Data Set dated 8/25/15 ognitive impairment and R39 mes with moving from a seated n, walking, turning around, oilet, and surface to surface			
	was started of R39 recliner located in t secure Woodland u the recliner until 4:2 practical nurse (LP awake R39 was ab to move the back o	a.m. a continuous observation A. R39 was asleep in a manual he public day area of the unit. R39 remained sleeping in 20 a.m. when licensed N)-B awakened R39. Once le to push against the recliner of the recliner to an upright her feet against the foot rest to			
	move the foot rest. bathroom to compl completion of morr to an electric reclin for positioning. LPN	LPN-B assisted R39 to the ete morning cares after the ning cares LPN-B assisted R39 er which used a remote control N-B used the remote control to PN-B then placed the remote			

STATEME	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00285	B. WING		11/05/2015			
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE	11/03/2013			
	N LUTHERAN HEALT	TH CARE CENTEE 125 5TH	AVENUE SOU	THEAST				
	1	SPRING	GROVE, MN 5					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 510	Continued From pa	ge 3	2 510					
	the recliner which F a.m. R39 was observed intermittently movin talking to herself, w a.m. R39 was observed attempting her feet on recliner, moving her down stating, "I war get out of the chair 6:19 a.m. R39 cont the chair noted her and arms. R39's leg the raised leg rest. attempting to push down on the recliner observed attemptin LPN-B ran to R39's control to return the With minimal assist up and walk indepe On 11/4/15 at 5:56 normally sleeps in a "She would fall out sleep on the floor. O recliner she will sleep on her own and she seems safer to hav close eye on her." T (TMA)-C added, "It" her and get to her s R39's care plan and is care planned" wh	e pocket on the right side of R39 could not reach. At 5:32 rved to be sleeping in the n. R39 began to move self in er feet hanging over side of t 5:54 a.m. R39 was g around in the recliner, ith her knees bent. At 6:10 rved to be moving her legs, the raised leg rest of the r torso and sitting up and nt to go too." R39 is unable to due to the leg rest raised. At inued to attempt to get out of to push off recliner with legs gs were hanging off the side of At 6:25 a.m. R39 was off on the recliner, pushing er arms. At 6:32 a.m. R39 was g to climb out of the recliner. • side and used the remote e chair to the upright position. tance R39 was able to stand ordently throughout the unit. a.m. LPN-B stated R39 a recliner in the day room, of her bed. At home she would Dnce she is settled into the ep pretty well. She had a room e wouldn't go into her room. It e her out here and keep a Trained medication aide s nice on nights to peek in on sooner." LPN-B reviewed d stated, "It doesn't look like it ten asked about the recliner and located near the nurses						

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00285	B. WING			05/0015
						05/2015
-	ROVIDER OR SUPPLIER	125 5TH	DDRESS, CITY, ST AVENUE SOU			
WEETE	N LUTHERAN HEAL		GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 510	Continued From pa	age 4	2 510			
	On 11/4/15 at 8:39 a.m. registered nurs a manager, stated R39 slept in the blue recliner and that she could sometimes independently get out of the chair on he adding, "If staff see her trying to get out should help her up otherwise it will caus distress."					
	stated, "If she [R39	a.m. nursing assistant (NA)-E] starts wiggly that's our cue to lue recliner is sitting up she car "				
	might not be care p recliner, she slept of would assess her, on that. She will put and the arm rest at trying to get up for say that it is a restr struggling a good a	7 p.m. RN-D stated, "She blanned for sleeping in the on the floor at home. Therapy I don't know what our policy is it her feet between the foot res nd push herself up. If she was long time I wouldn't want to raint all the time. If she was amount of time then yes it it, ten or five minutes."	t			
	assistant-D stated	5 a.m. physical therapist nursing would complete rding sleeping in recliners.				
	(DON) stated, "We assessment. It wou could normally get and can't." The not read to the DON as point it would be co	p.m. the director of nursing don't have a recliner uld be an observation. If they out of it [recliner] without help ted observations of R39 were nd she responded with, "At that onsidered a restraint." The cliner was not care planned.	t			
	[R39] may lower he	ted 12/4/13 reads, "At times, erself to the floor and sleep on at with her preferences and				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		00285	 B. WING	B. WING		05/2015
ME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE. ZIP CODE		55/2015
	N LUTHERAN HEAL	TH CARE CENTER 125 5TH	AVENUE SOUT	THEAST		
		SPRING	GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 510	Continued From pa	ige 5	2 510			
	on floor, ensure that	ears. If [R39] prefers to sleep at she is warm enough; do not to put back to bed, until she				
	reads; "Physical reads, "Physical reads, or physical material, or equipmone's body. Physical device or garment or resident behavior be movement of the read portion of the body unable to remove eroomResident's risks and abilities of with a significant characteristic structure of the significant s	sical Restraint, dated 1/20/06, straints are any manual or mechanical device, eent attached or adjacent to al restraints include any article, used primarily to modify y interfering with free esident or normal functioning or dy, and which the resident is easily, confinement in a locked will be assessed for safety n admission, re-admission, hange, and quarterly with eeded should a change in isks."				
	administrator or de resident restraint us	THOD OF CORRECTION: The signee could review the sage data to ensure residents vithout proper assessments				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/15/1
		omprehensive plan of care I personnel involved in the t.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00285	B. WING	B. WING		05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL	TH CARE CENTER	AVENUE SO GROVE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565			
	by: Based on observat review, the facility f as directed by the o (R13) who required failed to ensure the provide toileting ca plan for 1 of 1 resid assistance with toil In addition the facil assistance as direct	ent is not met as evidenced ion, interview and document failed to provide toileting cares care plan for 1 of 1 resident d assistance with toileting and e use of a tab alarm and res as directed by the care dent (R33) who required eting and had limited mobility. ity failed to provide transfer cted by the care plan for 1 of 1 o required assistance with		Corrected		
	AND LACK OF US ALARM WHILE IN FALLS: R13's care plan, da limited in ability to t with interventions of two hours and offer Establish routine for	le during waking hours and				
	11/04/2015, at 7:31 (NA)-C had washed incontinent product R13. NA-C then tra wheelchair, combe assisted R13 with e	of morning cares on a.m., nursing assistant d R13, changed R13's t and had assisted to dress ansferred R13 into a d R13's hair, shaved R13 and eye glasses. NA-C then f R13's room. NA-C failed to 13.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00285		B. WING		11/05/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
WEETE	N LUTHERAN HEAL	TH CARE CENTEE	AVENUE SOU GROVE, MN §			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	verified had not off	ered R13 the toilet.				
	director of nursing	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.					
		e sheet dated 10/13/15, brief at all times, do not				
		8:39 a.m., nursing assistant red to double pad R33 with ts.				
	observed sitting in	/15, at 9:49 a.m., R33 was wheelchair with a tab alarm of the wheelchair. The tab ched to R33.				
	verified had double products. NA-D fur wetness and was to	n 11/4/15, at 8:57 a.m., NA-D e padded R33 with incontinent ther stated R33 has a lot of rained to double pad R33. s care sheet read do not				
		n 11/4/15, at 9:49 a.m., NA-D rm was not attached to R33.				
	During interview or					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00285		B. WING		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL		AVENUE SOU ^T GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	R33's care plan reg place when in when sheets the nursing with the resident's care sheet read do incontinent product no residents should to the use of incont A facility policy rega implementation was provided.	arding care plan s requested, but was not				
	RECEIVING CARE R44's care plan da	EZ STAND WHILE ES: ted 10/15/15, indicated R44 of one and use of the EZ stand	I			
	R44 was transferrer nursing assistant (I from the recliner in wheelchair. NA-E p NA-E applied a gai upper torso region. sink where with exit R44 was pulled up directed R44 to hol to hold herself up. knobs of the fauce herself up. NA-E re pinching R44's upp extensively assiste R44 was once aga standing position, p the faucet handles NA-E continued to	ed on 11/4/15 at 7:41 a.m. by NA)-E using an easy stand the day area to R44's propelled R44 to her room. t belt snuggly around R44's . R44 was pushed up to the tensive assistance from NA-E to the sink. NA-E repeatedly Id on to the front lip of the sink R44 kept grabbing for the t and pulling on the sink to hold epositioned R44's gait belt, per torso region. NA-E then d R44 to sit on the commode. in extensively assisted to a pulling on the sink, grabbing and faucet to stay standing. assist R44 with her morning 44's morning cares, NA-E	k			

			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00285		B. WING		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
TWEETE	N LUTHERAN HEAL	TH CARE CENTER	AVENUE SOU [®] GROVE, MN 5	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 9	2 565			
	the sink to have he indicated it would b routine changed. N	nal routine for R44 to stand at r cares completed. NA-E e new to her if R44's transfer A-E then reviewed R44's care 44 was an assist of one with				
		Communication Note, dated nded use of EZ stand for				
	A facility policy rega implementation was provided.	arding care plan s requested, but was not				
	administrator or de	THOD OF CORRECTION: The signee could review the s to ensure they are being	,			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			12/15/1
	care must be review interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an im that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs practicable, with the resident, the resident's legal representative at least n seven days of the revision of resident assessment required subpart 3, item B.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
	00285		B. WING		11/05/2015	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
IWEETE	N LUTHERAN HEAL		AVENUE SO GROVE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 10	2 570			
	by: Based on observat review, the facility f according to the ph residents (R33) rev revise the care plan 1 of 3 residents (R3 conditions and faile include the use of a (R33) reviewed for facility failed to upd therapy recommen	ent is not met as evidenced ion, interview and record ailed to revise the care plan sysician orders for 1 of 3 riewed for nutrition; failed to n to include risk of bruising for 33) reviewed for skin ed to revise the care plan to a foot board for 1 of 3 residents restraints. In addition the late a care plan after physical ded changes for 1 of 1 ewed for positioning.	5	Corrected		
	R33'S CARE PLAN R33's quarterly Min 8/18/15, identified I Alzheimer's, demen impairment, require	IAN ORDERS INCLUDED IN I: nimum Data Set (MDS) dated R33 had diagnoses of ntia, had severe cognitive ed extensive assistance from nical altered diet and				
	through 11/5/15, ind mechanical soft, ca supplements with r may have regular v	der report dated 10/5/15 dicated order start date diet: arbohydrate controlled, neals, nectar thickened liquids vater in lidded cup in room 30 s after offered oral cares.				
	(NA)-D was observe breakfast which income of juice, water and	9:25 a.m., nursing assistant ed to assist R33 with cluded nectar thickened liquids milk, oatmeal, mighty shake d sausage and toast.				
	On 11/04/2015, 9:5	0 a.m., a lidded cup with				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00285		B. WING		11/05/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE		03/2013
	N LUTHERAN HEAL	TH CARE CENTER 125 5TH	AVENUE SOU	THEAST		
		ATEMENT OF DEFICIENCIES	GROVE, MN 5	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 570	Continued From pa	age 11	2 570			
	regular consistency room on a tray tabl	y water was observed in R33's e.				
	fluid intake with me monitored and reco between meals and food intakes with in table with staff to fe recorded in kitchen and recorded each controlled mechanic care plan failed to i meals and nectar th regular water in lide post meals after off On 11/04/2015, at 9 (RN)-A verified R33 nectar thickened lide	ated 5/11/15, indicated poor eals with interventions of fluids orded each meal, fluids offered d at structured activities. Varied interventions of eat at grace eed at meals, food dislikes are n, food intakes are monitored meal and offer carbohydrate ically altered diet. However, the include supplements with hickened liquids, may have ded cup on room 30 minutes fered oral cares. 9:52 a.m., registered nurse B's care plan failed to include quids, may have regular water im 30 minutes post meals after				
	On 11/5/15, at 4:53 director (DMD)-C v for supplements wi liquids. DMD-C ver	p.m., dietary manager erified R33's physician order th meals and nectar thickened ified R33's care plan failed to ts with meals and nectar				
	verified R33's phys and verified R33's of nectar thickened lic in lidded cup on roo after offered oral ca	3:05 p.m., director of nursing ician order dated 10/14/15, care plan failed to include quids, may have regular water om 30 minutes post meals ares and she would expect the included on R33's care plan.				
	LACK OF CARE P RISK OF BRUISIN	LAN INTERVENTION FOR G:				

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00285		B. WING	B. WING		05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	_	
TWEETE	N LUTHERAN HEAL		AVENUE SOU GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 12	2 570			
		on 11/04/2015, at 8:39 a.m., n the side of left hand and on				
	RN-A confirmed R3 left hand and on to wander if bruising f	on 11/05/2015, at 9:55 a.m., 33 had a bruise on the side of p of left forearm. RN-A stated I from EZ stand mechanical lift here the bruises are located.				
	through 10/15/15, i	gress notes dated 10/12/15 dentified R33 had prior w umbilicus of unknown origin s.				
	for pressure ulcers mobility. Report an	ated 5/11/15, indicated at risk related to impaired bed y signs of skin breakdown or broken areas). R33's care de risk of bruising.				
	RN-A verified R33's has had previous b care plan failed to i	n 11/05/2015, at 9:55 a.m., s progress notes identified R33 pruising. RN-A verified R33's include the risk of bruising and ruising should be care planned				
	DON verified R33's	n 11/05/2015, at 3:05 p.m., s care plan failed to include the l stated she would expect the be care planned.				
	FOOD BOARD IN	LAN INTERVENTION OF WHEELCHAIR: R33 was 5, at 9:29 a.m., a foot board 3's wheelchair.				
anoasta D	place footrests onto	a.m., NA-D was observed to o R33's wheelchair and then ard in place onto R33's				

Iinnesota Department of He TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00285	B. WING		11/05/2015	
AME OF PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2010
WEETEN LUTHERAN HEAL		AVENUE SOU GROVE, MN 5			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570 Continued From pa	age 13	2 570			
footrests.					
limited physical mo time related to physical with interventions of at meals and unsuju elevated to prevent	oblem date 5/28/15, indicated bility, chair fast all or most of sical limitations, depression of make sure reclined when not pervised, make sure foot rests t falling forward. R33's care le the use of a foot board.				
DON verified R33's use of a foot board	a 11/05/2015, at 3:05 p.m., care plan failed to include the and stated she would expect include the foot board.				
plan, the facility pro	policy for revision of the care ovided an untitled copy of listed addressed F280 and indicated sed as necessary to address of each resident.				
activity/mobility/trar balance/weakness to ambulate with re at this time up to 50 bid (twice daily) and consider offering a transfer/ambulate v R44's care plan inc	ted 1/12/15, identified limited hsfers with impaired . Interventions included, "offer sident on household tolerating 0 ft [FEET] with nursing staff d when she appears restless, walk. Resident will with 1 staff assist as needed." licated R44, with assistance th proper use of a walker and				
dated 10/14/15 incl instructions, "Disch	ress and Discharge Summary luded the following discharge arge to memory care unit with discharge] of walking program r transfers."				
Quarterly Minimum	Data Set (MDS) dated				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00285		B. WING		11/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL	TH CARE CENTER	AVENUE SOUT GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 14	2 570			
		R44 was a one person physical in room and corridor.				
		ed 10/20/15 indicated R44 did g the seven day look back				
	a manager, stated, because her knees worked with her for working with physic 10/14/15 R44 chan stand. RN-D said, '	a.m. registered nurse (RN)-D, R44 uses the EZ stand will buckle. Therapy has a while. She has been cal therapy since 9/16/15. On ged to the use of the EZ 'I'm gonna say that's the way done before I came. I haven't r care plan."				
	stated, "RN-D and process for the last	p.m. the director of nursing RN-F are new to the care plan t four months. The care is or as changes occur."				
	A facility policy on o but not provided.	care planning was requested				
	administrator or de	THOD OF CORRECTION: The signee could review the to ensure their accuracy of				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			12/15/15
	receive nursing car	general. A resident must e and treatment, personal and supervision based on				

If continuation sheet 15 of 34
	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
		00285	B. WING		11/05/20	15
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	11/00/20	10
WEETE	N LUTHERAN HEAL		AVENUE SO			
		ATEMENT OF DEFICIENCIES	GROVE, MN	55974 PROVIDER'S PLAN OF CORREC		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) MPLE DATE
2 830	Continued From pa	age 15	2 830			
	the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on observat review, the facility f care and services r	ent is not met as evidenced ion, interview and document failed to provide necessary related to monitoring of bruises (R53 & R33) reviewed for ed skin conditions.		Corrected		
	Findings include:					
	indicated that the re moderate protein-c of other specified E deficiency; thromb blood which can ca	nission record, dated 9/9/15, esident had diagnoses of: alorie malnutrition; deficiency 8 group vitamins; vitamin D ocytopenia (a disorder of the ause bleeding in to the tissues, blood clotting after injury).				
	staff were to condu on a daily basis. It inspect the skin for	ated 9/9/15, stated that nursing loct a systematic skin inspection further directed nursing staff to sites of concern when s of daily living including y bathing.				
		tion on 11/3/15 at 2:13 p.m., ave several sites of bruising of oth forearms.				

AME OF PROVIDER OR SUPPLIER IWEETEN LUTHERAN HEALTH CARE (X4) ID PREFIX TAG SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE I REGULATORY OR LSC IDENTIF 2 830 Continued From page 16 During record review of R53 was evident to indicate that I on either forearm: the care p documentation which stated susceptible to bruising; the in lacked any indication of any forearms; a document titled, Integrity Condition Report," of mention of any bruising for F the same title but dated 10/2 of any bruising. When interviewed on 11/4/19, nursing assistant (NA)-B stated aware that R53 had any bruis She stated that if a resident bruising she would notify the When interviewed on 11/5/19, registered nurse (RN)-A statataware of any bruising on R5	CENTEF 125 5TH SPRING DEFICIENCIES PRECEDED BY FULL YING INFORMATION) , no documentation R53 had any bruising	B. WING DDRESS, CITY, ST AVENUE SOUT GROVE, MN 5 PREFIX TAG 2 830	THEAST	ORRECTION ON SHOULD BE HE APPROPRIATE	D5/2015
IAME OF PROVIDER OR SUPPLIER WEETEN LUTHERAN HEALTH CARE (X4) ID PREFIX TAG SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE I REGULATORY OR LSC IDENTIF 2 830 Continued From page 16 During record review of R53 was evident to indicate that I on either forearm: the care p documentation which stated susceptible to bruising; the in lacked any indication of any forearms; a document titled, Integrity Condition Report," or mention of any bruising for F the same title but dated 10/2 of any bruising. When interviewed on 11/4/19 nursing assistant (NA)-B sta aware that R53 had any brui She stated that if a resident bruising she would notify the When interviewed on 11/5/19 registered nurse (RN)-A stat	STREET A 125 5TH SPRING F DEFICIENCIES PRECEDED BY FULL YING INFORMATION) , no documentation R53 had any bruising	AVENUE SOUT GROVE, MN 5 PREFIX TAG	THEAST 5974 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ORRECTION ON SHOULD BE HE APPROPRIATE	(X5) COMPLE
WEETEN LUTHERAN HEALTH CARE (X4) ID PREFIX TAG SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE I) REGULATORY OR LSC IDENTIF 2 830 Continued From page 16 During record review of R53 was evident to indicate that I on either forearm: the care p documentation which stated susceptible to bruising; the in lacked any indication of any forearms; a document titled, Integrity Condition Report," of mention of any bruising for F the same title but dated 10/2 of any bruising. When interviewed on 11/4/19 nursing assistant (NA)-B state aware that R53 had any bruis She stated that if a resident bruising she would notify the When interviewed on 11/5/19 registered nurse (RN)-A state	CENTEF 125 5TH SPRING DEFICIENCIES PRECEDED BY FULL YING INFORMATION) , no documentation R53 had any bruising	AVENUE SOUT GROVE, MN 5 PREFIX TAG	THEAST 5974 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLE
(X4) ID PREFIX TAGSUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE I REGULATORY OR LSC IDENTIF2 830Continued From page 162 830During record review of R53 was evident to indicate that I on either forearm: the care p documentation which stated susceptible to bruising; the in lacked any indication of any forearms; a document titled, Integrity Condition Report," of mention of any bruising for F the same title but dated 10/2 of any bruising.When interviewed on 11/4/19 nursing assistant (NA)-B stated aware that R53 had any bruis She stated that if a resident bruising she would notify the When interviewed on 11/5/19 registered nurse (RN)-A stated	SPRING F DEFICIENCIES PRECEDED BY FULL YING INFORMATION) , no documentation R53 had any bruising	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLE
PREFIX TAG (EACH DEFICIENCY MUST BE I REGULATORY OR LSC IDENTIF 2 830 Continued From page 16 During record review of R53 was evident to indicate that I on either forearm: the care p documentation which stated susceptible to bruising; the in lacked any indication of any forearms; a document titled, Integrity Condition Report," or mention of any bruising for F the same title but dated 10/2 of any bruising. When interviewed on 11/4/19 nursing assistant (NA)-B sta aware that R53 had any brui She stated that if a resident bruising she would notify the When interviewed on 11/5/19 registered nurse (RN)-A stat	PRECEDED BY FULL YING INFORMATION) , no documentation R53 had any bruising	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLE
During record review of R53 was evident to indicate that I on either forearm: the care p documentation which stated susceptible to bruising; the ii lacked any indication of any forearms; a document titled, Integrity Condition Report," of mention of any bruising for F the same title but dated 10/2 of any bruising. When interviewed on 11/4/19 nursing assistant (NA)-B stat aware that R53 had any brui She stated that if a resident bruising she would notify the When interviewed on 11/5/19 registered nurse (RN)-A stat	R53 had any bruising	2 830			
 was evident to indicate that is on either forearm: the care product documentation which stated susceptible to bruising; the is lacked any indication of any forearms; a document titled, Integrity Condition Report, "or mention of any bruising for F the same title but dated 10/2 of any bruising. When interviewed on 11/4/12 nursing assistant (NA)-B state aware that R53 had any bruis She stated that if a resident bruising she would notify the When interviewed on 11/5/12 registered nurse (RN)-A state 	R53 had any bruising				
She stated that after the resistered hurse of any braining on the second	that the resident was needisciplinary notes bruising on R53's "Tweeten Skin dated 11/2/15, had no R53; a document with 7/15 had no mention 5 at 9:11 a.m., ted that she was not sing on his forearms were to develop any nurse. 5 at 8:49 a.m., ed that she was not 3's bilateral forearms dent finished the resident. 5 at 10:28 a.m., fied that R53 had rms. She stated that ital on 10/15/15 and hospital stay. RN-A intation on the ot been monitoring tated that the nursing R53's bruising on his 5 at 12:07 p.m., the				

00285	B. WING	_	
NAME OF PROVIDER OR SUPPLIER		G	11/05/201
	STREET ADDRESS, C	CITY, STATE, ZIP CODE	
WEETEN LUTHERAN HEALTH CARE CENTE	125 5TH AVENUE		
	SPRING GROVE,		
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INF	D BY FULL PREF	IX (EACH CORRECTIVE ACT	ION SHOULD BE COM
2 830 Continued From page 17	2 830		
 When asked for a policy on develop plan for problems such as bruising, provided a copy of the state regulat high-lighted the title "Comprehensive care plans (no date on copy)." It state comprehensive care plan was to be each resident using the results of the comprehensive assessment. It state resident care plan should include mobjectives and timetables to meet a needs identified in the comprehensive assessment. It stated that all service provided should be included in each plan of care. It stated that the compreare plan should describe the service to attain the resident's highest well-R33's quarterly Minimum Data Set 8/18/15, identified R33 had diagnos Alzheimer's, dementia, had severe impairment and required extensive activities of daily living. R33's care plan, dated 5/11/15, indifor pressure ulcers related to impair mobility. Report any signs of skin be (sore, tender, red or broken areas). plan failed to address bruising. On 11/04/2015, at 8:39 a.m., during of R33's morning cares provided by assistant (NA)-D and nursing assist R33 was observed to have a bruise R33's left hand and on the top of R3 forearm. 	the facility ons which e resident ted that a developed for e ed that each easurable II resident ve es to be n resident's rehensive ces furnished being. MDS) dated es of cognitive assist with cated at risk ed bed eakdown R33's care observation nursing ant (NA)-C, on the side of 33's left		

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00285	B. WING		11/	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	1	
IWEETE	EN LUTHERAN HEALT		AVENUE SOU ⁻ GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	wander if bruising f use, because of wh RN-A reviewed R33 was no documenta located on R33's si of R33's left forearr assistants are to int has bruising, the nu bruises and docum under events regar- then notifies the far case manager. The in the resident's red next shift and adds RN-A stated we mo on the treatment se usually once a day order. During interview on when queried regar bruising, the directo assistants should n is observed with a r The facility policy A Reporting, dated 7/ of Gunderson Twee systemic approach follows: identificatio inadequate supervi potentially avoidabl environment; evalu and risks; impleme including adequate devices, to reduce hazards in the envir	rom EZ stand mechanical lift nere the bruises are located. B's record and confirmed there tion regarding the bruises de of left hand and on the top m. RN-A stated the nursing form a nurse when a resident urse then measures the ents in the resident record ding the bruising. The nurse mily, the physician and the e nurse makes a progress note cord, relays information to the to 24 hour report. In addition, pattern bruising by documenting ection of the residents record, until resolved as a nursing of nursing stated nursing potify the nurse when bruising				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00285	B. WING		11/	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
IWEETE	N LUTHERAN HEALT		VENUE SOUT GROVE, MN 5			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 19	2 830			
	administrator or des	HOD OF CORRECTION: The signee could review the sure an residents receive good				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for H. a system for products which affe disinfectants, antise incontinence product	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of oct infection control, such as eptics, gloves, and	21390			12/15/1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00285	B. WING		11/	05/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	ORRECTION IN SHOULD BE IE APPROPRIATE	
WEETE	N LUTHERAN HEAL	TH CARE CENTEE	AVENUE SO GROVE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 20	21390			
	by: Based on observat review, the facility infection control pr	tion, interview and document failed to ensure proper actices during the provision of or 2 of 5 residents (R13, R33) g cares.		Corrected		
	Findings include:					
	nursing assistant (I area and buttocks gloves and applied NA-C had laid the cleanse R13's peri of R13's night stan R13 NA-C then rer of the top of R13's washcloth in to a p R13's room. NA-C providing peri care	on 11/04/2015, at 7:31 a.m., NA)-C had washed R13's peri with a wash cloth, removed clean gloves. In addition, soiled washcloth used to area and buttocks on the top d. After providing cares for noved the soiled wash cloth off night stand, placed the lastic bag and walked out of had failed to wash hands after s and failed to sanitize the top d after removing the soiled				
	verified she had no peri cares. In addit a soiled wash cloth area and buttocks	n 11/4/15, at 8:59 a.m., NA-C ot washed hands after providing ion, NA-C verified she had laid n used to cleanse R13's peri on top of R13's night stand and he top of R13's night stand soiled wash cloth.				
	director of nursing expect staff to was cares. In addition, expect the nightsta	n 11/05/2015, at 2:48 p.m., (DON) stated she would h hands after providing peri the DON stated she would and to be sanitized after a wash de peri cares was laid on the				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00285	B. WING		11/	05/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
WEETE	N LUTHERAN HEAL		AVENUE SOU GROVE, MN §			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 21	21390			
	top of the night stand.					
	when NA-D donned wet incontinent pro- same soiled gloves cupboard, picked u wipes, cleansed R3 bowel movement), moved a commode onto the commode lift. NA-D then remo assisted to give R3 washed hands with R33 was done usin gloves, assisted R3 an EZ stand mecha buttocks (with visib disposable wipe. N stool soiled gloves disposable wipes b clean incontinent p R33's pants and tra wheelchair using the placed leg rests an wheelchair, change deodorant under R3 R33's lap and brust	on 11/04/2015, at 8:39 a.m., d gloves and removed R33's duct. NA-D then (with the s left on) opened R33's up a container of disposable 33's buttocks (with visible then with stool soiled gloves and assisted R33 to sit down using an EZ stand mechanicat oved the soiled gloves and 3 a drink of water before soap and water. Then when ug the commode NA-D donned 33 off of the commode using anical lift and cleansed R33's le bowel movement) using a A-D continued to wear the and placed the container of vack into a cupboard, applied a roduct onto R33, pulled up ansferred R33 into a ne EZ stand mechanical lift, d a foot board onto R33's ed R33's shirt, applied 33's arms, placed a blanket or hed R33's hair. NA-D then soiled gloves.				
	assistant (NA)-D ve the stool soiled glov removing R33's we cleansing R33's bu	erified she had not removed ves and washed hands after et incontinent product and ttocks.				
	During interview on DON stated she wo	n 11/05/2015, at 3:05 p.m.,				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00285	B. WING		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL	TH CARE CENTER	AVENUE SOU ⁻ GROVE, MN 5	-		
(X4) ID		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
21390	Continued From pa	age 22	21390			
	indicated change g procedures on the with material that n concentration of m promptly after use, non-contaminated surfaces and wash	icroorganisms. Remove gloves				
	indicated general in Observe (standard infection control sta appropriate facility	Perineal Care, undated, nfection control guidelines 1.) universal precautions or other andards as approved by committee. 2. Wash your after all procedures. Wear priate.				
	The administrator of	THOD OF CORRECTION: or designee could review the sure infections control g followed by staff.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21630	MN Rule 4658.135 Medications; Destr	0 Subp. 2 A.B. Disposition of uction	21630			12/15/15
	remaining in the nu discharge of a resid prescribed, or any discontinued perma manner recommen	on of medications. tions of controlled substances ursing home after death or dent for whom they were controlled substance anently must be destroyed in a ided by the Board of Pharmacy harmacist. The board or the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED	
		00285	B. WING		11/0	05/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS. CITY.	STATE, ZIP CODE	-		
		125 5TH	AVENUE SO				
WEETE	N LUTHERAN HEAL		GROVE, MN				
(X4) ID		ATEMENT OF DEFICIENCIES	ID				
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		COMPLE DATE	
IAG			IAG	DEFICIENCY)			
21630	Continued From pa	age 23	21630				
	pharmaaist must fu	Irnish the necessary					
		rms, a copy of which must be					
		iursing home for two years.					
		tions of other prescription					
		the nursing home after the					
		of the resident for whom they					
	were prescribed or						
		anently, must be destroyed					
		6800.6500, subpart 3, or must					
		pharmacy according to part					
	6800.2700, subpar	t 2. A notation of the					
		he date, quantity, name of					
		iption number, signature of the					
		the drugs, and signature of the					
		ruction must be recorded on					
	the clinical record.						
	This MN Requirem	ent is not met as evidenced					
	by:						
		ion, interview and document		Corrected			
		failed to properly secure					
		n while waiting for destruction					
		medications located in the					
		This had the potential to affect in the facility who receive					
	narcotics.	in the facility who receive					
	harootioor						
	Findings include:						
	LACK OF SOUND	SYSTEM FOR NARCOTIC					
		EVENT AVERSION:					
		isit on 11/2/15 at 5:06 p.m.,					
		RN)-B gave a tour of the					
		n this room contained a locked					
		sed narcotics to be destroyed in	1				
		abinet contained one bottle of					
		class two narcotic) which did					
		ount of liquid which had been ie it had been used. RN-B					
		dication had been used for a					
	epartment of Health	ncation had been used for a					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00285	B. WING		11/	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL		AVENUE SOU GROVE, MN 3			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21630	Continued From pa	age 24	21630			
	of liquid Oxycodone A document titled, " Tweeten Health Se dates and times thi The controlled drug physician order: Ox (milligrams) /ml (m sublingually (under needed for shortne 10/16/15 had been record; it stated that have been measur the count at 10:00 15.50 ml (milliliters there was spilled lid bag. The writer stat occurred. It advised the medication in th seal to prevent furt 11:30 p.m., the record had been given to the a.m., the record indicated to the resident. The indicated that the re was 14.75 milliliters reviewed with RN-B the bottle. RN-B stated that so missing amount of RN-B stated, "I dor stated this was the where discontinued stated that these na the end of each shi	ed in October 2015. The bottle e was placed in a plastic bag. "Controlled Drug record for ervices (no date)," indicated the is medication had been given. g record described the kycodone HCL-20 mg illiliters), give 0.25 ml the tongue) every 2 hours as ess of breath. A note dated taped to the controlled drug at the liquid in the bottle should ed at 18.25 ml (milliliters) but p.m. shift change indicated). The writer of the note stated quid oxycodone in the plastic ted they were unsure why this d that whoever administered he future to keep an eye on the her spillage. On 10/16/15 at ord indicated a dose of 0.25 m the patient; on 10/17/15 at 7:45 dicated that 0.25 ml had been nt; on 10/17/15 at 10:40 a.m. d that 0.25 ml had been given e controlled drug record emaining liquid in the bottle s (ml). When the bottle was 3, there was 12 ml of liquid in ated that every single nurse in ess to this locked cabinet. he did not know why there was liquid Oxycodone in the bottle. n't know what to tell you." RN-B only location in the facility d narcotic medications were on of being destroyed. RN-B arcotics were not counted at ift. RN-B stated that all nurses se narcotics and can access				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00285	B. WING		11/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WEETE	N LUTHERAN HEAL		AVENUE SOU GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21630	Continued From pa	age 25	21630			
	them with a key at	any time.				
	registered nurse (F staff does not count to be held until they cabinet. RN-B desc to be destroyed the drug record sheet of nurse then takes the narcotic and stores was only one nurse reiterated that no o of the narcotic once cabinet before it is "I don't ever count	on 11/2/15 at 5:48 p.m. RN)-B stated that the nursing at expired narcotics which are y are destroyed in the locked cribed that when a narcotic is a nurse will take the controlled but of the narcotic book; the his sheet along with the expired is it in the locked cabinet. There a that does this. RN-B one verifies the actual amount e it ends up in the locked to be destroyed. RN-B stated, (narcotic medication) again."				
	director of nursing consultant pharma narcotics on a mon and the pharmacis of the cabinet. The keep the sheet title Tweeten Health Se record of how muc resident. The DON scanned in to the re record. The DON s	on 11/2/15 at 5:56 p.m., the (DON) stated that she and the cist destroy the discontinued athly basis. She stated that she t take the expired narcotics out DON stated that she does ed, Controlled Drug Record For ervices, which was the only h was administered to the has this piece of paper esident's permanent medical stated that she does compare actual amount of medication the medication.	t			
	director of nursing be notified if there y of a medication and verified that there y discontinued liquid locked cabinet. The	on 11/2/15 at 7:21 p.m., the (DON) stated that she would was a discrepancy in the count d the actual amount. The DON was 12 ml (milliliters) of the Oxycodone medication in the e DON stated that only one newly discontinued narcotic				

STATEME	Dia Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00285	B. WING		11/	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	-	
rweete		125 5TH	AVENUE SOUT			
		SPRING	GROVE, MN 5	5974		-
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21630	Continued From pa	age 26	21630			
	When asked what medication along w Controlled Drug Re out of the locked ca would have no way had been taken. Th discontinued medic accompanying Cor Regarding the disc and the Controlled Oxycodone, the DC time yet to look in t When interviewed of consultant pharmade ensure to there would diversion, the syster verify an expired na being placed in the as of right now, onl this task and it sho The facility policy ti Facility (February 2 storage conditions basis by the pharm taken if problems a The facility policy ti Facility: Controlled 2015), stated that of subject to special h record keeping in th federal, state and of regulations. Any dis substance counts w	bocked cabinet at any time. would happen if a narcotic <i>i</i> th its accompanying ecord sheet were to be taken abinet, the DON stated she of knowing if the narcotics he DON stated that the cation was only identified by its htrolled Drug Record sheet. repancy in the actual count Drug Record of the liquid DN stated that she had not had o that to comment on that. on 11/14/15 at 9:38 a.m., the cist (Ph)-B stated that to uld be a lessened chance for em should have two nurses arcotic medication prior to locked cabinet. He stated that y one nurse was performing uld be done by two nurses. tled, Medication Storage in the 2015), stated that medication are monitored on a monthly acist and corrective action are identified. tled, Medication Storage in the Substance Storage (February controlled substances are handling, storage, disposal and he facility in accordance with other applicable laws and screpancy in controlled was to be reported to the immediately. The director or vestigate and make every				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00285	B. WING		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL		AVENUE SOL GROVE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21630	Continued From pa	age 27	21630			
	document irreconci to the administrator designee was to ro substance storage substances), record routine medication SUGGESTED MET administrator or de resident narcotics u accountability of na refrigerators are loo	director of nursing was to ilable discrepancies in a report r. The consultant pharmacist or utinely monitor controlled (of discontinued controlled ds and expiration dates during storage inspections. THOD OF CORRECTION: The signee could review the upon discharge to ensure arcotics and to ensure cked appropriately. R CORRECTION: Twenty-one				
21665	A nursing home m functional, comforta environment, allow	0 Physical Environment ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.	21665			12/15/1
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview, and document ailed to provide a safe transfer 2 residents (R44) observed for		Corrected		
	Findings Include:					
	nursing assistant (I the recliner in the d NA-E then propelle	d on 11/4/15 at 7:41 a.m. by NA)-E using an EZ stand from lay area to R44's wheelchair. d R44 to her room. NA-E snuggly around R44's upper				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00285	B. WING		11/	05/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
WEETE	N LUTHERAN HEAL		AVENUE SOU			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	GROVE, MN 5	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
21665	Continued From pa	age 28	21665			
	where with an exte was pulled up to the directed R44 to hol to hold herself up. It knobs of the fauced herself up. NA-E re- pinching R44's upp extensively assiste R44 was once again standing position, p the faucet handles NA-E continued to cares. Following R4 stated it was a norm the sink to have he On 11/4/15 at 8:33 a manager, stated; sink. We do that wit too. All the resident the sink to hold on asked if the sinks w grab bar for a resid	vas pushed up to the sink nsive assistant from NA-E R44 e sink. NA-E repeatedly d on to the front lip of the sink R44 kept grabbing for the t and pulling on the sink to hold epositioned R44's gait belt, per torso region. NA-E then d R44 to sit on the commode. in extensively assisted to a pulling on the sink, grabbing and faucet to stay standing. assist R44 with her morning 44's morning cares, NA-E mal routine for R44 to stand at r cares completed. a.m. registered nurse (RN)-D, "[R44] does very well with the ith [another residents name] ts pull on them [reference to to when standing]." RN-D was vere a safe alternative to a lent to use for standing and ding and she said, "I'm gonna				
	was questioned if the for residents to help support and he state bar, but they have up, they won't hurt manufacturer record	a.m. the maintenance worker he sink was a safe tool to use p them stand and use for ted, "The sink is not a grab used them to pull themselves anything. I don't know what the mmends. I think that is why ed faucet to grab onto."				
	stated, "As far as I as a transfer assist	a.m. the director of nursing know it is safe [using the sink :], it has been [routine] on the al is to get them to do it for				

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00285	B. WING		11/	05/2015
NAME OF I	PROVIDER OR SUPPLIER					
TWEETE	N LUTHERAN HEALT	TH CARE CENTER	AVENUE SOL GROVE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21665	Continued From pa	ige 29	21665			
	themselves."					
	required an assist o	ted 1/12/15 indicated R44 of one with daily cares and will aff assistance and staff tep cues.				
	7/1/08, reads: "This use appropriate teo residents of the fac and ensure safety of Resident can bear consistently, and ca follow simple direct	Patient Handling, dated s policy is to ensure that staff shniques in transferring the ility to avoid back injury to staff of residents1. PIVOT with 1, weight on one or both feet an lean forward, reach and ions, and can maintain a 0 degrees without support."				
	administrator or de	HOD OF CORRECTION: The signee could review the nt to ensure the environment hazards.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			12/15/15
	shall be encourage their stay in a facilit to understand and o patients, residents, residents may voice changes in policies and others of their interference, coerci including threat of c	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as				

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00285	B. WING		11/0	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TWEETE	N LUTHERAN HEAL	TH CARE CENTER	AVENUE SOU GROVE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 30	21880			
	Office of Health Fa nursing home omb Americans Act, see posted in a conspice Every acute care residential program 253C.01, every not facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pr an impartial decisio otherwise resolved residential program 253C.01 which are treatment program centers with sectio health maintenance 62D.11 is deemed	and telephone numbers for the acility Complaints and the area udsman pursuant to the Older ction 307(a)(12) shall be cuous place. e inpatient facility, every n as defined in section nacute care facility, and every nore than two people that t mental health services shall ornal grievance procedure that, a forth the process to be time limits, including time sponse; provides for the patient e the assistance of an a written response to written ovides for a timely decision by on maker if the grievance is not . Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the written internal grievance				
	by: Based on observat review, the facility individual grievanc	ion, interview and document failed to effectively respond to es, related loud noises made overnight hours, for 1 of 1		Corrected		

STATE FORM

90ML11

If continuation sheet 31 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00285	B. WING		11/	05/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	1	
WEETE	N LUTHERAN HEALT	TH CARE CENTER	AVENUE SOU [.] GROVE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	ge 31	21880			
	Findings include:					
	7/28/15, identified h problems with his m diagnosis of anxiet dementia. When ob 11/03/15, at 10:38 problem in this roor "stays awake and co management about had been done. I ta and registered nurs said they would do wanted to move to there are no open r has asked if it has it An interview on 11/ the process for grie brought up at care that time. SS-E sai concern with his roo she hasn't received said if a concern is affected departmen address it and than	inimum Data Set (MDS) dated his cognition intact, no hood, or behaviors. R40 had a sy, manic depressive and oserved and interviewed on a.m. R40 said he has a m. R40 said his roommate calls for mama all night." I told t it four weeks ago and nothing alked to social services (SS)-E se (RN)-F about it and they what they could. I said I another room and was told tooms to move into. No one improved. 04/15, at 8:37 a.m. SS-E said evances is if it is verbal and conference we talk about it at id she knew about R40's tommate talking at night but I any written grievances. SS-E received it goes to the th. That department will it comes back to the resident S-E than said that she doesn't				
	document some co not fill out a grievan because R40 had r time. SS-E was offe something for sleep	mplaints. SS-E said she did nee form on R40's behalf not complained more then one ered a different room or o but he chose neither option was no longer a concern.				
	of nurses (DON) sa manager and she r	04/15, at 1:17 p.m. the director aid RN-F who is the care eviews grievances form d she has not heard anything				

Minnesc	ta Department of H	ealth			FORM APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00285	B. WING		11/05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
TWEETE	N LUTHERAN HEAL		VENUE SOU ROVE, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETI
21880	Continued From pa	age 32	21880		
	doesn't think it is a	nce. The DON also said she grievance because he did not ator like the policy says he			
	a.m. said she knew said they (SS-E an said it was better b now that the room RN-F said they dou time. RN-F said S documentation reg She said she does about it. RN-F said deal about it. Our p you can move. RI wasn't resolved as her. We have a gr	with RN-F at 11/05/15, at 9:15 wabout R40's grievance. RN-F id RN-F) talked to R40 and he but she thinks it is worse again mate is back from the hospital. n't have any open rooms a the S-E does most of the larding resident complaints. n't know if the DON knows d we normally don't make a big policy is if you are not happy, N-F said she knew this issue R40 kept talking about it with ievance form but we normally ut. She agreed there is no progress note.			
	assistant (NA)-A sa sleeping because of when R40 mention	/05/15, at 9:37 a.m. nursing aid she knew about R40 not of his roommate. She said is it, she always tells the nurse. will tell her to lay him down the day.			
	NA-G said R40 tell the night by his roo nurses talk about a	v on 11/05/15, at 9:38 a.m. Is her about being woken up in ommate. She said that the and have said to lie him down JA-G said she has not heard of R40.			
inposet- D	administrator said care conferences, meetings or reside	/05/15, at 11:42 a.m. the they discuss grievances at stand up meetings, department nt council to address			
nnesota D IATE FORI	epartment of Health M		⁶⁸⁹⁹ 90	OML11	If continuation sheet 33 of

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00285	B. WING		11/	05/2015
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE. ZIP CODE		00/2010
	N LUTHERAN HEAL	125 5TH	AVENUE SOU			
		SPRING	GROVE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21880	Continued From pa	age 33	21880			
	grievances.					
	"How many times of night?" The answe A facility policy for p have the right to vo complaints will be of Director of Nurses Head/Supervisor of grievance. The De conduct an investig determine its validi Head/Supervisor e satisfactory answe you concern within Administrator in pe concerning your iss investigate and res SUGGESTED MET administrator or de resident grievance complaints are bein getting timely resol	f the area involving the epartment Head/Supervisor will gation of the matter to ty. If the Department ither does not have a r for you or does not answer seven days, report to the erson, in writing or by phone sue. The Administrator will spond to you within seven days. THOD OF CORRECTION: The signee could review the process to ensure their ng heard, and the residents are				