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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: F26S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00285

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245429**

2. STATE VENDOR OR MEDICAID NO. (L2) **068252700**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/18/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 01/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245429
January 30, 2018

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 January 12, 2018 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2018

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

RE: Project Number S5429028

Dear Ms. Borreson:

On December 19, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 18, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 12, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2017, effective January 12, 2018 and therefore remedies outlined in our letter to you dated December 19, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: F26S

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(L4) **125 5TH AVENUE SOUTHEAST**
(L5) **SPRING GROVE, MN** (L6) **55974**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/04/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE NE II 01/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 01/29/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
December 19, 2017

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

RE: Project Number S5429028

Dear Ms. Borreson:

On December 4, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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:

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

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

Remedies - 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;

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

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

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

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
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (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 January 13, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 13, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 4, 2018 (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 June 4, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	12/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 1 §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but	F 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	12/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 2 not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide information to 5 of 5 residents (R21, R1, R33, R35 and R18) who attended the resident council group meeting, for state agencies that would act as advocates for residents who resided in the facility with the name and telephone number of the state Ombudsman. This had the potential to affect all 43 residents residing in the facility. Findings include:	F 574	F574: Gundersen Tweeten Care Center will continue to ensure that all residents receive notices orally and in writing in a format and a language that her or she understands, including required notices in regards to: protecting personal funds, requirements and procedures for establishing eligibility for Medicaid, list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	12/04/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 3 During the resident group council interview held on 11/29/17, at 11:20 AM, with R21, R1, R33, R35 and R18 in attendance. All five stated they were not aware of the state advocacy agency (Ombudsman Office). The residents did not know the purpose of the ombudsman, who he was, or how they would contact that office if there was a need. During interview on 11/30/17, at 11:58 a.m., social services (SS)-A verified there was no name for the state ombudsman posted and the phone number that was posted was incorrect. During interview on 11/30/17, at 12:14 p.m. the Administrator stated, "My expectation is for all residents to be informed of who their local ombudsman is and how to contact him." During observation on 11/30/17, at 12:15 p.m., there was no contact name for state ombudsman identified on the board next to the dining room, along with an incorrect telephone number to contact the state ombudsman. A policy for informing residents about state ombudsman contact information was requested and none received.	F 574	agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and a statement that the resident may file a complaint with the State Survey agency concerning any suspected violation of state or federal nursing facility regulations. A new poster was put on the board by the dining room with the correct information regarding Advocacy and Regulatory Agencies. Gundersen Tweeten Care Center will continue to include information, including names, addresses (mailing and email) and telephone numbers of all pertinent State regulatory and informational agencies, in admission packets for all new residents. Along with this Gundersen Tweeten Care Center will continue to review the resident rights booklets with residents at resident council annually. All residents received cards with the name and phone number for the State Long-Term Ombudsman and the resident council members were informed on 12/27/17 of their right to contact the State Long-term care ombudsman. Reminders on the availability of the ombudsman will be given at each monthly resident council meeting. This will be monitored monthly by the Administrator after receiving minutes from each meeting.	

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	245429	A. BUILDING _____ B. WING _____	12/04/2017

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit a vulnerable adult report in a timely manner for 1 of 2 residents (R47) reviewed. Findings include:	F 609	F609 Gundersen Tweeten Care Center will continue to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	1/12/18

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F 609	Continued From page 5 R47's quarterly Minimum Data Set (MDS) dated 10/3/17, included a diagnoses include Alzheimer's Disease and dementia, necessitating the need for placement in a secured environment. R47's event report dated 9/10/17, indicated that at 11:00 a.m., R47 was found on the floor by staff with another male resident standing over him and striking him. According to a witness statement by activity aide (AA)-B two sets of eyeglasses and a part of a hearing aid were noted to be on the floor as well. A witness statement by nursing assistant (NA)-G indicated R47 had been observed arguing 10-15 minutes prior to the altercation with the other male resident. Injuries to R47 included bruising to his right knuckles and a cut on his right forehead. Progress note on 9/10/17 at 12:56 p.m., indicated the administrator had been notified of altercation. An incident report regarding R47's resident to resident altercation was reported to the Minnesota Department of Health (MDH) Office of Health Facility Complaints (OHFC) indicated R47's resident to resident abuse had been submitted on 9/11/17, at 2:39 p.m., more than 24 hours after the incident. The Plan for Abuse Prevention and the Reporting policy, revised 11/7/17, and received by the facility indicates the nursing home administrator or designee will report "abuse" to the state agency per state and federal requirements.	F 609	hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Vulnerable Adult report that was filed on 9/11/17, Gundersen Tweeten Care Center was notified on 10/24/17 that the information was reviewed and it was determined that no further action was necessary at the time. Education was provided to all staff regarding the reporting requirement of vulnerable adults on 11/13/17. The charge nurses have been educated on the procedure for submitting the initial OHFC reports to ensure prompt reporting per state and federal regulation on VA reporting requirements. This will be monitored by the Director of Nursing and Social Service Designee with each reported incident.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		1/12/18

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F 625	Continued From page 6 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bed hold notification was provided for 1 of 1 resident (R50) reviewed for hospitalization. Findings include: R50's progress notes identified on 9/10/17, resident was out all shift with her husband. Nurse from Gunderson ER (emergency room) called at 8:30 p.m. that resident was going to be admitted	F 625	F625: Gundersen Tweeten Care Center will continue to provide written information to the resident or resident representative in regards to the bed hold policy and return before transferring a resident to a hospital or the resident goes on therapeutic leave. This written notice specifies the duration of the bed-hold policy. R50 expired in the hospital and family notified the facility they no longer wanted the bed hold. All residents are	

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F 625	Continued From page 7 to the hospital for work up due to shortness of breath. Resident's family had brought her to the ER. Review of R50's record identified no documentation a bed hold notification had been provided to R50 or R50's responsible party During interview on 12/04/17, at 11:45 a.m., the director of nursing (DON) stated the charge nurse was responsible for providing bed hold notification to the resident (if the resident was capable of signing) or the family before the resident leaves the facility, or by calling the family to talk over the phone. R50 was not in the building at the time, she was out for supper. The DON reviewed R50's record and stated she could not find any documentation a bed hold notification was provided to R50 or R50's responsible party. The DON stated we did not have contact with family, as the husband and R50 were out for the day. We received a call from the hospital informing R50 was admitted, so it was kind of a different case. When queried what the facility procedure would be for the circumstance when a resident was not in the facility and was taken to the hospital by the family, who would provide a bed hold notification, the DON stated the social worker would. During interview on 12/04/17, at 12:01 p.m., social worker (SW)-A sated R50 was provided a bed hold, I could not tell you whether it was verbal or not. R50's husband had stopped into the facility and talked to the staff on the floor about it. SW-A reviewed R50's record and stated there was no documentation in R50's record of a bed hold notification having been provided. SW-A stated I did not provide a bed hold notification to	F 625	given the Bed Hold Policy upon admission. Staff will be educated that any verbal conversations with resident representative/resident/hospital staff about bed hold status needs to be documented in the resident chart. This will be monitored by QA nurse with routine chart audits for all residents that are discharged with return anticipated.	

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F 625	Continued From page 8 R50's husband. The hospital SW called and asked us about holding the bed and we said yes to saving a bed for R50. SW-A stated the staff on the floor provide the bed hold notification. If the bed hold notification does not occur with the staff on the floor then whoever would talk to the family would receive verbal notification and be responsible to fill out the bed hold notification paper work, then I would be responsible to let the hospital SW know we have a bed hold. The facility policy Bed Hold and Return to the Facility, dated effective 9/13/17, indicated Procedure: B. Bed Hold and Return notice upon transfer Gunderson Tweeten Care Center will provide the resident and resident representative a written notice which specifies the duration of the bed-hold policy at the time of transfer for hospitalization or therapeutic leave. 5. In cases of emergency transfer, notice at the time of transfer means that the Gunderson Tweeten Care Center will send the notice along with the necessary paperwork to the receiving setting and the resident representative will receive a notice sent within 24 hours of transfer or next business day. 6. Documentation of bed hold notice will be completed in the individual medical record. Gunderson Tweeten Care Center Procedure: 3. The nurse will inform the resident representative , on the telephone if necessary, about the bed hold and return to facility policy and ask how best to provide a copy of the notice to the representative. b) The nurse will document the provision of the bed hold policy and return to the facility notice to the resident and information given to the representative in the resident's record. 4. The social service designee will contact the resident representative on the next working day to ensure that the representative understands the bed hold	F 625		

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F 625	Continued From page 9 and return to facility information.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) an assessment for a change in functional ability for toileting and status of urinary continence for 1 of 3 residents (R16) reviewed for activities of daily living (ADL). Findings include: R16's quarterly MDS dated 6/13/17, identified R16 required for toilet use supervision (oversight, encouragement or cueing) with set up help only and for urinary continence R16 was always continent, had severe cognitive impairment and had diagnosis of dementia. R16's quarterly MDS dated 9/12/17, identified R16 required for toilet use extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist and for urinary	F 637	F637: Gundersen Tweeten Care Center will continue to complete a significant change Minimum Data Set (MDS) within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident□s physical or mental condition. R16□s had an annual MDS assessment completed on 12/12/17. Gundersen Tweeten Care Center IDT team will review all residents for condition changes weekly. MDS Coordinator was re-educated to help ensure that information reported in the MDS doesn□t warrant a significate change assessment. All residents were reviewed at IDT rounding meeting. This will be monitored by Director of Nursing weekly x3 months to ensure accurate coding and monitor of need for significant	1/12/18

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F 637	Continued From page 10 continence R16 was occasionally incontinent, had severe cognitive impairment and had diagnosis of dementia. During interview on 11/30/17, at 7:15 a.m., R16 stated she wears an incontinent pad and goes to the bathroom on her own. During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B stated R16 wears a pull up (incontinent product), R16 is on a list for staff to check hourly for needing to use the toilet and R16 was usually continent, but once in a while may be wet. During observation on 11/30/17, at 12:49 p.m., a nursing assistant asked R16 if she needed to use the bathroom and R16 replied "no." During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the two quarterly MDS's dated 6/13/17 and 9/12/17. R16's MDS Notes Report dated 9/15/17, documented by RN-A, indicated resident is extensive assist with toileting with assist needed to complete bowel hygiene and clothing management. Resident needs constant cueing. Resident is occasionally incontinent of bladder due to bipolar disorder and impaired balance. All above care areas preformed three or more times during ARD (assessment reference date) period. During interview on 11/30/17, at 3:06 p.m., RN-A confirmed the change in status R16 had from supervision to extensive assist for toileting and from always continent to occasionally incontinent for urinary continence would qualify for a significant change MDS to be completed. RN-A	F 637	changes. Results of monitoring will be reported to quarterly QAA meeting.	

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F 637	Continued From page 11	F 637		

stated I do not think it was a significant change in status for R16. I think it was staff lacking in following up, as she can stay continent but staff lacked following up for reminding R16 to go to the bathroom. RN-A stated I did not make a note in R16's record why a significant change MDS was not completed.

During interview on 11/30/17, at 3:09 p.m., the director of nursing stated I thought three areas needed to change for a significant change MDS to be completed. If not three areas, I would expect one to be done. I would have to look up the rules. A policy regarding completing a significant change MDS was requested.

The following was provided by the DON; CMS's (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual pages 2-21 through 2-28 indicated 03. Significant Change in Status Assessment (SCSA). Assessment Management Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. Guidelines for Determining a Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's

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F 637	Continued From page 12 condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Decline in two or more of the following: Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur; Resident incontinence pattern changes or there was placement of an indwelling catheter.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		1/12/18

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F 656	Continued From page 13 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a person centered care plan for fingernail care for 1 of 3 residents (R42); and failed to implement the care plan for fingernail care for 1 of 3 residents, (R37) reviewed for activities of daily living (ADLs). Findings include: R42's resident face sheet identified a current admission date of 2/9/16, and a diagnosis of vascular dementia without behavioral disturbance and traumatic hemorrhage of left cerebrum without loss of consciousness. R42's quarterly Minimum Data Set (MDS) dated 10/31/17, identified R42 to have a moderate cognitive deficit and requires one person	F 656	F656: Gundersen Tweeten Care Center will continue to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at 483.10 (c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Care plans were revised for resident□s R42 and R37 to include fingernail care. All other resident care plans were reviewed to ensure fingernail care is person centered and included in their care plans. The Fingernail/Toenail Policy was reviewed and updated. Staff were re-educated on the	

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F 656	Continued From page 14 extensive assist with personal hygiene needs. R42's comprehensive care plan dated 6/3/16, identified R42 needs extensive assist with ability to complete ADLs related to brain hemorrhage and weakness, with an approach to provide 1 staff assist for nail care to hands and feet. R42 was noted to use artificial nails and this had not been identified on R42's current plan of care. Facility document, "Unit 2 bath list AM," week of 11/27/17-12/03/17, identified R42 will get a whirlpool bath on Tuesday, 11/28/17, and on Friday 12/1/17. Document further indicated to: Shampoo hair, trim nails, check for chin hairs on females and shave as needed and do a complete skin inspection on bath days. Charge nurse to initial daily with shower for adequate grooming, ensuring skin inspection is completed and to monitor for privacy with transportation to and from the shower. Charge nurse to document any abnormalities noted on skin inspection and notify director of nursing or medical doctor if noted. Turn into director of nursing weekly. During observation on 11/30/17, at 7:15 a.m., R42 had been seated in her wheelchair in her room and noted to have long painted red artificial fingernails. There was a brown substance packed and hard to touch located underneath all R42's fingernails. During interview on 11/30/17, at 7:38 a.m., nursing assistant (NA)-A verified R42 has brown substance packed underneath all of her fingernails. Further verifies R42 her bath was Tuesday morning and nail care should have been completed then.	F 656	Fingernail/Toenail Policy. This will be monitored by the charge nurses daily and weekly monitoring by Case Manager. Results of monitoring will be reported to quarterly QAA meeting.	

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F 656	Continued From page 15 During interview on 11/30/17, at 7:46 a.m., NA-B stated, "We don't usually do nail care on R42, she goes out and gets her nails done." NA-B verified resident has artificial nails that her family member (FM)-A takes her out in the community to get done. NA-B further verified brown substance underneath all of R42's fingernails and stated that nail care should have been done. During interview on 11/30/17, at 7:50 a.m., licensed practical nurse (LPN)-A verified that nail care is typically done on bath days and R42 had a bath Tuesday morning. LPN-A further verified that resident has artificial nails and stated, "We don't 'monkey' with her fingernails." LPN-A further stated that R42's daughter takes her to get her nails done every 3-4 weeks. Interview on 11/30/17, at 8:55 a.m., director of nursing (DON) stated all residents should nail care completed on bath days. Further stated nails should be checked every a.m. and p.m. with cares. DON continued to say, "My expectation is for staff to check R42's fingernails every day and clean as necessary regardless whether she has fake fingernails or not." On 11/30/17, at 12:54 p.m., DON verified R42 goes out in the community to get artificial fingernails and that her expectation is to have her care plan to be resident centered to include going out into the community for artificial nail care. Facility policy, "Baseline Care Plan Policy," dated 10/4/17, identified the care plan at a minimum will identify the following information: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and instructions needed to provide	F 656		

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F 656	Continued From page 16	F 656		

person-centered care that meets professional standards of care.
R37 was observed on 11/28/17, at 2:49 p.m., to have soiled finger nails on right and left hands.

During observations on 11/30/17, at 9:14 a.m., R37 was awake and in bed. Observations at that time revealed under finger nails soiled with debris. R37 stated finger nails were cleaned with shower two times a week.

R37's care plan dated 10/13/17, directed staff R37 was limited in ability to complete activities of daily living related to weakness and recent hospitalization. Interventions included to provide one staff assist for nail care to hands and feet.

During interview on 11/30/17, at 9:17 a.m., nursing assistant (NA)-B verified R37 received baths two times a week. NA-B stated facility routine was to check finger nails, clean and trim on bath days, and check nails often. NA-B verified the soiled finger nails at this time.

During interview on 11/30/17, at 9:23 a.m., director of nursing (DON) verified the soiled finger nails. DON stated she expected staff to provide nail care on bath days and as needed.

During interview on 11/30/17, at 12:53 p.m., DON stated she expected staff to provide nail care according to the care plan.

Document review of facility Care of Fingernails/Toenails policy dated revised 10/2010, revealed the following: Purpose-The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines-nail care includes daily

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F 656	Continued From page 17 cleaning and regular trimming. Steps in the procedure include allow hand or foot to soak in warm soapy water for approximately five minutes, rinse, dry, gently remove dirt from around and under each nail with an orange stick. Documentation included the date and time the nail care was given, name and title of person who administered nail care, if nail care was refused, document reason and intervention taken, signature and title of person recording data, and notify supervisor if resident refused care.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		1/12/18

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F 657	Continued From page 18 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the care plan following a change in urinary continence for 1 of 1 resident (R16) reviewed for activities of daily living (ADL). Also the facility failed to revise the plan of care after changes to fall prevention measure for 1 of 1 resident (R47) reviewed. Findings include: R16's quarterly Minimum Data Set (MDS) an assessment dated 9/12/17, identified R16 required for toilet use extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist and for urinary continence R16 was occasionally incontinent, had severe cognitive impairment and had diagnosis of dementia. R16's MDS Notes Report dated 9/15/17, documented by registered nurse (RN)-A, indicated R16 has been assessed as needing extensive assist with toileting, with assist needed to complete bowel hygiene, and clothing management. Resident needs constant cueing. Resident is occasionally incontinent of bladder due to bipolar disorder and impaired balance. All above care areas preformed three or more times during ARD (assessment reference date) period. R16's current care plan identified, Problem Activity of Daily Living: I require one staff assist with daily ADL's. Short Term Goal Target Date: 12/12/17, I want staff to assist me to the toilet and	F 657	F657: Gundersen Tweeten Care Center will continue to develop comprehensive care plans within 7 days after completion of the comprehensive assessment. This comprehensive care plan will be prepared by the interdisciplinary team that includes the attending physician, a registered nurse that is responsible for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, to the extent practicable, the participation of the resident and the resident□s representative, and other appropriate staff or professionals in disciplines as determined by the resident□s needs or as requested by the resident. This comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. GTCC will continue to revise care plans with significant change MDS assessments. Care plans were reviewed and updated for resident R16 and R47 to include care needs and fall interventions. All other resident care plans will be reviewed for updates as their MDS comes due over the next quarter. Interventions identified on the fall investigation summary will be added to the residents care plan at time of completion, fall investigation summaries will be completed weekly by the fall team.	

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F 657	Continued From page 19 assist me with cares. Approach start date 3/19/17, I want staff to assist me with my pericare and clothing management as needed. Approach start date 12/21/16, I want Staff to walk with me to the toilet. R16's nursing assistant (NA) care plan (used by NAs to reference needed cares/services) updated 10/30/17, identified toilet: stand by assist and walker. During interview on 11/30/17, at 7:15 a.m., R16 stated she wears an incontinent pad and goes to the bathroom on her own. At 12:31 p.m., R16 was observed walking down the hallway independently using a seated four wheeled walker. During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B stated R16 wears a pull up incontinent product. R16 is on a list for staff to check hourly for needing to use the toilet and R16 was usually continent, but once in a while may be wet. During observation on 11/30/17, at 12:49 p.m., an unidentified NA asked R16 if she needed to use the bathroom and R16 replied no. During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the MDS's dated 9/12/17, and confirmed R16 had a decline with toilet use and urinary continence. During interview on 11/30/17, at 3:22 p.m., RN-A reviewed R16's care plan and confirmed the care plan had not been revised to identify R16's occasional incontinent of urine nor were incontinence interventions developed based on	F 657	This will be monitored by the IDT team at quarterly care plan conferences.	

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F 657	Continued From page 20 the current assessment completed. During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) verified R16's care plan did not address R16 being occasionally incontinent of bladder or how often R16 should be offered use of the toilet. R47 was admitted on 8/1/17 according to the face sheet. Also found on the face sheet was diagnosis of Alzheimer's disease with delirium, chronic pain-bilateral arthritis (in both knees), vascular dementia with behavioral disturbance, restlessness and agitation, repeated falls, and insomnia. R47's quarterly Minimum Data Set (MDS), dated 11/7/17, identified through the use of a brief indicator of mental status (BIMS) a score of 3 indicating R47 is assessed to have severe cognitive impairment. The MDS also identified R47 had difficulty focusing attention, was easily distracted, had difficulty keeping track of what was said, and disorganized thinking. On 8/11/17, at 6:05 p.m.,, R47 had initial fall, unwitnessed in hallway wearing another resident's glasses. On 8/12/17, at 8:20 pm, unwitnessed, found with left leg lying over the leg of the Hoyer lift. On 8/24/17, at 10:45 pm, unwitnessed, found lying on the floor. On 9/8/17, at 5:40 a.m. unwitnessed, found lying on the floor in his room with a chair over his abdomen. Interventions to prevent further falls include: frequent observation, offer to toilet, continue to ensure has shoes available, room	F 657		

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F 657	Continued From page 21 free of clutter, lights on at night. On 9/10/17 at 11:00 a.m., unwitnessed, found on floor another resident was hitting him, eyeglasses were on the floor. On 9/10/17 at 9:10 p.m., unwitnessed, nursing in the next room, according to progress note, "Res [resident] was heard moving furniture from the room next door to his. Staff heard a loud noise and went to check on Res and found him lying on the floor on his back." Resident sustained a hematoma to the back of his head and complained of left arm/shoulder pain. Interventions to prevent further falls included: monitor frequently, refer to MD for analgesic (pain) medication review related to the knee pain. On 9/25/17, at 2:55 p.m. unwitnessed, found in nursing office on floor, fell from wheeled chair. Interventions to prevent further falls include: close door to office, monitor seating to ensure safety, frequent rounding. On 10/5/17, at 6:20 a.m., unwitnessed, found in room on floor lying on left side. Interventions to prevent further falls include: continue care plan as currently stated, attempt to have R47 wear shoes. On 10/6/17, at 12:15 a.m. this fall is classified as witnessed by the facility. Staff called for assist as R47 was on the edge of his recliner. Called back and said R47 was on the floor. Interventions to prevent further falls include: ensure safe sitting position. On 10/12/17, at 5:05 a.m., unwitnessed. Found on floor in his room next to a chair. Interventions to prevent further falls include: frequent	F 657		

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F 657	Continued From page 22 supervision and continue care plan as stated. On 10/13/17, R47 found sitting on floor and when asked denied he fell. Unwitnessed. No incident form filled out. On 10/23/17, at 3:40 a.m., unwitnessed. Staff heard someone yelling help. R47 found sitting on the floor in bathroom doorway. A garbage can was noted to be in the toilet. Interventions to prevent further falls include: provide supervision and assistance, provide footwear. On 10/25/17, at 6:00 a.m., unwitnessed. Staff heard R47 hollering in his room. Found sitting on floor with no lower clothing or brief on. Urine was on the floor where he fell. Interventions to prevent further falls include: provide supervision and assistance when noticed he has a need. On 10/31/17, at 2:30 a.m., unwitnessed. Heard saying "help me, I can't stand up. Found sitting in his room by the door. Interventions to prevent further falls include: follow care plan as stated, anticipate needs. On 11/2/17, at 12:35 a.m., unwitnessed. Found on floor in his doorway with another resident standing over R47. The staff member on the unit was trying to assist another resident who was trying to get out of bed at the same time. Interventions to prevent further falls include: frequent supervision and anticipate needs. On 11/9/17, at 6:56 p.m., unwitnessed. Found lying on the floor in his room between dresser and night stand. Interventions to prevent further falls include: continue care plan as stated. Anticipate needs and frequently monitor.	F 657		

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F 657	Continued From page 23 On 11/10/17, at 4:44 a.m., unwitnessed. Staff member doing rounds, heard resident "scream" found on floor in living room. Interventions to prevent further falls include: follow care plan, anticipate needs. On 11/11/17 at 3:45 p.m., unwitnessed. Fell in his room. Hit his head on the wall. Interventions to prevent further falls include: frequent monitoring and anticipate needs. On 11/12/17 at 7:45 a.m., unwitnessed. Found in dining room. Interventions to prevent further falls include: follow care plan. On 11/15/17 at 1:15 p.m.., unwitnessed, found lying on floor in dining room. Interventions to prevent further falls include: provide distraction, one to one care, and frequent supervision. On 11/15/17 at 5:55 p.m., unwitnessed. R47 found in his room on the floor. No interventions provided. On 11/17/17 at 11:15 a.m., unwitnessed. Found on mat next to bed. Interventions to prevent further falls include: continue with mat at the bedside. On 11/17/17, at 3:15 p.m.., unwitnessed. Found in dining room next to his wheelchair. Dining room chair was tipped over next to him. Interventions to prevent further falls include: provide frequent supervision, offer 1:1 or distractions. On 11/18/17, at 4:30 p.m., witnessed. NA-witnessed R47 shaking and fall from his chair. A	F 657		

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F 657	Continued From page 24 family member who had been visiting in the dementia unit went to go get help. Interventions to prevent further falls include: frequent supervision, medication review. On 11/21/17, at 4:10 p.m., unwitnessed. Found on floor in dining room. Interventions to prevent further falls include: continue to work with physician and physician assistant for effective medications for aggressive behavior. On 11/24/17, at 5:45 p.m., witnessed. The NA on the unit observe R47 get up from his wheelchair, take a few steps and fall. Interventions to prevent further falls include: provide distraction, redirection, frequent supervision, monitor for restlessness and provide for needs, Frequent rounding On 11/29/17, at 4:12 p.m.., witnessed. NA- saw R47 fall from wheelchair and land on his left side. R47's care plan dated 8/1/17, identified a risk for falls due to memory loss and poor safety awareness as well as the need for assistance for safe mobility. The interdisciplinary team had indicated in multiple post fall follow ups that the resident was to be frequently observed, monitored, keep separated from other resident when argumentative, keep the door closed to the nursing office, anticipate needs, provide distraction, one to one care, mat on the floor, and medication review. These interventions were not included in R47's care plan, nor were any fall related interventions located on the nursing assistant (NA) kardex (a trademark for a card-filing system that allows quick reference to the particular needs of each resident for aspects of nursing care).	F 657		

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F 657	Continued From page 25 During an interview on 12/4/17, at 3:03 p.m., the director of nursing (DON) stated she would expect the interventions following a fall be included on the current care plan for the residents. Also for staff to follow the care plan interventions as written.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ¿ §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		1/12/18

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F 676	Continued From page 26 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess and implement interventions to improve toileting ability and urinary incontinence or prevent decline for 1 of 1 resident (R16), who had a decline with toilet use and urinary continence. Findings include: R16's quarterly Minimum Data Set (MDS) dated 6/13/17, identified R16 required for toilet use supervision (oversight, encouragement or cueing) with set up help only and for urinary continence R16 was always continent, had severe cognitive impairment and had diagnosis of dementia. R16's quarterly MDS dated 9/12/17, identified R16 required for toilet use extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist and for urinary continence R16 was occasionally incontinent, had severe cognitive impairment and had diagnosis of dementia. During interview on 11/30/17, at 7:15 a.m., R16 stated she wears an incontinent brief and goes to the bathroom on her own. At 12:31 p.m., R16 was observed walking down the hallway independently using a seated four wheeled walker.	F 676	F676: Gundersen Tweeten Care Center will continue to provide the necessary care and services to ensure that a resident□s abilities in activities of daily living do not diminish unless circumstances of the individual□s clinical condition demonstrate that such diminution was unavoidable, based off of the comprehensive assessment of a resident and consistent with the resident□s needs and choices. Resident R16 was referred to Occupational Therapy for decline in urinary incontinence. All other residents were reviewed for a decline in urinary incontinence and toileting ability and addressed as appropriate. The IDT will monitor monthly with review of Casper Report. Results of monitoring will be reported to quarterly QAA meeting.	

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	245429	A. BUILDING _____ B. WING _____	12/04/2017

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F 676	Continued From page 27 During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B stated R16 wears a pull up (incontinent product), R16 is on a list for staff to check hourly for needing to use the toilet and R16 was usually continent, but once in a while may be wet. During observation on 11/30/17, at 12:49 p.m., an unidentified NA asked R16 if she needed to use the bathroom and R16 replied no. During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the MDS's dated 6/13/17 and 9/12/17. R16's MDS Notes Report dated 9/15/17, documented by RN-A, indicated resident is extensive assist with toileting with assist needed to complete bowel hygiene and clothing management. Resident needs constant cueing. Resident is occasionally incontinent of bladder due to bipolar disorder and impaired balance. All above care areas preformed three or more times during ARD (assessment reference date) period. R16's Elimination urinary Incontinence Observation assessment date 9/15/17, identified: does resident have a prior history of incontinence - yes, onset prior history - new, duration of prior history - one year, precipitants of urinary incontinence in prior history - pain, product type - brief, urinary continence - occasionally incontinent (less than 7 episodes of incontinence), medication review - antidepressants/diuretics, factors that could enhance urinary continence and limitations that could adversely affect continence - decreased vision/impaired cognitive function/impaired mobility, toilet use - extensive	F 676		

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F 676	Continued From page 28 assist, toilet use support - one person physical assist, does resident recognize need to void and in the appropriate place - yes, reversible/controllable conditions or pertinent diagnoses that could affect the urinary tract or its function - arthritis/depression/falls, cognitive skills - modified independence/some difficulty in new situations only, incontinence symptom profile - no nocturia or incontinence at night, environmental factors and assistive devices - grab bars/use of side rails. Evaluation: may benefit from facility defined toileting schedule, absorbent products, adaptive equipment. Referrals: activities, physician update. Plan of care: continue plan of care. Analysis of bladder assessment: resident is occasionally incontinent of bladder. No interventions are needed. Resident is able to use call light to let staff know needs to toilet. Keep call light in reach. The assessment lacked to identify the type of incontinence (stress, urge, mixed, overflow, functional) and a comprehensive analysis. R16's current care plan identified, Problem Activity of Daily Living: I require one staff assist with daily ADL's. Short Term Goal Target Date: 12/12/17, I want staff to assist me to the toilet and assist me with cares. Approach start date 3/19/17, I want staff to assist me with my pericare and clothing management as needed. Approach start date 12/21/16, I want Staff to walk with me to the toilet. R16's nursing assistant care plan (used by nursing assistants to provide cares/services for each resident) updated 10/30/17, identified toilet: stand by assist and walker.	F 676		

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F 676	Continued From page 29 During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the MDS's dated 6/13/17 and 9/12/17, and confirmed R16 had a decline with toilet use and urinary continence. During interview on 11/30/17, at 2:32 p.m., RN-A confirmed R16 urinary assessment dated 9/15/17, lacked to identify the type of incontinence. RN-A stated no she had not notified R16's physician regarding R16's decline with toilet use and urinary continence. When queried if R16's decline with toilet use and urinary continence was discussed as a team, RN-A stated I bring it up in care conference. When queried if R16 had received occupational therapy (OT) evaluation for the decline in toilet use and urinary incontinence, RN-A replied I did not notify OT about it. When queried regarding the assessment dated 9/15/17, lacked a comprehensive analysis, RN-A stated staff (referring to NAs) told me it was behavioral and R16 would benefit from prompting/cueing, so I told them to do that. During interview on 11/30/17, at 3:22 p.m., RN-A reviewed R16's care plan and confirmed the care plan lacked to be revised to identify R16 was occasionally incontinent of urine and interventions related to urinary incontinence. During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) stated she was not aware R16 had a decline with toilet use and urinary continence. The DON reviewed R16's assessment dated 9/15/17, and confirmed the assessment lacked to identify the type of incontinence and a comprehensive analysis. The DON stated she would expect the decline for	F 676		

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F 676	Continued From page 30 toilet use and urinary continence be evaluated why and interventions put in place. When queried what the facility system was for discussing declines in status the DON stated I am not part of the interdisciplinary team right now. Recently we have been talking about me going in and going through residents if any concerns, but we have not put anything in place yet. The DON verified R16's care plan did not address R16 being occasionally incontinent of bladder or how often R16 should be offered use of the toilet. The facility Bladder Assessment Policy, dated effective 11/27/16, indicated it is the policy of Gunderson Tweeten Health Care Center to ensure that a resident who enters the facility continent of bladder and bowel receive services and assistance to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. Procedure: Nursing staff should follow the following guidelines when evaluating whether a resident would qualify for the bladder retraining program or not. 1. Is the resident orientated to time, person, or place? 2. Can the resident follow simple instructions? 3. Is the resident capable of being cooperative for six to eight weeks? 4. Is the resident partially or totally incontinent? 5. Can the resident sit, stand, ambulate? 6. Does the resident have a neurogenic bladder, chronic urinary tract infections, benign prostate hypertrophy or any other diagnosis that would affect their bladder retraining?	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		1/12/18

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F 677	Continued From page 31 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R16, R37, R42) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed and clean fingernails. Findings Include: R16's quarterly Minimum Data Set (MDS) an assessment dated 9/12/17, identified R16 required for personal hygiene extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist, had severe cognitive impairment and had diagnosis of dementia. During observation on 11/28/17, at 1:32 p.m., R16 was seated in a chair in the living room area. R16's fingernails were long with black debris underneath the nailbeds on both hands. R16 had dry light colored scabs on right side of chin and some scabs on left side of cheek. R16 stated she itches it. R16 was observed to be picking scabs on chin with soiled fingernails during observation. During observation on 11/29/17, at 9:51 a.m., R16's fingernails again noted with black debris under nails. During observation on 11/30/17, at 7:15 a.m., R16 was sitting on the edge of her bed in her room. R16's fingernails were trimmed and clean. R16 stated she had a bath. On 11/30/17, at 7:35 a.m., observation of the	F 677	F677: Gundersen Tweeten Care Center will continue to ensure that residents will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene if he/she is unable to carry out activities of daily living. Care plans were revised for resident□s R16, R42 and R37 to include fingernail care. All other resident care plans were reviewed to ensure fingernail care is person centered and included in their care plans. The Fingernail/Toenail Policy was reviewed and updated. Staff were re-educated on the Fingernail/Toenail Policy. This will be monitored by the charge nurses daily and weekly monitoring by Case Manager. Results of monitoring will be reported to quarterly QAA meeting.	

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F 677	Continued From page 32	F 677		

facility bath sheet read R16 received a whirlpool on Thursday a.m. The following was to be provided: trim nails, shampoo hair, complete skin inspection.

During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B verified she had given R16 a bath and trimmed and cleaned R16's fingernails.

R16's care plan included target date: 12/12/17, Goal: I would like to be as independent as possible with bathing. My goal for level of independence is: take a shower with help I need one assist for foot care by nurse/podiatry. I would like one assist with lower body bathing including perineum, incontinence care, etc. daily am/pm. Approach: I would like one assist with upper body bathing including hands, face, armpits, etc. daily am/pm. I need staff to cue/encourage me to participate with performing my upper body dressing/personal hygiene.

R16's physician progress note dated 11/27/17, identified R16 was seen by physician assistant certified (PAC)-D and R16 had lesions on her left cheek and chin that she picks at, and these have resolved in the past with mupirocin ointment (antibiotic used to treat infections of the skin such as impetigo). Assessment and plan: skin picking habit, order mupirocin 2% ointment TID (three times a day) for seven days for superficial infection. Trim fingernails short. R16's current physician orders identified mupirocin ointment 2% thin layer topical to open areas on left cheek and chin three times a day, diagnosis impetigo.

During interview on 11/30/17, at 9:48 a.m., PAC-D stated she ordered nails to be trimmed due to

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F 677	Continued From page 33 R16 picking skin. PAC-D stated the diagnosis R16 had of impetigo was a staph or strep infection. Any draining lesions should be covered and was transmitted by contact, by touching face and then touching someone else. Proper handwashing hygiene needed. I guess she could touch lesions and spread infection, but after being on the antibiotic, not an issue. I would have hoped the order to trim nails, R16's fingernails would have been trimmed by later that night at least. During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) stated she did not know R16 had an infection until today. The DON stated she would expect R16's fingernails to be trimmed that evening or the next morning as soon as we could get it done, depending on what is going on. The DON stated fingernails were to be trimmed on bath days or looked, but I also think daily when doing other cares fingernails should be looked at and encourage R16 to wash hands. The facility policy Care of Fingernails/Toenails, dated revised 10/16, indicated the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. R37 was identified by the facility on the admission Minimum Data Set (MDS), an assessment dated 10/20/17, to have intact cognition and required extensive assist of one staff for personal hygiene. Also R37 was identified by the facility on the care area assessment (CAA) to require extensive assistance for grooming and needed assistance with activities of daily living due to recent	F 677		

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F 677	Continued From page 34	F 677		

hospitalization, history of falls, osteoporosis, osteoarthritis, obesity and weakness.

During observations on 11/28/17, at 2:49 p.m., R37 was observed with soiled fingers nails on right and left hands.

During observations on 11/30/17, at 9:14 a.m., R37 was awake and in bed. Observations at that time revealed under finger nails soiled with debris. R37 stated her finger nails were cleaned on shower days which were two times a week.

Document review of R37's care plan dated 10/13/17, directed staff: R37 was limited in ability to complete activities of daily living related to weakness and recent hospitalization. Interventions included to provide one staff assist for nail care to hands and feet.

Document review of facility unit 2 Bath List for week of 11/27/17 to 12/3/17, revealed staff directions, updated 11/20/17, included: to shampoo hair, trim nails, check for chin hairs on females and shave if needed and do complete skin inspection on bath days.

Document review of weekly unit two bath list for morning baths were reviewed from 10/30/17-11/26/17, revealed R37 was assigned baths on Mondays and Fridays.

Document review of facility progress notes 11/27/17, revealed R37 received a whirlpool bath and had usual daily routine.

During interview on 11/30/17, at 9:17 a.m., nursing assistant (NA)-B verified R37 received baths two times a week. NA-B stated facility

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F 677	Continued From page 35 routine was to check finger nails, clean and trim on bath days, and check nails often. NA-B verified the soiled nails at this time. During interview on 11/30/17, at 9:23 a.m., director of nursing (DON) verified the soiled finger nails. DON stated she expected staff to provide nail care on bath days and as needed. During interview on 11/30/17, at 12:53 p.m., DON stated she expected staff to provide nail care according to the care plan. R42's resident face sheet identified a current admission date of 2/9/16, and a diagnosis of vascular dementia without behavioral disturbance and traumatic hemorrhage of left cerebrum without loss of consciousness. R42's quarterly Minimum Data Set (MDS) an assessment dated 10/31/17, identified R42 to have a moderate cognitive deficit and requires one person extensive assist with personal hygiene. Care plan dated 6/3/16, identified R42 needs extensive assist in ability to complete adls related to brain hemorrhage and weakness, with an approach to provide 1 staff assist for nail care to hands and feet. Facility document, "Unit 2 bath list AM," week of 11/27/17-12/03/17, identified R42 will get a whirlpool bath on Tuesday, 11/28/17. During observation on 11/30/17, at 7:15 a.m., R42 was observed seated in her wheelchair in her room and noted to have long painted red fingernails. There was noted to be a brown substance that is packed and hard underneath all	F 677		

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F 677	Continued From page 36 R42's fingernails. During interview on 11/30/17, at 7:38 a.m., nursing assistant (NA)-A verified R42 has brown substance packed underneath all of her fingernails. Further verifies R42 her bath was Tuesday morning and nail care should have been completed then. During interview on 11/30/17, at 7:46 a.m., NA-B stated, "We don't usually do nail care on R42, she goes out and gets her nails done." NA-B verified the resident has artificial nails that her family member (FM)-A takes her out in the community to get done. NA-B further verified brown substance underneath all of R42's fingernails and stated that nail care should have been done. Interview on 11/30/17, at 8:55 a.m., director of nursing (DON) stated all residents should have nail care completed on bath days. Further stated nails should be checked every a.m. and p.m. with cares. DON said, "My expectation is for staff to check [R42's] fingernails every day and clean as necessary regardless whether she has fake fingernails or not." Undated facility policy, "Care of Fingernails/Toenails," indicated the purpose of this procedure is to clean the nail bed, to keep the nails trimmed, and to prevent infections. Preparation: review the care plan to assess for any special needs of the resident. General Guidelines: Nail care includes daily cleaning and regular trimming. Documentation: Any problems or complaints made by the resident with his/her hands or feet or any complaints related to the procedure.	F 677		

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F 684	Continued From page 37	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to reassess pain control measures and notify the physician timely when pain was not controlled for 1 of 1 resident (R48) reviewed for a death record. Findings include: R48's quarterly Minimum Data Set (MDS) dated 7/4/17, identified R48 had moderate cognitive impairment, had occasional pain, pain intensity (numeric rating scale 0-10) was three and had no pressure ulcers. R48's wound care skin integrity evaluation, dated 8/1/17, identified R48 had an unstageable pressure ulcer right ischial tuberosity. R48's care plan identified Last Reviewed/Revised: 8/23/17, Problem: I am at risk for skin breakdown and bruising. I have a Braden score of 20. Start Date: 8/23/17, Approach: Open area will be cleansed and dressed daily. Area will be measured frequently and wound nurse will follow. Approach: I have an open area on right	F 684	F684: Gundersen Tweeten Care Center will continue to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident□s choices. R48 expired on 8/31/17. All charge nurses were educated on policy to notify the physician when pain is not controlled adequately for all residents on 11/13/17. This will be monitored by QA nurse with routine chart audits for all residents that are requiring pain management. Results of monitoring will be reported to quarterly QAA meeting.	1/12/18

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hip. Staff to turn and reposition me off that area. Approach: I agree that the nurses will monitor my ability to move, reposition, and the status of my skin. If anything changes with my mobility or skin status, the nurses will again monitor. Last Reviewed/Revised: 8/23/17, Problem: I have pain related to arthritis that is mild in my back and my legs. Approach: I would like Nurse to monitor and record any complaints of pain: location, frequency, intensity, affect on function, alleviating factors, aggravating factors. Start Date: 4/04/17, Approach: I would like staff to monitor and record any non-verbal signs of pain I might experience: (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.). Start Date: 4/04/17, Approach: I would like the nurse to administer medications: Tylenol. Evaluate/record/report effectiveness and any adverse side effects I develop to my doctor. Approach: I would like to try non-medicine pain relief measures before taking a pill or narcotic: (e.g., position changes, biofeedback, application of heat/cold, massage, physical therapy, stretching and strengthening exercises, acupuncture, etc.). Monitor effectiveness and offer alternatives to me.

R48's nursing progress notes dated from 7/21/17 through 8/30/17, identified the following:
-7/21/17, nurse practitioner (NP)-E know of open area. Changed dressing from bid (twice daily) to qd (everyday) with dressing order of wash, pat dry, mix collagen and hydrogel together to form a gel and fill cavity, and cover with foam dressing.
-8/01/17, was complaining of her bottom hurting ever since laying in bed last evening. Resident was repositioned multiple times.
-8/02/17, was complaining of pain in her bottom at HS (bedtime) last evening and then periodically

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F 684	Continued From page 39 throughout the night. -8/03/17, was not feeling well this morning and eating breakfast in her room. On Monday she was afraid to be alone as she thought she was going to die. -8/03/17, did not want to eat lunch but was persuaded to come out to the dining room. Had a small emesis and large liquid stool at 12:00 p.m. -8/03/17, resident stated to staff she was having increased pain to buttocks area where sore is currently located. Dressing was changed and resident was turned onto side to help eliminate pain to the area. Currently resting with eyes closed. Will continue to monitor. -8/06/17, Resident yelled out "help me" many times this shift, because her bottom and back hurt. Resident was repositioned frequently. Resident complained of a lot of pain during her dressing change last evening. Staff gently patted the area to clean it and resident winced and said "ow" the entire time. -8/06/17, did c/o (complained of) R (right) leg pain and refused to come to dining room or eat anything for lunch due to feeling nauseous. -8/07/17, complained of back and bottom pain with cares. -8/07/17, aid reported that resident had a large emesis after lunch. -8/08/17, complained of pain in buttocks related to open sore. -8/09/17, yelled out "help me" multiple times this shift to complain of back and bottom pain. Resident was repositioned many times during the night. Resident never once rang her call light for help and told staff that she did not have it, but it was clipped to her chest. -8/10/17, yelled out "help me" once this shift because she was having back pain. Resident was repositioned and had no further complaints.	F 684		

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F 684	Continued From page 40 -8/11/17, yelled out "help me" once this shift because of pain in her bottom. Resident was repositioned at this time to help relieve the pressure on her bottom. Resident was repositioned every two hours this shift -8/12/17, complained of pain in her bottom a few times this shift. Resident was repositioned every time and given Soothing Relief essential oils once. Interventions were effective. -8/12/17, was gaggy mid-morning, but has had no actual emesis yet. -8/13/17, complained of a sore bottom at bedtime and once in the overnight. Resident was repositioned and had no further complaints. -8/14/17, vomited earlier in the shift foods she had recently ate. Showed an increase in confusion, rang call light several times and when asked what she needed she stated she did not know and did not realize she had pressed her call light. Complained of pain to her bottom. Will continue to monitor. -8/14/17, dressing change done---no change noticed by this nurse, since I last dressed it 8/9/17. C/O's of much discomfort with the dressing change. -8/16/17, C/O R leg pain and buttock pain. Resident refused to get out of bed this a.m. -8/16/17, refused her medication this evening, because she said staff was trying to poison her. Resident finally agreed to take medication after staff explained that she could trust the staff, but resident held them in her mouth and refused to swallow. -8/17/17, called out "help me" almost the entire night. Resident was repositioned multiple times this shift. Resident continued to yell when staff had just helped her with all of her needs. -8/17/17, ate breakfast in the dining room. Lunch brought to her room but did not eat. She did drink	F 684		

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F 684	Continued From page 41	F 684		

two glasses of boost. Threw up AM meds.
-8/18/17, dressing changed last evening. Resident yelled out "help me" once in the overnight because she was sore in her bottom. Resident repositioned and had no further complaints.
-8/19/17, c/o pain in her buttock area due to sore. Resident agreed to be repositioned onto her side in bed. No further c/o pain where offered as of this time.
-8/20/17, vomited this morning after taking medications.
-8/21/17, yelled out "help me" frequently during the overnight, but did not always need anything from staff or she would continue to yell when staff was already helping with what she needed.
-8/23/17, does not use call light she yells out "help me" or just yells. Staff reminds her where her call light is and she is to use to summons staff for assistance. She has been turned off her bottom every couple hours. She has offered no complaints of discomfort.
-8/23/17, dressing changed this evening. Resident complained of pain when dressing was being taken off and when wound was being cleaned. Resident yelled "help me" almost constantly this shift. Staff would go into resident room and ask what she needed and resident would say she did not need anything. Resident yelled "help me" during dressing change. When staff asked what she needed she said "I need help". Staff asked what she needed for help and resident said "I don't need anything". Other staff mentioned that resident did the same thing when they went in to see what she needed multiple times.
-8/24/17, had complained of aching all over PRN Tylenol given along with use of Soothing relief EO. Has yelled out much of the night saying

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F 684	Continued From page 42 "help" but when asked what she needs help with she would state nothing. Attempted to place on her R side for different position but this did not last long. -8/24/17, complained of pain during cares and when staff was doing her dressing change. Resident yelled out "help me" many times this shift, but said she did not need anything when staff went to check on her. Resident threw up at 9 p.m. this evening. TMA (trained medication aide) mentioned that it was a lot of emesis at this time. -8/25/17, has been yelling out help me all night when staff is providing cares and when standing at bedside to help she would yell. She complained of discomfort when being repositioned. PRN (as needed) Tylenol was given and also used Calming EO with little effectiveness. -8/26/17, yelled out "help me" almost constantly all night. Resident complained of pain on her bottom. PRN Tylenol was given and Soothing Relief essential oils applied, both were not effective. -8/26/17, up at 10 a.m. Stating, "Help me!" Out to dining room for noon meal but refused to eat. Drank 120 cc of Health shake. Will continue to monitor. -8/27/17, dressing changed last evening. Resident yelled "help me" almost all night, but when staff checked on her she just continued to say "help me" and never say what she needed. -8/28/17, lying in bed restless tonight. Resident continues to complain of pain to buttocks area. Tylenol offered and not effective. Dressing changed on previous shift and wound appears to be deeper and bleeding a little. Resident yells out "help me" on and off throughout the shift, when asked what she needs Resident replies that she does not know or that her bottom is hurting her.	F 684		

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F 684	Continued From page 43 -8/28/17, notified daughter of the Dr. visit scheduled for tomorrow for referral to Hospice. She is in agreement that this is appropriate at this time. -8/28/17, was weak throughout a.m. cares. Did sit up in her recliner but continues to yell "help me". When asked how we can help she offers c/o pain in her buttock area or will say, "i don't know how you can help me". Resident refused to come out for lunch. She is resting at this time. -8/28/17, is eating very little and is unsettled often yelling "help me, help me" from her bed. C/O pain on her butt where she has a 1.1 x 1.0 open area on R buttock. Nsg (nursing) doing tx (treatment) t (to) R buttock wound. Hard to heal wound when eating so poorly. Dietary. -8/29/17, yelled out "help me" this entire shift and did not get much sleep. Resident would not say what she needed when staff went in to check on her, she just continued to yell for help. -8/29/17, complained of pain all over and in buttock area. Resident repeating "help me" but cannot tell aids or nurse what we can do to help her. Continue to monitor resident condition. -8/29/17, seen by MD (medical doctor) to order consult for Hospice, lorazepam (antianxiety) 0.5 mg (milligrams) p.o. (oral) once now, morphine (narcotic)20 mg/1 ml (milliliter) 2 mg p.o. every 2H (hours) prn hold if patient is not responsive to voice. -8/30/17, has been resting at times she will say "help me" staff has been providing cares as needs-difficulty with drinking water or any fluids through straw. Has no MSO4 (morphine) here yet and need to fax hard copy to pharmacy to take out of E-kit. -8/30/17, family here visiting. Family not happy about resident not having morphine available yet. Morphine finally given at 12:58 p.m.	F 684		

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F 684	Continued From page 44 R48's record identified a pain management/observation assessment was completed last on 7/10/17 and indicated had complaints of right hip/thigh pains. Did have several falls at home. X-ray revealed osteoarthritis. Does not complain of any other pain. Physician orders for pain treatments as follows: R48's physician orders identified the following orders with start dates: 4/18/17 Tylenol 650 mg three times a day 6/19/17 lidocaine patch 4% apply patch every am and remove every HS 7/7/17 may use soothing relief essential oil to support relief of anxiety, nausea and muscle or joint aches. 8/3/17 open area on right buttock, cleanse/pat dry/mixture of collagen and normal saline to form gel/place in wound bed/cover with hydrogel sheet/cover with foam dressing/change every day until healed 8/2/17 apply calming oil for anxiety 8/7/17 to lay on left side and back reposition with pillows every two hours 8/13/17 Tylenol 500 mg one tablet every four hours PRN for fever greater than 100 degrees, mild pain or headache. Maximum dosage 3000 mg/24 hours 8/29/17 lorazepam 0.5 mg one time 8/29/17 morphine concentrate 100 mg/5 ml (20 mg/ml) 2 mg (0.1 ml) every two hours PRN chronic pain, hold for signs and symptoms of over sedation (unresponsiveness to voice, low heart rate) 8/29/17 Hospice consult R48's medication and treatment records for the	F 684		

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F 684	Continued From page 45 month of 8/17 identified the following had been administered: Calming oil for anxiety was applied for relief on 8/4, 8/5 and 8/25. Soothing relief essential oil to support relief of anxiety, nausea and muscle joint aches was applied 8/2, 8/4, 8/24 and 8/25 Lidocaine patch as ordered Tylenol 650 mg three times a day as ordered Tylenol 500 mg on 8/14, 8/23 and 8/25 (twice) Treatment to open area right buttock as ordered Lorazepam 0.5 mg one time as ordered Morphine concentrate 0.1 ml first dose on 8/30/17 at 12:58 p.m., at 4:47 p.m. and on 8/31/17 at 8:00 a.m. R48's record lacked documentation regarding a comprehensive pain assessment had been completed after 8/1/17 when R48 had increased complaints of pain buttock area. In addition, the record lacked documentation a physician had been notified regarding the increased complaints of buttock pain and R48 having had emesis. There is also no documentation that the resident received pain medication prior to dressing change to decubitus ulcer. During interview on 12/01/17, at 10:50 a.m., the director of nursing (DON) stated all resident records were in the computer system, and there were no paper records. When queried if the physician was notified of increased pain complaints in buttocks, emesis and refusing medications, the DON stated it could be on the 24 hour report sheets. When queried if the 24 hour sheets would show the physician was notified the DON replied it could be. At 2:28 p.m. the DON said registered nurse (RN)-A had no luck finding the physician was notified of the pain in buttocks	F 684		

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F 684	Continued From page 46 and emesis. DON stated she had reviewed the physician orders and physician notes and could not find where the physician was notified either. The DON reviewed R48's progress notes and stated the physician was made aware of the wound on 8/1/17 because he signed the wound nurse orders. DON stated in regards to Morphine availability, we have morphine on hand in the E-kit (emergency kit) unless it would have been pulled for somebody else already. DON stated the pharmacy had to be faxed a hard copy of the order, then the pharmacy gives a code for us to take the medication out of the Ekit. We cannot take it out of the Ekit until they give us a code. DON stated I cannot prove one way or another if the physician was notified of pain in buttocks and emesis. During interview on 12/04/17, at 12:55 p.m., registered nurse (RN)-A verified she completed R48's wound assessments. RN-A stated I do not put pain on the wound assessments, but we do talk about that when we measure and usually the nurse who helps me at the time of the wound treatment documents that in the nurse notes. When queried if she was aware R48 had pain in buttocks, RN-A stated I asked the family member (FM)-B and she said R48 was not having pain in buttocks, because R48 was getting pain meds and she did not want her in pain. That is why I could trust what FM-B said. I asked FM-B how she knows R48 was doing well because R48 was yelling and how did she know was not pain and FM-B said because R48 told me. RN-A stated I asked the nurse if thought R48 was in pain and if was to get physician assistant certified (PAC)-D on it. When queried if she had ever notified the physician regarding R48 complaints of pain, RN-A reviewed R48's record and stated no. RN-A	F 684		

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F 684	Continued From page 47 verified a physician had not been notified regarding complaints of pain in buttocks. During phone interview on 12/04/17, at 1:18 p.m., nurse practitioner (NP)-E reviewed R48's clinic record and stated there was no record of a physician being notified about pain from 7/7/17 until 8/29/17, when he mentioned buttocks pain and then we started morphine and ordered Hospice services. The facility policy Pain Management dated effective 12/1616, indicated Policy: The pain management program is based on a facility wide commitment to resident comfort in which staff will help to identify pain in the resident, and will develop interventions that are consistent with resident's goals and needs and that address the underlying causes of pain. Procedure: 1. Upon admission, quarterly, with significant change and when there is a new onset of new pain or worsening of existing pain, a pain assessment will be completed. The facility policy Notification of Changes, dated effective 9/12/17, Procedure: Purpose Gunderson Tweeten Care Center shall promptly notify the resident and/or the resident representative and his or her physician or delegate of changes in the resident's condition or status in order to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences. Procedure 1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list is not all inclusive): b. A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial	F 684		

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F 684	Continued From page 48 status in either life threatening conditions or clinical complications.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision for falls for 2 of 3 residents (R47, R10) reviewed for falls who reside in the Woodlands Memory Unit. Findings include: R47 was admitted to the facility on 8/1/17 according to the face sheet, with the diagnosis of Alzheimer disease with delirium, chronic pain-bilateral arthritis (in both knees), vascular dementia with behavioral disturbance, restlessness and agitation, repeated falls, and insomnia. R47's quarterly Minimum Data Set (MDS) an assessment, dated 11/7/17, identified through the use of a brief indicator of mental status (BIMs) a score of 3 indicating R47 suffers from severe cognitive impairment. The MDS also identified R47 had difficulty focusing attention, was easily distracted, had difficulty keeping track of what was said, and disorganized thinking.	F 689	F689: Gundersen Tweeten Care Center will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. R47 has been seen by PA-C for medication adjustments; OT has evaluated R47 and working on safe w/c positioning to decrease risk of falls. R10 was assessed by the PA-C and family was contacted regarding medication adjustments for him as his behavior has been agitated and restless causing an increase in falls. Interventions identified on the fall investigation summary will be added to the residents care plan and resident care assignment sheets at time of completion, fall investigation summaries will be completed weekly by the fall team. This will be monitored by the IDT team at quarterly care plan conferences.	1/12/18

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F 689	Continued From page 49 From the date of admission, 8/1/17 to 12/2/17, R47 sustained 27 falls. One additional episode of being found on the floor without an incident report completed. Twenty four of the 27 falls were episodes of being on the floor were unwitnessed by staff. On 8/11/17, at 6:05 p.m., R47 had initial fall, unwitnessed in hallway wearing another resident's glasses. On 8/12/17, at 8:20 p.m., unwitnessed, found with left leg lying over the leg of the Hoyer lift. On 8/24/17, at 10:45 p.m., unwitnessed, found lying on the floor. On 9/8/17, at 5:40 a.m., unwitnessed, found lying on the floor in his room with a chair over his abdomen. Interventions to prevent further falls include: frequent observation, offer to toilet, continue to ensure has shoes available, room free of clutter, lights on at night. On 9/10/17, at 11:00 a.m., unwitnessed, found on floor another resident was hitting him, eyeglasses were on the floor. On 9/10/17, at 9:10 p.m., unwitnessed, nursing in the next room, according to progress note, "Res [resident] was heard moving furniture from the room next door to his. Staff heard a loud noise and went to check on Res and found him lying on the floor on his back." Resident sustained a hematoma to the back of his head and complained of left arm/shoulder pain. Interventions to prevent further falls included: monitor frequently, refer to medical doctor for analgesic (pain) medication review related to the knee pain. On 9/25/17, at 2:55 p.m.,unwitnessed, found in nursing office on floor, fell from wheeled chair. Interventions to prevent further falls include: close door to office, monitor seating to ensure safety, frequent rounding.	F 689		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50 On 10/5/17, at 6:20 a.m., unwitnessed, found in room on floor lying on left side. Interventions to prevent further falls include: continue care plan as currently stated, attempt to have R47 wear shoes. On 10/6/17, at 12:15 a.m., fall is classified as witnessed by the facility. Staff called for assist as R47 was on the edge of his recliner. Called back and said R47 was on the floor. Interventions to prevent further falls include: ensure safe sitting position. On 10/12/17, at 5:05 a.m., unwitnessed. Found on floor in his room next to a chair. Interventions to prevent further falls include: frequent supervision and continue care plan as stated. On 10/13/17, according to documentation at 6:35 a.m., by nursing assistant (NA)-E, R47 found sitting on floor and when asked denied he fell. Unwitnessed. No incident form filled out. On 10/23/17, at 3:40 a.m., unwitnessed. Staff heard someone yelling help. R47 found sitting on the floor in bathroom doorway. A garbage can was noted to be in the toilet. Interventions to prevent further falls include: provide supervision and assistance, provide footwear. On 10/25/17, at 6:00 a.m., unwitnessed. Staff heard R47 hollering in his room. Found sitting on floor with no lower clothing or brief on. Urine was on the floor where he fell. Interventions to prevent further falls include: provide supervision and assistance when noticed he has a need. On 10/31/17, at 2:30 a.m., unwitnessed. Heard saying "help me, I can't stand up." Found sitting in his room by the door. Interventions to prevent further falls include: follow care plan as stated, anticipate needs. On 11/2/17, at 12:35 a.m., unwitnessed. Found on floor in his doorway with another resident (who had been involved in prior resident to resident altercation) standing over R47. The staff member	F 689		

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F 689	Continued From page 51 on the unit was trying to assist another resident who was trying to get out of bed at the same time. Interventions to prevent further falls include: frequent supervision and anticipate needs. On 11/9/17, at 6:56 pm., unwitnessed. Found lying on the floor in his room between dresser and night stand. Interventions to prevent further falls include: continue care plan as stated. Anticipate needs and frequently monitor. On 11/10/17, at 4:44 a.m., unwitnessed. Staff member doing rounds, heard resident "scream" found on floor in living room. Interventions to prevent further falls include: follow care plan, anticipate needs. On 11/11/17, at 3:45 p.m., unwitnessed. Fell in his room. Hit his head on the wall. Interventions to prevent further falls include: frequent monitoring and anticipate needs. On 11/12/17 at 7:45 a.m., unwitnessed. Found in dining room. Interventions to prevent further falls include: follow care plan. On 11/15/17, at 1:15 p.m., unwitnessed, found lying on floor in dining room. Interventions to prevent further falls include: provide distraction, one to one care, and frequent supervision. On 11/15/17, at 5:55 p.m., unwitnessed. R47 found in his room on the floor. No interventions provided. On 11/17/17, at 11:15 a.m., unwitnessed. Found on mat next to bed. Interventions to prevent further falls include: continue with mat at the bedside. On 11/17/17 at 3:15 p.m., unwitnessed. Found in dining room next to his wheelchair. Dining room chair was tipped over next to him. Interventions to prevent further falls include: provide frequent supervision, offer 1:1 or distractions. On 11/18/17, at 4:30 p.m., witnessed. NA-witnessed R47 shaking and fall from his chair. A	F 689		

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F 689	Continued From page 52	F 689		

family member who had been visiting in the dementia unit went to go get help. Interventions to prevent further falls include: frequent supervision, medication review.
On 11/21/17, at 4:10 p.m., unwitnessed. Found on floor in dining room. Interventions to prevent further falls include: continue to work with physician and physician assistant for effective medications for aggressive behavior.
On 11/24/17, at 5:45 p.m., witnessed. The NA on the unit observe R47 get up from his wheelchair, take a few steps and fall. Interventions to prevent further falls include: provide distraction, redirection, frequent supervision, monitor for restlessness and provide for needs, Frequent rounding
On 11/29/17, at 4:12 p.m., witnessed. NA- saw R47 fall from wheelchair and land on his left side.
On 12/2/17, witnessed by familiy member (FM)-C who was visiting in the afternoon. Fell from chair in his room.
According to the event forms provided by the facility, in 12 of R47's falls, the interdisciplinary team identified the intervention of providing supervision, rounding, observing, one to one care, or monitoring of resident even though this intervention continued to be ineffective and did not address the root cause of the falls.
During an observation on 12/4/17, at 11:24 a.m., NA-E stated R47 was resting in his room, she went in to check on him and he was sitting on the edge of the bed, with one grip sock on and one half off. Door had been open a crack and no lights were on in the room.
During an observation on 12/4/17, at 11:40 a.m., it was noted the door to the nursing office was open.
During an interview with NA-C on 12/4/17, at 2:07 p.m., R47 is observed in his wheelchair with his

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F 689	Continued From page 53 feet on the floor and wearing grip socks. He is bending forward in his chair attempting to pick up a playing card. NA-C excuses self and picks up card for R47 and returns to continue the interview. NA-C asks to position self within line of sight of R47. At 2:10 p.m. R47 attempts to rise from his chair and NA-C leaves interview to attend to R47, getting him a cookie and some cranberry juice. At 2:12 p.m., asked NA-C if any other staff were present on the unit. NA-C stated, "That is a good question, there is another NA but she is busy with a resident in a room." Fall risk factor report from 8/17-11/17, identified that R47 is more likely to fall if unattended, and is at highest risk if unattended in his room. R10 readmitted to facility on 6/10/16 according to face sheet. R10 has a diagnosis of unspecified dementia with behavioral disturbances, Sleep disorders, Alzheimer's disease, Psychotic disorder with delusions due to known physiological condition, chronic pain, hypertension, Anxiety disorder, age-related osteoporosis without current pathological fracture. R10's quarterly Minimum Date Set an assessment dated 9/5/17, indicated that brief interview for mental status (BIMS) was a score of 3, which indicates severe cognitive impairment. R10's Care Area Assessments dated 6/6/17, for Delirium analysis of findings, R10 has periods with disorientation related to dementia. R10 does not have acute delirium. R10 is at risk for falls/frustration. CAA also includes cognitive loss and dementia dated 6/12/17, analysis of findings. R10 has dementia with disorientation and poor recall. R10 at risk for falls and frustration. CAA includes for communication dated 6/12/17,	F 689		

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F 689	Continued From page 54 analysis of findings R10 is slightly hard of hearing (HOH) and needs quiet environment to participate in conversation. R10 has periods when speech is difficult to understand. CAA included for behavioral symptoms dated 6/12/17, analysis of findings R10 has dementia with periods of paranoia and can be verbally and physically abusive, R10 at risk for injury and increased frustration. CAA included for falls dated 6/12/17, analysis of findings R10 fall risk score is 16, indicating at risk. Nursing staff to provide assist with all transfers using total lift, place pad alarms in wheelchair and bed, place floor mats at bedside and against wall, and try to anticipate needs. R10's comprehensive Care Plan reviewed and revised on 9/12/17, indicates that R10's requires assistance of two staff and total lift with all transfers. R10 at risk for falls related to dementia, incontinence, joint pain, delusions, hallucinations, and medications, R10 has hallucinations and delusions related to reasons unknown. Upset with help or rescue others. R10 has verbal behavioral symptoms directed toward others, (examples, threatening others, screaming at others, cursing at others). Falls care plan indicates that R10 has bed and personal alarms to notify staff of attempts to self-transfer. Give verbal reminders not to ambulate, transfer without assistance. Place a mat on floor when R10 is in bed and a mat against wall was to protect R10 when kicking and hitting toward wall. Provide proper footwear. Keep bed in low position with brakes on. Falls in past 6 months were reveiwed and found the following:	F 689		

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F 689	Continued From page 55 6/11/17, progress note at 9:36 p.m. indicated R10 fell at 1:25 p.m. No injuries. Vitals signs taken and were in normal range. Neuro's checks every 2 two hours normal-baseline for resident. New alarm was place on bed. 6/19/17, progress note at 10:19 p.m., indicated R10 was found at 3:15 p.m. on his hand and knees on the red mat on his floor next to his bed facing east. Vitals were taken and no injuries noted. 8/15/17, progress notes indicated R10 fell at 11:51 a.m., was observed falling to the right of out of his wheelchair. R10 sustained some bruising at site of right forearm skin tear. Also bruising at right knee, approximately 1 centameter, round. A small pinpoint area, which appears to be open, dry, not draining or bleeding in any way. No bruising to any other area noted directly from fall. Prior to fall resident was swearing, yelling and hallucinating, moving his body around in his chair and also using his legs to propel himself. R10 monitored at close distance. 9/18/19, fall at 1:30 p.m. events report: R10 found on floor unwitnessed in his room, mental status is alert, confused, agitated. Cause of fall: R10 was attempting to walk, self-transfers to remove a person from his room. Describe intervention to prevent future falls: Ensure R10 is unable to manipulate recline chair, as he is not able to run it appropriately; frequent supervision, prefer to rest in recliner in living room area unless loud, disruptive. Intra disciplinary team (IDT) note: 3rd fall in 90 days. Is there a pattern to residents' falls? Self-transferring, summarize potential factors that could have contributed to the fall: agitation,	F 689		

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F 689	Continued From page 56 confusion, poor judgment, physical function. Describe measures/ interventions to be taken to prevent further falls: frequent supervision, ensure controls are not within reach on recliner, use of chair/bed alarm in place. 11/2/17, fall at 2:30 p.m., events report: unwitnessed from wheelchair in dining room. Mental status: confused, no change, not restless, agitated, very calm. No as needed medication given in last 6 hours. No medication change in past week. R10 did not hit head, no sign of pain, discomfort or injury noted. Cause of fall, self-transferring. IDT note: 3rd fall in 90 days. Pattern for falls self-transferring and attempting to ambulate on own. Potential factors: dementia with impaired judgement and poor balance. New interventions to prevent further falls: to continue frequent observation, anticipate needs, observe closely when restless or attempting to stand up from wheelchair. 11/6/17, fall at 2:27 a.m., events report: unwitnessed fall R10 found on floor in R10's room. Mental status, restless. Cause of fall: reaching for and getting shoes. Root cause of fall: mood behavior, dementia. IDT note: Fall history 4th fall in 90 days. Pattern yes, though this fall does not follow expected pattern. Summarize factors: dementia related to confusion, delusion, poor physical function. New interventions to prevent future falls: frequent supervision, continue with bed alarm and floor mat. 11/10/17 fall at 1:10 a.m., events report: Staff heard alarm sound and entered R10's room R10 sitting on floor. Mental status confused. Cause of fall: R10 tried to get self out of bed. R10 was hallucinating about working on some machine.	F 689		

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F 689	Continued From page 57 IDT note: Fall history 5th fall in 90 days. Pattern to R10 falls 2nd attempt to self-transfer from bed. Summarize factors: Impaired balance with advanced dementia. New interventions to prevent falls: Continue with mat on floor and observe for restlessness during rounding. On 11/30/17, at 9:30 a.m., interview with NA-E said R10 directs his care; this morning started out with him yelling from is bed. That is usually a clue to get him up, we got him out of bed and offered to something to eat, fluids. He was continuing to yell out, so I put the essential oil calming cotton ball on his shirt, which has helped today. I know that the night staff will get him up, will offer food or drink, the essential oil sometimes does not have an effective, on him. One time it works and other times it does not. On 11/30/17 at 3:20 p.m., interview with NA-F said, "R10 kinda does what R10 wants when he wants, not always redirectable." "We try the essential oils, which sometimes help, but most of the time "I don't think so." "R10's family is very involved and do not let us do much with his medication, I know that at night they will offer him snacks, attempt to get up at times." On 12/01/17, at 1:26 p.m., interview with NA-C R10's behaviors are increasingly going up, R10 will go from calm to out of control, R10 has no triggers that we have found. On 12/04/17, at 2:28 pm., interview with NA-C regarding falls, When we have a fall we go in and make sure the resident is safe, start vitals if able, other NA will go get charge nurse or call them. Asked resident what they were doing. If injury, would have charge nurse direct appropriate care	F 689		

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F 689	Continued From page 58 to the extent of being sent to emergency department for further evaluation. I was working on 11/2/17, when R10 from wheelchair, "we were both at time of the fall helping another resident that required two person assistance, no other staff was on unit at the time of fall to monitor common living area and dining room. On 12/04/17, at 3:30 p.m., interview with Social Services SS-A regarding R10's falls, SS-A stated that the fall out of recliner, and indicated to keep control out of reach of R10, one in the dining from wheelchair, 2 out of bed during night, looking for something. Indicated that family refused psychotic meds. R10 does have as needed order for gabapentin for mood and pain, essential oils as needed, with schedules essential oils. R10 has had a non-formal restorative program, which is not consistent. Also R10 is very impulsive, mood changes in a blink of an eye. R10 may hear something or see something real or not real. You can sometimes tell R10'S tone of voice will sound irritated, or will just start yelling, question explosive personality. On 12/04/17 at 4:05 p.m. interview with director of nursing, states R10's family refused therapy as an option. Family requested the antipsychotic medication discontinued in 4/2017. Since June behaviors and falls have gradually increased. Received Fall prevention policy with effective date of 7/17/17 Policy Gunderson Tweeten Care Center strives to make the environment as free from accidents hazards as possible the fall prevention program spans the entire organization and demonstrates the organization's commitment to eliminate preventable pain and suffering.	F 689		

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F 689	Continued From page 59 Safety Committee The safety committee is interdisciplinary group. This group meets monthly with the purpose of * address safety risks and environmental hazards for residents * Evaluate and analyze the cause(s) of accidents hazards identified and develop strategies to mitigate or remove the hazards to the extent possible * Review falls for the month and identify trends. * Review any equipment concerns * Report to the Quality Assurance Committee quarterly. Procedure: Resident falls are a complex problem and successful reduction plan requires and interdisciplinary and multifaceted approach. The following standard operating procedure outlines the steps to: * Identify resident who are at risk to fall * Reduce the risk of falls * Prevent injury from falls * Care for a resident who has fallen * Prevent a repeat fall.	F 689		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These	F 741		1/12/18

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F 741	Continued From page 60 competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficient staff to adequately monitor according to assessed needs for 1 of 1 resident R47 reviewed. Findings include: R47 was admitted on 8/1/17 according to the face sheet. From date of admission, 8/1/17 to 12/2/17, R47 sustained 27 falls. On review of the 27 falls it was noted that 24 of them had not been witnessed by staff which included time of day for majority of to be evening and night time. R47's interventions following the falls was to increase monitoring of resident which had not been assessed if this was affective for preventing or decreasing falls. Please see F686 for a more detailed list of R47's falls and relationship to lack of monitoring frequently as care planned related to staffing deployment/levels.	F 741	F741: Gundersen Tweeten Care Center will continue to have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering number, acuity and diagnoses of the facility□s resident population in accordance with 483.70(e). GTCC continues to staff above the national 5 star standard based on acuity. R47 has been seen by PA-C for medication adjustments; OT has evaluated R47 and are working on safe w/c positioning to decrease risk of falls. Interventions	

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F 741	Continued From page 61 During a review of the staffing pattern for day and evening shift in the secured dementia unit where R47 resided, it was noted that the staff postings indicated one nursing assistant (NA) and one trained medication aide (TMA) or one licensed nurse. Also an activity aide was scheduled 4 hours on the day shift (7:45 a.m.-11:45 a.m.) and evening shift (4:00 p.m. to 8 p.m.) most days. There was only one staff present on secured unit during the night shift. Review of the nursing care sheets provided to the nursing assistants for 12/1/17 day, evening and night shift revealed 5 of 10 residents residing on the unit were an assist of 2 staff assessed to need help with transfers and associated physical needs. Also a resident was assessed to need 1-2 staff to meet physical needs. On 12/1/17, at 10:30 a.m. during interviews with nursing assistant (NA)-C, NA-D, and NA-E, related to unit staffing, NA-E stated that there is not enough time to get the work done for all the residents then stated, "Not if I want to do all of rounds and cleaning, and behavioral and ADL [activities of daily living] charting. I do not do a lot of charting. I believe resident cares come first." NA-E then said she recently "talked to" the nurse about not getting her intakes charted, NA-E stated, "I asked, what care for which resident do you not want me to get done." NA-E also stated that room cleaning had recently been added to their workload as well and they were required to clean 2 rooms on morning and evening shift. She went onto say that there was only one staff on at night and one of her colleagues had been alone at night when she was repeatedly punched in the face by a resident and was unable to get help.	F 741	identified on the fall investigation summary will be added to the residents care plan and resident care assignment sheets at the time of completion, fall investigation summaries will be completed weekly by the fall team. This will be monitored by the IDT team at quarterly care plan conferences. Acuity levels will be monitored monthly by Administrator and Director of Nursing. Results of monitoring will be reported to quarterly QAA meeting.	

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

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F 741	Continued From page 62	F 741		

NA-C, D & E, were interviewed about getting resident care/services completed and they all said that the director of nursing (DON) was aware of their concerns of lack of help on the unit and the DON responded to their concern that they are overstaffed on the unit. NA-E stated she was not aware that staff had ever been asked for their input related to sufficient staffing. NA-E went on to say that there were times there was only one staff in the unit as the residents who have baths/showers leave the unit due to the tub/shower being outside the secured unit. NA-D verified there was one staff in the secured unit on the night shift. NA-D stated she had worked a night shift one time and will not do it again because "it's not safe." Stated there are multiple transfers that need lifts and if there are 2 staff in the room, there is often no one to supervise the residents on the unit. NA-C stated that due to the unit having residents with dementia and their special behavioral health needs the unit should not be staffed according to number of residents alone.

During an interview and observation with NA-C who is also the designated household manager, on 12/4/17 at 2:07 p.m., NA-C said that R47 was observed in his wheelchair with his feet on the floor and wearing grip socks. He was bending forward in chair attempting to pick up a playing card. NA-C excused self and picked up card for R47 and returns to continue the interview. NA-C asks to position self within line of sight of R47. At 2:10 p.m., R47 attempts to rise from his chair and NA-C again left interview to attend to R47, getting him a cookie and some cranberry juice. At 2:12 p.m., asked NA-C if any other staff were present on the unit. NA-C stated, "That is a good question, there is another NA but she is busy with

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F 741	Continued From page 63 a resident in a room." On 12/4/17, at 3:03 p.m., during an interview with the director of nursing (DON), she stated that the administrator had done the work to determine the staffing levels for the unit and that the resident utilization group levels (RUGs) were used to determine staffing an physical needs, assistance, acuity and intensity of care were considered. She stated that the dementia unit was not a one to one unit and the residents will not always be supervised if two staff are in a room. The DON stated that they try to schedule a third person during higher acuity times of the day. The DON stated the dementia unit would be comparable to the rest of the building in determining staff needs. The DON stated she was unaware of any staffing concerns with the exception of the NA that had been physically assaulted on the night shift.	F 741		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/12/18

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F 761	Continued From page 64 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure a multi-use Aplisol (used to test for tuberculosis) was dated when opened and destroyed in a timely manner; this had the potential to affect all new admission or new staff hired after 11/3/17. Findings included On 11/30/17, at 8:40 a.m., during review of medication refrigerator. An open vial of Aplisol solution (solution for testing for tuberculosis) was observed undated, with delivery date of 10/4/17, vial would have expired on 11/3/17, (30 days after delivery) since no open date on vial, Lot 301013 with manufacturer's expiration date of 2/2019. LPN-A was interviewed at this time and verified no open date was located on Aplisol vial. LPN-A also stated, Aplisol solution expires 30 days after opening or by manufacturer expiration date whichever comes first. LPN-A stated that the vial is about half-full. On 11/30/17, at 9:04 a.m. during an interview with the Director of nursing regarding the outdated Aplisol. The DON said, "I would expect vial is date when it is opened."	F 761	F761: Gundersen Tweeten Care Center will continue to ensure that drugs and biological drugs used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Licensed Nursing staff were re-educated on 12/22/17 regarding open dates and expiration dates for biological drugs and medications in multi-use vials. Compliance will be monitored weekly x12 weeks, by QA nurse auditor. Gundersen Tweeten Care Center Multi-Dose Vial Storage policy was reviewed and updated.	

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F 761	Continued From page 65 Policy: Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Effective date 2/2015. Page 48 reads: D. When the original seal of a manufacturer's container or vial is broken, the container or vial will be dated. 1) The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a "date opened" and "expiration" notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating. E. Nurse will check the expiration date of each medication before administering it. F. No expired medication will be administered to a resident.	F 761		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		1/12/18

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F 865	Continued From page 66 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility quality assessment and assurance (QAA) committee failed to identify and monitor on-going compliance of a quality deficiency related to falls in the woodland (memory care) unit, while discussing and reviewing of falls though-out the year. This resulted in another issued deficient practice for 2 of 3 residents (R47 & R10) reviewed for fall that resided on the Woodland unit issued at F689. Findings include: Fall committee minute reviewed for past 4 months were requested, received and included the following: 8/8/17, indicated there were eight falls, since last meeting. No date available. Also indicates that trends show more falls occurring in the evening. 9/12/17, indicated there were seventeen falls, since last meeting on 8/8/17, with one resident having six falls and his family does not want therapy. There had been no indication of time of falls include in meeting minutes. 10/10/17, indicated that there were nine falls since 9/12/17, with two residents having multiple falls. Also indicating that taking of medications, time of day (evening worse than day), diagnoses as common trends for falls. Also indicated that falls rate is three times higher in Unit I (Woodlands/Memory Care) vs. Unit II (Whispering Pines). 11/14/17, indicated that since last meeting on	F 865	F865: Gundersen Tweeten Care Center□s Quality Assessment and Assurance Committee will continue to identify and monitor gaps in systems and work to improve these gaps based off of the QAPI plan developed for the facility. R47 has been seen by PA-C (date) for medication adjustments; OT has evaluated R47 and are working on safe w/c positioning to decrease risk of falls. R10 was assessed by the PA-C (date) and family was contacted regarding medication adjustments for him as his behavior has been agitated and restless causing an increase in falls. Interventions identified on the fall investigation summary will be added to the residents care plan and resident care assignment sheets at time of completion. GTCC continues to work on falls as a quality initiative and reports are given at quarterly QAA meetings.	

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F 865	Continued From page 67 10/10/17, there were 29 falls in the facility, with 3 residents identified as having had multiple falls. It identifies that 80 percent (%) of falls have been related to medication changes within the past two weeks, more falls are happening in the evenings, 75% are taking medication that add risk to falling. During interview on 12/4/17, at 5:10 p.m. registered nurse (RN)-B stated, that they had been in a two-year Performance-based Improvement Project Program (PIPP) grant for falls. They identify tends, look at contributing factors, and reevaluate and change program as needed. Falls are reviewed at safety committee meetings and IDT. However, the QAPI had not included falls as a goal to identify and determine quality deficiencies regarding falls even though falls was cited in the past two surveys. Quality Assurance and Performance Improvement (QAPI) Written Facility Plan: Effective date 11/1/2017 Purpose: The purpose of a QAPI plan is to identify, track, organize, analyze, and improve healthcare outcomes at Gunderson Tweeten Care Center, towards a healthy population of residents and staff, who are functioning at their best possible ability level. I. Addressing Clinical Care Clinical care quality is addressed in our QAPI program though the following a. Audit clinical record internally b. Monitor delivery of care c. Mentoring and orientation processes d. Track care outcomes through standardized reports e. Discuss clinical situational problem solving	F 865		

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F 865	Continued From page 68 among leaders at daily standup, bimonthly department head, and meetings as needed. f. Consultant Pharmacist feedback monthly g. QA (Quality Assurance)meeting quarterly h. RA meetings monthly (in the policy) i. Medicare Meetings weekly j. Care Conference quarterly and prn (as needed) Gunderson Tweeten Care Center strives to provide excellence in care, our leadership team will focus on evidence based reporting to gauge success. We will look to internal data to monitor trends, track incidences and review cases; look to standardized benchmarking to compare our data now to our historical data and compare out outcomes to comparable state and national outcomes. An undesirable or outlier result may be a candidate for an improvement process. Gunderson Tweeten Care Center may utilize the following in this decision-making: i. Internal falls data tracking and rates. m. Existing policy and protocol comparative work patterns n. Evaluation of existing systems and effectiveness of them based on staff feedback. o. Internal staff feedback and expertise regarding a specific concern, problem, or situation.	F 865		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		1/12/18

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F 880	Continued From page 69 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 70 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were aware of a skin infection and physician orders were not completed timely regarding interventions to prevent the spread of facial infection for 1 of 1 resident (R16) who was diagnosed with impetigo. In addition, the facility failed to prevent the spread of infection regarding he use of a glucometer stored with other glucometers and not being disinfected as recommended by the centers of disease control (CDC) this had the potential to affect 1 of 4 residents (R20) who utilized a multi use glucometer. Findings Include: R16's physician progress note dated 11/27/17, identified R16 was seen by physician assistant certified (PAC)-D due to lesions on her left cheek.	F 880	F880: Gundersen Tweeten Care Center will continue to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. R16 impetigo has since healed and no other residents showed signs or symptoms of impetigo. All licensed nursing staff and medical providers were re-educated on common diagnoses requiring precautionary measures and type of precaution recommended. Nursing staff was educated on importance of following physician orders and the cleaning/disinfecting procedure and storage of glucometers. GTCC Infection	

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F 880	Continued From page 71 R16 had multiple lesions on her left cheek and chin which she picks at, and these have resolved in the past with mupirocin ointment (antibiotic used to treat infections of the skin such as impetigo) according to PAC-D notes. PAC-D's assessment and plan included: skin picking habit, order mupirocin 2% ointment TID (three times a day) for seven days for superficial infection. Trim fingernails short. R16's current physician orders identified mupirocin ointment 2% thin layer topical to open areas on left cheek and chin three times a day, diagnosis impetigo. During observation on 11/28/17, at 1:32 p.m., R16 was seated in a chair in the living room area. R16's fingernails were long with visible black debris underneath the nailbeds on both hands. R16 had dry light colored scabs on right side of chin and some scabs on left side of cheek. R16 stated she itches it. R16 was observed to be picking scabs on chin with soiled fingernails during observation. During observation on 11/29/17, at 9:51 a.m., R16's fingernails remained soiled with black debris on all fingers of both hands. During observation on 11/30/17, at 7:15 a.m., R16 was sitting on the edge of her bed in her room. R16's fingernails were trimmed and clean. R16 stated she had a bath. During interview on 11/30/17, at 7:24 a.m., licensed practical nurse (LPN)-A stated R16 had an order for Neosporin for areas on her face. LPN-A stated R16 was burnt from oil a long time ago and it started flaring up now, that is why R16 was getting the Neosporin to her face. When queried if R16 had an infection LPN-A stated no.	F 880	Prevention Program Guidelines Policy was reviewed and updated accordingly for precautionary measures and glucometer cleaning. Infection Control Nurse will monitor bi-monthly x3 months. Results of monitoring will be reported quarterly QAA meeting.	

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F 880	Continued From page 72	F 880		

LPN-A showed surveyor a tube mupirocin ointment 2%, which LPN-A stated was being applied to R16's face.

During observation on 11/30/17, at 8:45 a.m., trained medication aide (TMA)-A administered oral medications to R16. R16 was in the living room area doing an activity of folding clothes. At the time TMA-A stated R16 had a skin thing going on, I do not know if it is an infection. TMA-A stated R16 was getting an ointment and was not on any antibiotics, even though the PAC-D diagnosed it as impetigo and ordered an antibiotic ointment. TMA-A stated there was no precautions to follow for R16.

During interview on 11/30/17, at 8:31 a.m., activity aide (AA)-A the clothing R16 was sorting was not four use by anyone else, just an activity for R16 to do. AA-A stated she was not aware R16 had any infections.

During interview on 11/30/17, at 8:35 a.m., activity director (AD)-C stated she was aware R16 had had an infection, I do not know if currently active or not. AD-C reviewed notes from daily stand up meeting and stated I do not see anything in notes about an infection for R16.

During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B verified she had given R16 a bath and trimmed and cleaned R16's fingernails. When queried if R16 had an infection NA-B stated I do not think so.

During interview on 11/30/17, at 9:09 a.m., NA-A stated was not aware R16 had an infection. NA-A stated R16 had some sores on face, but was clear now. NA-A stated was not aware of any

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F 880	Continued From page 73 precautions to follow for R16. During interview on 11/30/17, at 9:48 a.m., PAC-D stated she ordered nails to be trimmed due to R16 picking skin. PAC-D stated the diagnosis R16 had of impetigo was a staph or strep infection. Any draining lesions should be covered and was transmitted by contact, by touching face and then touching someone else. Proper handwashing hygiene needed. I guess she could touch lesions and spread infection, but after being on the antibiotic, not an issue. I would have hoped with the order to trim nails, that R16's fingernails would have been trimmed by later that night (12/27/17) at least. During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) stated she did not know R16 had an infection until today. The DON stated she would expect R16's fingernails to be trimmed the evening the PAC-D ordered nails to be trimmed (12/27/17) or the next morning as soon as we could get it done, depending on what is going on. The DON stated fingernails were to be trimmed on bath days, but I also think daily when doing other cares fingernails should be looked at and to encourage R16 to wash hands often. The facility policy Care of Fingernails/Toenails, dated revised 10/16, indicated the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. The facility policy Infection prevention Program Guidelines, dated effective 11/1/17, indicated the	F 880		

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F 880	Continued From page 74 infection program exists to assure safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. R20 was observed during glucometer check on 12/01/17, at 11:01 a.m. when licensed practical nurse (LPN)-A was observed performing a blood glucose check for R20. LPN-A washed her hands and applied gloves prior to doing the procedure, LPN-A then wipe the glucometer with an alcohol pad prior to using the glucometer. After completing the blood sugar check, LPN-A placed the glucometer directly on the medication cart, removed her gloves, went to the sink and washed her hands, then went to the computer to chart the blood sugar reading, then reviewed order for insulin. Following this LPN-A went to medication cart picked up the soiled glucometer with ungloved hand, went into medication room opened treatment cart and placed soiled glucometer in a gray bin with 3 other glucometers machines. On asking about disinfecting the glucometer after testing blood sample, LPN-A said, "No, I don't think I did" LPN-A then proceeded to reopen the treatment cart and remove the glucometer used on R20. LPN-A then wiped the glucometer with an alcohol wipe and place it back into the bin with the other three glucometers. On asking about alcohol as a disinfectant, LPN-A stated, "That is what I usually clean it with." During interview with director of nursing (DON) on 12/1/17, at 11:28 a.m. the DON Stated, "We use alcohol wipe to clean the glucometer and each resident has their own machine." DON verified that even though each resident had their own machine they are stored in the same bin they	F 880		

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	245429	A. BUILDING _____ B. WING _____	12/04/2017

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F 880	Continued From page 75 have the potential of being contaminated by a glucometer that has not ben fully disinfected. During interview with registered nurse (RN)-B on 12/1/17, at 2:21 p.m. RN-B stated, "I would accept alcohol wipes to disinfect the glucometers, though I like the Sani-wipes (disinfectant germicidal wipe) better. RN-B did confirm that the maintenance guideline states that alcohol is ok for cleaning but not disinfecting the glucometers. Review of facility policy for Blood Glucose monitors, cleaning and disinfecting policy. Effective date 10/20/2016 Policy: Gunderson Tweeten Care Center will ensure that resident care items such as Blood Glucose Meters will be cleaned and disinfected according to current recommendations between each use. Review for manufactures guidelines in section B on page 19, MAINTENANCE Cleaning and Disinfecting Guidelines: Healthcare professionals should wear gloves when cleaning and disinfecting the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use. The policy to advise healthcare professionals to clean and disinfect meters between each patient test to avoid cross contamination issues. Out cleaning and disinfecting guidelines are as follows: ARKRAY's Disinfecting Guidelines: to disinfect the meter, with a 1:10 bleach solution or wipe.	F 880		

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F 880	Continued From page 76 Alternatively, if unable to use bleach solution use one of the following recommendations: Steris coverage spray HB, or Super Sani-Cloth, and Sani-Cloth HB Germicidal Disposable Wipes. These are pre-moistened towelettes manufactures by professional disposables international, Inc. To use these products, remove wipe from container and follow product instructions to disinfect meter.	F 880		

Electronically delivered
December 19, 2017

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

Re: State Nursing Home Licensing Orders - Project Number S5429028

Dear Ms. Borreson:

The above facility was surveyed on November 28, 2017 through December 4, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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 contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 28, 29, 30, December 1, & 4, 2017, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) an assessment for a change in functional ability for toileting and status of urinary continence for 1 of 3 residents (R16) reviewed for activities of daily living (ADL). Findings include: R16's quarterly MDS dated 6/13/17, identified R16 required for toilet use supervision (oversight, encouragement or cueing) with set up help only and for urinary continence R16 was always continent, had severe cognitive impairment and had diagnosis of dementia. R16's quarterly MDS dated 9/12/17, identified R16 required for toilet use extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist and for urinary continence R16 was occasionally incontinent, had	2 545	Gundersen Tweeten Care Center will continue to complete a significant change Minimum Data Set (MDS) within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident□s physical or mental condition. R16□s had an annual MDS assessment completed on 12/12/17. Gundersen Tweeten Care Center IDT team will review all residents for condition changes weekly. MDS Coordinator was re-educated to help ensure that information reported in the MDS doesn□t warrant a significate change assessment. All residents were reviewed at IDT rounding meeting. This will be monitored by Director of Nursing weekly x3 months to ensure accurate coding and monitor of need for significant changes. Results of monitoring will be	1/12/18

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2 545	Continued From page 3 severe cognitive impairment and had diagnosis of dementia. During interview on 11/30/17, at 7:15 a.m., R16 stated she wears an incontinent pad and goes to the bathroom on her own. During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B stated R16 wears a pull up (incontinent product), R16 is on a list for staff to check hourly for needing to use the toilet and R16 was usually continent, but once in a while may be wet. During observation on 11/30/17, at 12:49 p.m., a nursing assistant asked R16 if she needed to use the bathroom and R16 replied "no." During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the two quarterly MDS's dated 6/13/17 and 9/12/17. R16's MDS Notes Report dated 9/15/17, documented by RN-A, indicated resident is extensive assist with toileting with assist needed to complete bowel hygiene and clothing management. Resident needs constant cueing. Resident is occasionally incontinent of bladder due to bipolar disorder and impaired balance. All above care areas preformed three or more times during ARD (assessment reference date) period. During interview on 11/30/17, at 3:06 p.m., RN-A confirmed the change in status R16 had from supervision to extensive assist for toileting and from always continent to occasionally incontinent for urinary continence would qualify for a significant change MDS to be completed. RN-A stated I do not think it was a significant change in status for R16. I think it was staff lacking in	2 545	reported to quarterly QAA meeting.	

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2 545	Continued From page 4	2 545		

following up, as she can stay continent but staff lacked following up for reminding R16 to go to the bathroom. RN-A stated I did not make a note in R16's record why a significant change MDS was not completed.

During interview on 11/30/17, at 3:09 p.m., the director of nursing stated I thought three areas needed to change for a significant change MDS to be completed. If not three areas, I would expect one to be done. I would have to look up the rules. A policy regarding completing a significant change MDS was requested.

The following was provided by the DON; CMS's (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual pages 2-21 through 2-28 indicated 03. Significant Change in Status Assessment (SCSA). Assessment Management Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. Guidelines for Determining a Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the

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2 545	Continued From page 5 resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Decline in two or more of the following: Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur; Resident incontinence pattern changes or there was placement of an indwelling catheter. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop a system to identify when a significant change MDS should be completed and provide education to staff on when the MDS should be completed. The DON or her designee could develop a monitoring system of completed assessments to ensure no significant change assessments were missed. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 545		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		1/12/18

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2 560	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a person centered care plan for fingernail care for 1 of 3 residents (R42); and failed to implement the care plan for fingernail care for 1 of 3 residents, (R37) reviewed for activities of daily living (ADLs). Findings include: R42's resident face sheet identified a current admission date of 2/9/16, and a diagnosis of vascular dementia without behavioral disturbance and traumatic hemorrhage of left cerebrum without loss of consciousness. R42's quarterly Minimum Data Set (MDS) dated 10/31/17, identified R42 to have a moderate cognitive deficit and requires one person extensive assist with personal hygiene needs. R42's comprehensive care plan dated 6/3/16, identified R42 needs extensive assist with ability to complete ADLs related to brain hemorrhage and weakness, with an approach to provide 1 staff assist for nail care to hands and feet. R42 was noted to use artificial nails and this had not been identified on R42's current plan of care. Facility document, "Unit 2 bath list AM," week of 11/27/17-12/03/17, identified R42 will get a whirlpool bath on Tuesday, 11/28/17, and on Friday 12/1/17. Document further indicated to: Shampoo hair, trim nails, check for chin hairs on females and shave as needed and do a complete skin inspection on bath days. Charge nurse to initial daily with shower for adequate grooming, ensuring skin inspection is completed and to monitor for privacy with transportation to and from	2 560	Gundersen Tweeten Care Center will continue to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at 483.10 (c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Care plans were revised for resident□s R42 and R37 to include fingernail care. All other resident care plans were reviewed to ensure fingernail care is person centered and included in their care plans. The Fingernail/Toenail Policy was reviewed and updated. Staff were re-educated on the Fingernail/Toenail Policy. This will be monitored by the charge nurses daily and weekly monitoring by Case Manager. Results of monitoring will be reported to quarterly QAA meeting.	

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2 560	Continued From page 7 the shower. Charge nurse to document any abnormalities noted on skin inspection and notify director of nursing or medical doctor if noted. Turn into director of nursing weekly. During observation on 11/30/17, at 7:15 a.m., R42 had been seated in her wheelchair in her room and noted to have long painted red artificial fingernails. There was a brown substance packed and hard to touch located underneath all R42's fingernails. During interview on 11/30/17, at 7:38 a.m., nursing assistant (NA)-A verified R42 has brown substance packed underneath all of her fingernails. Further verifies R42 her bath was Tuesday morning and nail care should have been completed then. During interview on 11/30/17, at 7:46 a.m., NA-B stated, "We don't usually do nail care on R42, she goes out and gets her nails done." NA-B verified resident has artificial nails that her family member (FM)-A takes her out in the community to get done. NA-B further verified brown substance underneath all of R42's fingernails and stated that nail care should have been done. During interview on 11/30/17, at 7:50 a.m., licensed practical nurse (LPN)-A verified that nail care is typically done on bath days and R42 had a bath Tuesday morning. LPN-A further verified that resident has artificial nails and stated, "We don't 'monkey' with her fingernails." LPN-A further stated that R42's daughter takes her to get her nails done every 3-4 weeks. Interview on 11/30/17, at 8:55 a.m., director of nursing (DON) stated all residents should nail care completed on bath days. Further stated nails	2 560		

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2 560	Continued From page 8	2 560		

should be checked every a.m. and p.m. with cares. DON continued to say, "My expectation is for staff to check R42's fingernails every day and clean as necessary regardless whether she has fake fingernails or not."

On 11/30/17, at 12:54 p.m., DON verified R42 goes out in the community to get artificial fingernails and that her expectation is to have her care plan to be resident centered to include going out into the community for artificial nail care.

Facility policy, "Baseline Care Plan Policy," dated 10/4/17, identified the care plan at a minimum will identify the following information: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and instructions needed to provide person-centered care that meets professional standards of care.

R37 was observed on 11/28/17, at 2:49 p.m., to have soiled finger nails on right and left hands.

During observations on 11/30/17, at 9:14 a.m., R37 was awake and in bed. Observations at that time revealed under finger nails soiled with debris. R37 stated finger nails were cleaned with shower two times a week.

R37's care plan dated 10/13/17, directed staff R37 was limited in ability to complete activities of daily living related to weakness and recent hospitalization. Interventions included to provide one staff assist for nail care to hands and feet.

During interview on 11/30/17, at 9:17 a.m., nursing assistant (NA)-B verified R37 received baths two times a week. NA-B stated facility routine was to check finger nails, clean and trim

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

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2 560	Continued From page 9 on bath days, and check nails often. NA-B verified the soiled finger nails at this time. During interview on 11/30/17, at 9:23 a.m., director of nursing (DON) verified the soiled finger nails. DON stated she expected staff to provide nail care on bath days and as needed. During interview on 11/30/17, at 12:53 p.m., DON stated she expected staff to provide nail care according to the care plan. Document review of facility Care of Fingernails/Toenails policy dated revised 10/2010, revealed the following: Purpose-The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines-nail care includes daily cleaning and regular trimming. Steps in the procedure include allow hand or foot to soak in warm soapy water for approximately five minutes, rinse, dry, gently remove dirt from around and under each nail with an orange stick. Documentation included the date and time the nail care was given, name and title of person who administered nail care, if nail care was refused, document reason and intervention taken, signature and title of person recording data, and notify supervisor if resident refused care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise the facility's care plan policies and procedures to ensure a person centered care plan is implemented. Pertinent personnel could be re-trained on these procedures. An auditing system could be developed for on-going compliance, with the results of those audits being presented to the facility's Quality Assessment & Assurance committee.	2 560		

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2 560	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the care plan following a change in urinary continence for 1 of 1 resident (R16) reviewed for activities of daily living (ADL). Also the facility failed to revise the plan of care after changes to fall prevention measure for 1 of 1 resident (R47) reviewed. Findings include: R16's quarterly Minimum Data Set (MDS) an assessment dated 9/12/17, identified R16 required for toilet use extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist and for urinary continence R16 was	2 570	Gundersen Tweeten Care Center will continue to develop comprehensive care plans within 7 days after completion of the comprehensive assessment. This comprehensive care plan will be prepared by the interdisciplinary team that includes the attending physician, a registered nurse that is responsible for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, to the extent practicable, the participation of the resident and the resident□s representative, and other appropriate staff or professionals in disciplines as determined by the resident□s needs or as	1/12/18

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2 570	Continued From page 11 occasionally incontinent, had severe cognitive impairment and had diagnosis of dementia. R16's MDS Notes Report dated 9/15/17, documented by registered nurse (RN)-A, indicated R16 has been assessed as needing extensive assist with toileting, with assist needed to complete bowel hygiene, and clothing management. Resident needs constant cueing. Resident is occasionally incontinent of bladder due to bipolar disorder and impaired balance. All above care areas preformed three or more times during ARD (assessment reference date) period. R16's current care plan identified, Problem Activity of Daily Living: I require one staff assist with daily ADL's. Short Term Goal Target Date: 12/12/17, I want staff to assist me to the toilet and assist me with cares. Approach start date 3/19/17, I want staff to assist me with my pericare and clothing management as needed. Approach start date 12/21/16, I want Staff to walk with me to the toilet. R16's nursing assistant (NA) care plan (used by NAs to reference needed cares/services) updated 10/30/17, identified toilet: stand by assist and walker. During interview on 11/30/17, at 7:15 a.m., R16 stated she wears an incontinent pad and goes to the bathroom on her own. At 12:31 p.m., R16 was observed walking down the hallway independently using a seated four wheeled walker. During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B stated R16 wears a pull up incontinent product. R16 is on a list for staff to check hourly for needing to use the toilet and R16 was usually continent, but once in a while may be	2 570	requested by the resident. This comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. GTCC will continue to revise care plans with significant change MDS assessments. Care plans were reviewed and updated for resident R16 and R47 to include care needs and fall interventions. All other resident care plans will be reviewed for updates as their MDS comes due over the next quarter. Interventions identified on the fall investigation summary will be added to the residents care plan at time of completion, fall investigation summaries will be completed weekly by the fall team. This will be monitored by the IDT team at quarterly care plan conferences.	

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2 570	Continued From page 12 wet. During observation on 11/30/17, at 12:49 p.m., an unidentified NA asked R16 if she needed to use the bathroom and R16 replied no. During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the MDS's dated 9/12/17, and confirmed R16 had a decline with toilet use and urinary continence. During interview on 11/30/17, at 3:22 p.m., RN-A reviewed R16's care plan and confirmed the care plan had not been revised to identify R16's occasional incontinent of urine nor were incontinence interventions developed based on the current assessment completed. During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) verified R16's care plan did not address R16 being occasionally incontinent of bladder or how often R16 should be offered use of the toilet. R47 was admitted on 8/1/17 according to the face sheet. Also found on the face sheet was diagnosis of Alzheimer's disease with delirium, chronic pain-bilateral arthritis (in both knees), vascular dementia with behavioral disturbance, restlessness and agitation, repeated falls, and insomnia. R47's quarterly Minimum Data Set (MDS), dated 11/7/17, identified through the use of a brief indicator of mental status (BIMS) a score of 3 indicating R47 is assessed to have severe cognitive impairment. The MDS also identified R47 had difficulty focusing attention, was easily distracted, had difficulty keeping track of what	2 570		

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2 570	Continued From page 13 was said, and disorganized thinking. On 8/11/17, at 6:05 p.m.,, R47 had initial fall, unwitnessed in hallway wearing another resident's glasses. On 8/12/17, at 8:20 pm, unwitnessed, found with left leg lying over the leg of the Hoyer lift. On 8/24/17, at 10:45 pm, unwitnessed, found lying on the floor. On 9/8/17, at 5:40 a.m. unwitnessed, found lying on the floor in his room with a chair over his abdomen. Interventions to prevent further falls include: frequent observation, offer to toilet, continue to ensure has shoes available, room free of clutter, lights on at night. On 9/10/17 at 11:00 a.m., unwitnessed, found on floor another resident was hitting him, eyeglasses were on the floor. On 9/10/17 at 9:10 p.m., unwitnessed, nursing in the next room, according to progress note, "Res [resident] was heard moving furniture from the room next door to his. Staff heard a loud noise and went to check on Res and found him lying on the floor on his back." Resident sustained a hematoma to the back of his head and complained of left arm/shoulder pain. Interventions to prevent further falls included: monitor frequently, refer to MD for analgesic (pain) medication review related to the knee pain. On 9/25/17, at 2:55 p.m. unwitnessed, found in nursing office on floor, fell from wheeled chair. Interventions to prevent further falls include: close door to office, monitor seating to ensure safety, frequent rounding.	2 570		

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2 570	Continued From page 14 On 10/5/17, at 6:20 a.m., unwitnessed, found in room on floor lying on left side. Interventions to prevent further falls include: continue care plan as currently stated, attempt to have R47 wear shoes. On 10/6/17, at 12:15 a.m. this fall is classified as witnessed by the facility. Staff called for assist as R47 was on the edge of his recliner. Called back and said R47 was on the floor. Interventions to prevent further falls include: ensure safe sitting position. On 10/12/17, at 5:05 a.m., unwitnessed. Found on floor in his room next to a chair. Interventions to prevent further falls include: frequent supervision and continue care plan as stated. On 10/13/17, R47 found sitting on floor and when asked denied he fell. Unwitnessed. No incident form filled out. On 10/23/17, at 3:40 a.m., unwitnessed. Staff heard someone yelling help. R47 found sitting on the floor in bathroom doorway. A garbage can was noted to be in the toilet. Interventions to prevent further falls include: provide supervision and assistance, provide footwear. On 10/25/17, at 6:00 a.m., unwitnessed. Staff heard R47 hollering in his room. Found sitting on floor with no lower clothing or brief on. Urine was on the floor where he fell. Interventions to prevent further falls include: provide supervision and assistance when noticed he has a need. On 10/31/17, at 2:30 a.m., unwitnessed. Heard saying "help me, I can't stand up. Found sitting in his room by the door. Interventions to prevent further falls include: follow care plan as stated,	2 570		

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2 570	Continued From page 15 anticipate needs. On 11/2/17, at 12:35 a.m., unwitnessed. Found on floor in his doorway with another resident standing over R47. The staff member on the unit was trying to assist another resident who was trying to get out of bed at the same time. Interventions to prevent further falls include: frequent supervision and anticipate needs. On 11/9/17, at 6:56 p.m., unwitnessed. Found lying on the floor in his room between dresser and night stand. Interventions to prevent further falls include: continue care plan as stated. Anticipate needs and frequently monitor. On 11/10/17, at 4:44 a.m., unwitnessed. Staff member doing rounds, heard resident "scream" found on floor in living room. Interventions to prevent further falls include: follow care plan, anticipate needs. On 11/11/17 at 3:45 p.m., unwitnessed. Fell in his room. Hit his head on the wall. Interventions to prevent further falls include: frequent monitoring and anticipate needs. On 11/12/17 at 7:45 a.m., unwitnessed. Found in dining room. Interventions to prevent further falls include: follow care plan. On 11/15/17 at 1:15 p.m.., unwitnessed, found lying on floor in dining room. Interventions to prevent further falls include: provide distraction, one to one care, and frequent supervision. On 11/15/17 at 5:55 p.m., unwitnessed. R47 found in his room on the floor. No interventions provided.	2 570		

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2 570	Continued From page 16 On 11/17/17 at 11:15 a.m., unwitnessed. Found on mat next to bed. Interventions to prevent further falls include: continue with mat at the bedside. On 11/17/17, at 3:15 p.m.., unwitnessed. Found in dining room next to his wheelchair. Dining room chair was tipped over next to him. Interventions to prevent further falls include: provide frequent supervision, offer 1:1 or distractions. On 11/18/17, at 4:30 p.m., witnessed. NA-witnessed R47 shaking and fall from his chair. A family member who had been visiting in the dementia unit went to go get help. Interventions to prevent further falls include: frequent supervision, medication review. On 11/21/17, at 4:10 p.m., unwitnessed. Found on floor in dining room. Interventions to prevent further falls include: continue to work with physician and physician assistant for effective medications for aggressive behavior. On 11/24/17, at 5:45 p.m., witnessed. The NA on the unit observe R47 get up from his wheelchair, take a few steps and fall. Interventions to prevent further falls include: provide distraction, redirection, frequent supervision, monitor for restlessness and provide for needs, Frequent rounding On 11/29/17, at 4:12 p.m.., witnessed. NA- saw R47 fall from wheelchair and land on his left side. R47's care plan dated 8/1/17, identified a risk for falls due to memory loss and poor safety awareness as well as the need for assistance for safe mobility. The interdisciplinary team had	2 570		

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2 570	Continued From page 17 indicated in multiple post fall follow ups that the resident was to be frequently observed, monitored, keep separated from other resident when argumentative, keep the door closed to the nursing office, anticipate needs, provide distraction, one to one care, mat on the floor, and medication review. These interventions were not included in R47's care plan, nor were any fall related interventions located on the nursing assistant (NA) kardex (a trademark for a card-filing system that allows quick reference to the particular needs of each resident for aspects of nursing care). During an interview on 12/4/17, at 3:03 p.m., the director of nursing (DON) stated she would expect the interventions following a fall be included on the current care plan for the residents. Also for staff to follow the care plan interventions as written. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident care plans are updated and revised as appropriate. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		1/12/18

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2 830	Continued From page 18 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to reassess pain control measures and notify the physician timely when pain was not controlled for 1 of 1 resident (R48) reviewed for a death record. Findings include: R48's quarterly Minimum Data Set (MDS) dated 7/4/17, identified R48 had moderate cognitive impairment, had occasional pain, pain intensity (numeric rating scale 0-10) was three and had no pressure ulcers. R48's wound care skin integrity evaluation, dated 8/1/17, identified R48 had an unstageable pressure ulcer right ischial tuberosity. R48's care plan identified Last Reviewed/Revised: 8/23/17, Problem: I am at risk for skin breakdown and bruising. I have a Braden score of 20. Start Date: 8/23/17, Approach: Open area will be cleansed and dressed daily. Area will be measured frequently and wound nurse will	2 830	Gundersen Tweeten Care Center will continue to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident□s choices. R48 expired on 8/31/17. All charge nurses were educated on policy to notify the physician when pain is not controlled adequately for all residents on 11/13/17. This will be monitored by QA nurse with routine chart audits for all residents that are requiring pain management. Results of monitoring will be reported to quarterly QAA meeting.	

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2 830	Continued From page 19 follow. Approach: I have an open area on right hip. Staff to turn and reposition me off that area. Approach: I agree that the nurses will monitor my ability to move, reposition, and the status of my skin. If anything changes with my mobility or skin status, the nurses will again monitor. Last Reviewed/Revised: 8/23/17, Problem: I have pain related to arthritis that is mild in my back and my legs. Approach: I would like Nurse to monitor and record any complaints of pain: location, frequency, intensity, affect on function, alleviating factors, aggravating factors. Start Date: 4/04/17, Approach: I would like staff to monitor and record any non-verbal signs of pain I might experience: (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.). Start Date: 4/04/17, Approach: I would like the nurse to administer medications: Tylenol. Evaluate/record/report effectiveness and any adverse side effects I develop to my doctor. Approach: I would like to try non-medicine pain relief measures before taking a pill or narcotic: (e.g., position changes, biofeedback, application of heat/cold, massage, physical therapy, stretching and strengthening exercises, acupuncture, etc.). Monitor effectiveness and offer alternatives to me. R48's nursing progress notes dated from 7/21/17 through 8/30/17, identified the following: -7/21/17, nurse practitioner (NP)-E know of open area. Changed dressing from bid (twice daily) to qd (everyday) with dressing order of wash, pat dry, mix collagen and hydrogel together to form a gel and fill cavity, and cover with foam dressing. -8/01/17, was complaining of her bottom hurting ever since laying in bed last evening. Resident was repositioned multiple times. -8/02/17, was complaining of pain in her bottom at HS (bedtime) last evening and then periodically	2 830		

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2 830	Continued From page 20 throughout the night. -8/03/17, was not feeling well this morning and eating breakfast in her room. On Monday she was afraid to be alone as she thought she was going to die. -8/03/17, did not want to eat lunch but was persuaded to come out to the dining room. Had a small emesis and large liquid stool at 12:00 p.m. -8/03/17, resident stated to staff she was having increased pain to buttocks area where sore is currently located. Dressing was changed and resident was turned onto side to help eliminate pain to the area. Currently resting with eyes closed. Will continue to monitor. -8/06/17, Resident yelled out "help me" many times this shift, because her bottom and back hurt. Resident was repositioned frequently. Resident complained of a lot of pain during her dressing change last evening. Staff gently patted the area to clean it and resident winced and said "ow" the entire time. -8/06/17, did c/o (complained of) R (right) leg pain and refused to come to dining room or eat anything for lunch due to feeling nauseous. -8/07/17, complained of back and bottom pain with cares. -8/07/17, aid reported that resident had a large emesis after lunch. -8/08/17, complained of pain in buttocks related to open sore. -8/09/17, yelled out "help me" multiple times this shift to complain of back and bottom pain. Resident was repositioned many times during the night. Resident never once rang her call light for help and told staff that she did not have it, but it was clipped to her chest. -8/10/17, yelled out "help me" once this shift because she was having back pain. Resident was repositioned and had no further complaints. -8/11/17, yelled out "help me" once this shift	2 830		

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2 830	Continued From page 21 because of pain in her bottom. Resident was repositioned at this time to help relieve the pressure on her bottom. Resident was repositioned every two hours this shift -8/12/17, complained of pain in her bottom a few times this shift. Resident was repositioned every time and given Soothing Relief essential oils once. Interventions were effective. -8/12/17, was gaggy mid-morning, but has had no actual emesis yet. -8/13/17, complained of a sore bottom at bedtime and once in the overnight. Resident was repositioned and had no further complaints. -8/14/17, vomited earlier in the shift foods she had recently ate. Showed an increase in confusion, rang call light several times and when asked what she needed she stated she did not know and did not realize she had pressed her call light. Complained of pain to her bottom. Will continue to monitor. -8/14/17, dressing change done---no change noticed by this nurse, since I last dressed it 8/9/17. C/O's of much discomfort with the dressing change. -8/16/17, C/O R leg pain and buttock pain. Resident refused to get out of bed this a.m. -8/16/17, refused her medication this evening, because she said staff was trying to poison her. Resident finally agreed to take medication after staff explained that she could trust the staff, but resident held them in her mouth and refused to swallow. -8/17/17, called out "help me" almost the entire night. Resident was repositioned multiple times this shift. Resident continued to yell when staff had just helped her with all of her needs. -8/17/17, ate breakfast in the dining room. Lunch brought to her room but did not eat. She did drink two glasses of boost. Threw up AM meds. -8/18/17, dressing changed last evening.	2 830		

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2 830	Continued From page 22 Resident yelled out "help me" once in the overnight because she was sore in her bottom. Resident repositioned and had no further complaints. -8/19/17, c/o pain in her buttock area due to sore. Resident agreed to be repositioned onto her side in bed. No further c/o pain where offered as of this time. -8/20/17, vomited this morning after taking medications. -8/21/17, yelled out "help me" frequently during the overnight, but did not always need anything from staff or she would continue to yell when staff was already helping with what she needed. -8/23/17, does not use call light she yells out "help me" or just yells. Staff reminds her where her call light is and she is to use to summons staff for assistance. She has been turned off her bottom every couple hours. She has offered no complaints of discomfort. -8/23/17, dressing changed this evening. Resident complained of pain when dressing was being taken off and when wound was being cleaned. Resident yelled "help me" almost constantly this shift. Staff would go into resident room and ask what she needed and resident would say she did not need anything. Resident yelled "help me" during dressing change. When staff asked what she needed she said "I need help". Staff asked what she needed for help and resident said "I don't need anything". Other staff mentioned that resident did the same thing when they went in to see what she needed multiple times. -8/24/17, had complained of aching all over PRN Tylenol given along with use of Soothing relief EO. Has yelled out much of the night saying "help" but when asked what she needs help with she would state nothing. Attempted to place on her R side for different position but this did not	2 830		

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2 830	Continued From page 23 last long. -8/24/17, complained of pain during cares and when staff was doing her dressing change. Resident yelled out "help me" many times this shift, but said she did not need anything when staff went to check on her. Resident threw up at 9 p.m. this evening. TMA (trained medication aide) mentioned that it was a lot of emesis at this time. -8/25/17, has been yelling out help me all night when staff is providing cares and when standing at bedside to help she would yell. She complained of discomfort when being repositioned. PRN (as needed) Tylenol was given and also used Calming EO with little effectiveness. -8/26/17, yelled out "help me" almost constantly all night. Resident complained of pain on her bottom. PRN Tylenol was given and Soothing Relief essential oils applied, both were not effective. -8/26/17, up at 10 a.m. Stating, "Help me!" Out to dining room for noon meal but refused to eat. Drank 120 cc of Health shake. Will continue to monitor. -8/27/17, dressing changed last evening. Resident yelled "help me" almost all night, but when staff checked on her she just continued to say "help me" and never say what she needed. -8/28/17, lying in bed restless tonight. Resident continues to complain of pain to buttocks area. Tylenol offered and not effective. Dressing changed on previous shift and wound appears to be deeper and bleeding a little. Resident yells out "help me" on and off throughout the shift, when asked what she needs Resident replies that she does not know or that her bottom is hurting her. -8/28/17, notified daughter of the Dr. visit scheduled for tomorrow for referral to Hospice. She is in agreement that this is appropriate at this time.	2 830		

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2 830	Continued From page 24 -8/28/17, was weak throughout a.m. cares. Did sit up in her recliner but continues to yell "help me". When asked how we can help she offers c/o pain in her buttock area or will say, "i don't know how you can help me". Resident refused to come out for lunch. She is resting at this time. -8/28/17, is eating very little and is unsettled often yelling "help me, help me" from her bed. C/O pain on her butt where she has a 1.1 x 1.0 open area on R buttock. Nsg (nursing) doing tx (treatment) t (to) R buttock wound. Hard to heal wound when eating so poorly. Dietary. -8/29/17, yelled out "help me" this entire shift and did not get much sleep. Resident would not say what she needed when staff went in to check on her, she just continued to yell for help. -8/29/17, complained of pain all over and in buttock area. Resident repeating "help me" but cannot tell aids or nurse what we can do to help her. Continue to monitor resident condition. -8/29/17, seen by MD (medical doctor) to order consult for Hospice, lorazepam (antianxiety) 0.5 mg (milligrams) p.o. (oral) once now, morphine (narcotic)20 mg/1 ml (milliliter) 2 mg p.o. every 2H (hours) prn hold if patient is not responsive to voice. -8/30/17, has been resting at times she will say "help me" staff has been providing cares as needs-difficulty with drinking water or any fluids through straw. Has no MSO4 (morphine) here yet and need to fax hard copy to pharmacy to take out of E-kit. -8/30/17, family here visiting. Family not happy about resident not having morphine available yet. Morphine finally given at 12:58 p.m. R48's record identified a pain management/observation assessment was completed last on 7/10/17 and indicated had complaints of right hip/thigh pains. Did have	2 830		

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2 830	Continued From page 25 several falls at home. X-ray revealed osteoarthritis. Does not complain of any other pain. Physician orders for pain treatments as follows: R48's physician orders identified the following orders with start dates: 4/18/17 Tylenol 650 mg three times a day 6/19/17 lidocaine patch 4% apply patch every am and remove every HS 7/7/17 may use soothing relief essential oil to support relief of anxiety, nausea and muscle or joint aches. 8/3/17 open area on right buttock, cleanse/pat dry/mixture of collagen and normal saline to form gel/place in wound bed/cover with hydrogel sheet/cover with foam dressing/change every day until healed 8/2/17 apply calming oil for anxiety 8/7/17 to lay on left side and back reposition with pillows every two hours 8/13/17 Tylenol 500 mg one tablet every four hours PRN for fever greater than 100 degrees, mild pain or headache. Maximum dosage 3000 mg/24 hours 8/29/17 lorazepam 0.5 mg one time 8/29/17 morphine concentrate 100 mg/5 ml (20 mg/ml) 2 mg (0.1 ml) every two hours PRN chronic pain, hold for signs and symptoms of over sedation (unresponsiveness to voice, low heart rate) 8/29/17 Hospice consult R48's medication and treatment records for the month of 8/17 identified the following had been administered: Calming oil for anxiety was applied for relief on 8/4, 8/5 and 8/25. Soothing relief essential oil to support relief of anxiety, nausea and muscle joint aches was	2 830		

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2 830	Continued From page 26 applied 8/2, 8/4, 8/24 and 8/25 Lidocaine patch as ordered Tylenol 650 mg three times a day as ordered Tylenol 500 mg on 8/14, 8/23 and 8/25 (twice) Treatment to open area right buttock as ordered Lorazepam 0.5 mg one time as ordered Morphine concentrate 0.1 ml first dose on 8/30/17 at 12:58 p.m., at 4:47 p.m. and on 8/31/17 at 8:00 a.m. R48's record lacked documentation regarding a comprehensive pain assessment had been completed after 8/1/17 when R48 had increased complaints of pain buttock area. In addition, the record lacked documentation a physician had been notified regarding the increased complaints of buttock pain and R48 having had emesis. There is also no documentation that the resident received pain medication prior to dressing change to decubitus ulcer. During interview on 12/01/17, at 10:50 a.m., the director of nursing (DON) stated all resident records were in the computer system, and there were no paper records. When queried if the physician was notified of increased pain complaints in buttocks, emesis and refusing medications, the DON stated it could be on the 24 hour report sheets. When queried if the 24 hour sheets would show the physician was notified the DON replied it could be. At 2:28 p.m. the DON said registered nurse (RN)-A had no luck finding the physician was notified of the pain in buttocks and emesis. DON stated she had reviewed the physician orders and physician notes and could not find where the physician was notified either. The DON reviewed R48's progress notes and stated the physician was made aware of the wound on 8/1/17 because he signed the wound nurse orders. DON stated in regards to Morphine	2 830		

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2 830	Continued From page 27 availability, we have morphine on hand in the E-kit (emergency kit) unless it would have been pulled for somebody else already. DON stated the pharmacy had to be faxed a hard copy of the order, then the pharmacy gives a code for us to take the medication out of the Ekit. We cannot take it out of the Ekit until they give us a code. DON stated I cannot prove one way or another if the physician was notified of pain in buttocks and emesis. During interview on 12/04/17, at 12:55 p.m., registered nurse (RN)-A verified she completed R48's wound assessments. RN-A stated I do not put pain on the wound assessments, but we do talk about that when we measure and usually the nurse who helps me at the time of the wound treatment documents that in the nurse notes. When queried if she was aware R48 had pain in buttocks, RN-A stated I asked the family member (FM)-B and she said R48 was not having pain in buttocks, because R48 was getting pain meds and she did not want her in pain. That is why I could trust what FM-B said. I asked FM-B how she knows R48 was doing well because R48 was yelling and how did she know was not pain and FM-B said because R48 told me. RN-A stated I asked the nurse if thought R48 was in pain and if was to get physician assistant certified (PAC)-D on it. When queried if she had ever notified the physician regarding R48 complaints of pain, RN-A reviewed R48's record and stated no. RN-A verified a physician had not been notified regarding complaints of pain in buttocks. During phone interview on 12/04/17, at 1:18 p.m., nurse practitioner (NP)-E reviewed R48's clinic record and stated there was no record of a physician being notified about pain from 7/7/17 until 8/29/17, when he mentioned buttocks pain	2 830		

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2 830	Continued From page 28 and then we started morphine and ordered Hospice services. The facility policy Pain Management dated effective 12/1616, indicated Policy: The pain management program is based on a facility wide commitment to resident comfort in which staff will help to identify pain in the resident, and will develop interventions that are consistent with resident's goals and needs and that address the underlying causes of pain. Procedure: 1. Upon admission, quarterly, with significant change and when there is a new onset of new pain or worsening of existing pain, a pain assessment will be completed. The facility policy Notification of Changes, dated effective 9/12/17, Procedure: Purpose Gunderson Tweeten Care Center shall promptly notify the resident and/or the resident representative and his or her physician or delegate of changes in the resident's condition or status in order to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences. Procedure 1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list is not all inclusive): b. A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review, revise and/or develop polices and procedures regarding pain and notifying the physician for change in condition.. The Director of Nursing or designee could educate staff on the policies and	2 830		

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2 830	Continued From page 29 procedures. The Director of Nursing or designee could develop a monitoring system to ensue residents receive the appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess and implement interventions to improve toileting ability and urinary incontinence or prevent decline for 1 of 1 resident (R16), who had a decline with toilet use and urinary continence.	2 915	Gundersen Tweeten Care Center will continue to provide the necessary care and services to ensure that a resident□s abilities in activities of daily living do not diminish unless circumstances of the individual□s clinical condition demonstrate that such diminution was unavoidable,	1/12/18

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2 915	Continued From page 30 Findings include: R16's quarterly Minimum Data Set (MDS) dated 6/13/17, identified R16 required for toilet use supervision (oversight, encouragement or cueing) with set up help only and for urinary continence R16 was always continent, had severe cognitive impairment and had diagnosis of dementia. R16's quarterly MDS dated 9/12/17, identified R16 required for toilet use extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist and for urinary continence R16 was occasionally incontinent, had severe cognitive impairment and had diagnosis of dementia. During interview on 11/30/17, at 7:15 a.m., R16 stated she wears an incontinent brief and goes to the bathroom on her own. At 12:31 p.m., R16 was observed walking down the hallway independently using a seated four wheeled walker. During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B stated R16 wears a pull up (incontinent product), R16 is on a list for staff to check hourly for needing to use the toilet and R16 was usually continent, but once in a while may be wet. During observation on 11/30/17, at 12:49 p.m., an unidentified NA asked R16 if she needed to use the bathroom and R16 replied no. During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the MDS's dated 6/13/17 and 9/12/17. R16's MDS Notes Report dated 9/15/17, documented by RN-A, indicated resident is	2 915	based off of the comprehensive assessment of a resident and consistent with the resident□s needs and choices. Resident R16 was referred to Occupational Therapy for decline in urinary incontinence. All other residents were reviewed for a decline in urinary incontinence and toileting ability and addressed as appropriate. The IDT will monitor monthly with review of Casper Report. Results of monitoring will be reported to quarterly QAA meeting.	

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2 915	Continued From page 31 extensive assist with toileting with assist needed to complete bowel hygiene and clothing management. Resident needs constant cueing. Resident is occasionally incontinent of bladder due to bipolar disorder and impaired balance. All above care areas preformed three or more times during ARD (assessment reference date) period. R16's Elimination urinary Incontinence Observation assessment date 9/15/17, identified: does resident have a prior history of incontinence - yes, onset prior history - new, duration of prior history - one year, precipitants of urinary incontinence in prior history - pain, product type - brief, urinary continence - occasionally incontinent (less than 7 episodes of incontinence), medication review - antidepressants/diuretics, factors that could enhance urinary continence and limitations that could adversely affect continence - decreased vision/impaired cognitive function/impaired mobility, toilet use - extensive assist, toilet use support - one person physical assist, does resident recognize need to void and in the appropriate place - yes, reversible/controllable conditions or pertinent diagnoses that could affect the urinary tract or its function - arthritis/depression/falls, cognitive skills - modified independence/some difficulty in new situations only, incontinence symptom profile - no nocturia or incontinence at night, environmental factors and assistive devices - grab bars/use of side rails. Evaluation: may benefit from facility defined toileting schedule, absorbent products, adaptive equipment. Referrals: activities, physician update. Plan of care: continue plan of care. Analysis of bladder assessment: resident is occasionally incontinent of bladder. No interventions are needed. Resident is able to use call light to let staff know needs to toilet. Keep call light in reach.	2 915		

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2 915	Continued From page 32 The assessment lacked to identify the type of incontinence (stress, urge, mixed, overflow, functional) and a comprehensive analysis. R16's current care plan identified, Problem Activity of Daily Living: I require one staff assist with daily ADL's. Short Term Goal Target Date: 12/12/17, I want staff to assist me to the toilet and assist me with cares. Approach start date 3/19/17, I want staff to assist me with my pericare and clothing management as needed. Approach start date 12/21/16, I want Staff to walk with me to the toilet. R16's nursing assistant care plan (used by nursing assistants to provide cares/services for each resident) updated 10/30/17, identified toilet: stand by assist and walker. During interview on 11/30/17, at 12:58 p.m., registered nurse (RN)-A confirmed the above documented information for the MDS's dated 6/13/17 and 9/12/17, and confirmed R16 had a decline with toilet use and urinary continence. During interview on 11/30/17, at 2:32 p.m., RN-A confirmed R16 urinary assessment dated 9/15/17, lacked to identify the type of incontinence. RN-A stated no she had not notified R16's physician regarding R16's decline with toilet use and urinary continence. When queried if R16's decline with toilet use and urinary continence was discussed as a team, RN-A stated I bring it up in care conference. When queried if R16 had received occupational therapy (OT) evaluation for the decline in toilet use and urinary incontinence, RN-A replied I did not notify OT about it. When queried regarding the assessment dated 9/15/17, lacked a	2 915		

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2 915	Continued From page 33	2 915		

comprehensive analysis, RN-A stated staff (referring to NAs) told me it was behavioral and R16 would benefit from prompting/cueing, so I told them to do that.

During interview on 11/30/17, at 3:22 p.m., RN-A reviewed R16's care plan and confirmed the care plan lacked to be revised to identify R16 was occasionally incontinent of urine and interventions related to urinary incontinence.

During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) stated she was not aware R16 had a decline with toilet use and urinary continence. The DON reviewed R16's assessment dated 9/15/17, and confirmed the assessment lacked to identify the type of incontinence and a comprehensive analysis. The DON stated she would expect the decline for toilet use and urinary continence be evaluated why and interventions put in place. When queried what the facility system was for discussing declines in status the DON stated I am not part of the interdisciplinary team right now. Recently we have been talking about me going in and going through residents if any concerns, but we have not put anything in place yet. The DON verified R16's care plan did not address R16 being occasionally incontinent of bladder or how often R16 should be offered use of the toilet.

The facility Bladder Assessment Policy, dated effective 11/27/16, indicated it is the policy of Gunderson Tweeten Health Care Center to ensure that a resident who enters the facility continent of bladder and bowel receive services and assistance to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. Procedure: Nursing staff should follow the following

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2 915	Continued From page 34 guidelines when evaluating whether a resident would qualify for the bladder retraining program or not. 1. Is the resident orientated to time, person, or place? 2. Can the resident follow simple instructions? 3. Is the resident capable of being cooperative for six to eight weeks? 4. Is the resident partially or totally incontinent? 5. Can the resident sit, stand, ambulate? 6. Does the resident have a neurogenic bladder, chronic urinary tract infections, benign prostate hypertrophy or any other diagnosis that would affect their bladder retraining? SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents are given appropriate treatment and services to maintain abilities of daily living. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		1/12/18

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2 920	Continued From page 35 by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R16, R37, R42) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed and clean fingernails. Findings Include: R16's quarterly Minimum Data Set (MDS) an assessment dated 9/12/17, identified R16 required for personal hygiene extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist, had severe cognitive impairment and had diagnosis of dementia. During observation on 11/28/17, at 1:32 p.m., R16 was seated in a chair in the living room area. R16's fingernails were long with black debris underneath the nailbeds on both hands. R16 had dry light colored scabs on right side of chin and some scabs on left side of cheek. R16 stated she itches it. R16 was observed to be picking scabs on chin with soiled fingernails during observation. During observation on 11/29/17, at 9:51 a.m., R16's fingernails again noted with black debris under nails. During observation on 11/30/17, at 7:15 a.m., R16 was sitting on the edge of her bed in her room. R16's fingernails were trimmed and clean. R16 stated she had a bath. On 11/30/17, at 7:35 a.m., observation of the facility bath sheet read R16 received a whirlpool on Thursday a.m. The following was to be provided: trim nails, shampoo hair, complete skin inspection.	2 920	Gundersen Tweeten Care Center will continue to ensure that residents will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene if he/she is unable to carry out activities of daily living. Care plans were revised for resident□s R16, R42 and R37 to include fingernail care. All other resident care plans were reviewed to ensure fingernail care is person centered and included in their care plans. The Fingernail/Toenail Policy was reviewed and updated. Staff were re-educated on the Fingernail/Toenail Policy. This will be monitored by the charge nurses daily and weekly monitoring by Case Manager. Results of monitoring will be reported to quarterly QAA meeting.	

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2 920	Continued From page 36 During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B verified she had given R16 a bath and trimmed and cleaned R16's fingernails. R16's care plan included target date: 12/12/17, Goal: I would like to be as independent as possible with bathing. My goal for level of independence is: take a shower with help I need one assist for foot care by nurse/podiatry. I would like one assist with lower body bathing including perineum, incontinence care, etc. daily am/pm. Approach: I would like one assist with upper body bathing including hands, face, armpits, etc. daily am/pm. I need staff to cue/encourage me to participate with performing my upper body dressing/personal hygiene. R16's physician progress note dated 11/27/17, identified R16 was seen by physician assistant certified (PAC)-D and R16 had lesions on her left cheek and chin that she picks at, and these have resolved in the past with mupirocin ointment (antibiotic used to treat infections of the skin such as impetigo). Assessment and plan: skin picking habit, order mupirocin 2% ointment TID (three times a day) for seven days for superficial infection. Trim fingernails short. R16's current physician orders identified mupirocin ointment 2% thin layer topical to open areas on left cheek and chin three times a day, diagnosis impetigo. During interview on 11/30/17, at 9:48 a.m., PAC-D stated she ordered nails to be trimmed due to R16 picking skin. PAC-D stated the diagnosis R16 had of impetigo was a staph or strep infection. Any draining lesions should be covered and was transmitted by contact, by touching face and then touching someone else. Proper	2 920		

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2 920	Continued From page 37 handwashing hygiene needed. I guess she could touch lesions and spread infection, but after being on the antibiotic, not an issue. I would have hoped the order to trim nails, R16's fingernails would have been trimmed by later that night at least. During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) stated she did not know R16 had an infection until today. The DON stated she would expect R16's fingernails to be trimmed that evening or the next morning as soon as we could get it done, depending on what is going on. The DON stated fingernails were to be trimmed on bath days or looked, but I also think daily when doing other cares fingernails should be looked at and encourage R16 to wash hands. The facility policy Care of Fingernails/Toenails, dated revised 10/16, indicated the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. R37 was identified by the facility on the admission Minimum Data Set (MDS), an assessment dated 10/20/17, to have intact cognition and required extensive assist of one staff for personal hygiene. Also R37 was identified by the facility on the care area assessment (CAA) to require extensive assistance for grooming and needed assistance with activities of daily living due to recent hospitalization, history of falls, osteoporosis, osteoarthritis, obesity and weakness. During observations on 11/28/17, at 2:49 p.m., R37 was observed with soiled fingers nails on	2 920		

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2 920	Continued From page 38 right and left hands. During observations on 11/30/17, at 9:14 a.m., R37 was awake and in bed. Observations at that time revealed under finger nails soiled with debris. R37 stated her finger nails were cleaned on shower days which were two times a week. Document review of R37's care plan dated 10/13/17, directed staff: R37 was limited in ability to complete activities of daily living related to weakness and recent hospitalization. Interventions included to provide one staff assist for nail care to hands and feet. Document review of facility unit 2 Bath List for week of 11/27/17 to 12/3/17, revealed staff directions, updated 11/20/17, included: to shampoo hair, trim nails, check for chin hairs on females and shave if needed and do complete skin inspection on bath days. Document review of weekly unit two bath list for morning baths were reviewed from 10/30/17-11/26/17, revealed R37 was assigned baths on Mondays and Fridays. Document review of facility progress notes 11/27/17, revealed R37 received a whirlpool bath and had usual daily routine. During interview on 11/30/17, at 9:17 a.m., nursing assistant (NA)-B verified R37 received baths two times a week. NA-B stated facility routine was to check finger nails, clean and trim on bath days, and check nails often. NA-B verified the soiled nails at this time. During interview on 11/30/17, at 9:23 a.m., director of nursing (DON) verified the soiled finger	2 920		

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2 920	Continued From page 39 nails. DON stated she expected staff to provide nail care on bath days and as needed. During interview on 11/30/17, at 12:53 p.m., DON stated she expected staff to provide nail care according to the care plan. R42's resident face sheet identified a current admission date of 2/9/16, and a diagnosis of vascular dementia without behavioral disturbance and traumatic hemorrhage of left cerebrum without loss of consciousness. R42's quarterly Minimum Data Set (MDS) an assessment dated 10/31/17, identified R42 to have a moderate cognitive deficit and requires one person extensive assist with personal hygiene. Care plan dated 6/3/16, identified R42 needs extensive assist in ability to complete adls related to brain hemorrhage and weakness, with an approach to provide 1 staff assist for nail care to hands and feet. Facility document, "Unit 2 bath list AM," week of 11/27/17-12/03/17, identified R42 will get a whirlpool bath on Tuesday, 11/28/17. During observation on 11/30/17, at 7:15 a.m., R42 was observed seated in her wheelchair in her room and noted to have long painted red fingernails. There was noted to be a brown substance that is packed and hard underneath all R42's fingernails. During interview on 11/30/17, at 7:38 a.m., nursing assistant (NA)-A verified R42 has brown substance packed underneath all of her fingernails. Further verifies R42 her bath was	2 920		

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2 920	Continued From page 40 Tuesday morning and nail care should have been completed then. During interview on 11/30/17, at 7:46 a.m., NA-B stated, "We don't usually do nail care on R42, she goes out and gets her nails done." NA-B verified the resident has artificial nails that her family member (FM)-A takes her out in the community to get done. NA-B further verified brown substance underneath all of R42's fingernails and stated that nail care should have been done. Interview on 11/30/17, at 8:55 a.m., director of nursing (DON) stated all residents should have nail care completed on bath days. Further stated nails should be checked every a.m. and p.m. with cares. DON said, "My expectation is for staff to check [R42's] fingernails every day and clean as necessary regardless whether she has fake fingernails or not." Undated facility policy, "Care of Fingernails/Toenails," indicated the purpose of this procedure is to clean the nail bed, to keep the nails trimmed, and to prevent infections. Preparation: review the care plan to assess for any special needs of the resident. General Guidelines: Nail care includes daily cleaning and regular trimming. Documentation: Any problems or complaints made by the resident with his/her hands or feet or any complaints related to the procedure. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise the facility's activities of daily living policies and procedures to ensure nail care is completed. Pertinent personnel could be re-trained on these procedures. An auditing system could be developed for on-going	2 920		

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2 920	Continued From page 41 compliance, with the results of those audits being presented to the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were aware of a skin infection and physician orders were not completed timely regarding interventions to prevent the spread of facial infection for 1 of 1 resident (R16) who was diagnosed with impetigo. In addition, the facility failed to prevent the spread of infection regarding he use of a glucometer stored with other glucometers and not being disinfected as recommended by the centers of disease control (CDC) this had the potential to affect 1 of 4 residents (R20) who utilized a multi use glucometer. Findings Include: R16's physician progress note dated 11/27/17, identified R16 was seen by physician assistant certified (PAC)-D due to lesions on her left cheek. R16 had multiple lesions on her left cheek and chin which she picks at, and these have resolved	21375	F880: Gundersen Tweeten Care Center will continue to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. R16 impetigo has since healed and no other residents showed signs or symptoms of impetigo. All licensed nursing staff and medical providers were re-educated on common diagnoses requiring precautionary measures and type of precaution recommended. GTCC Infection Prevention Program Guidelines Policy was reviewed and updated accordingly for precautionary measures. Infection Control Nurse will monitor bi-monthly x3 months. Results of monitoring will be reported quarterly QAA meeting.	1/12/18

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21375	Continued From page 42	21375		

in the past with mupirocin ointment (antibiotic used to treat infections of the skin such as impetigo) according to PAC-D notes. PAC-D's assessment and plan included: skin picking habit, order mupirocin 2% ointment TID (three times a day) for seven days for superficial infection. Trim fingernails short. R16's current physician orders identified mupirocin ointment 2% thin layer topical to open areas on left cheek and chin three times a day, diagnosis impetigo.

During observation on 11/28/17, at 1:32 p.m., R16 was seated in a chair in the living room area. R16's fingernails were long with visible black debris underneath the nailbeds on both hands. R16 had dry light colored scabs on right side of chin and some scabs on left side of cheek. R16 stated she itches it. R16 was observed to be picking scabs on chin with soiled fingernails during observation.

During observation on 11/29/17, at 9:51 a.m., R16's fingernails remained soiled with black debris on all fingers of both hands.

During observation on 11/30/17, at 7:15 a.m., R16 was sitting on the edge of her bed in her room. R16's fingernails were trimmed and clean. R16 stated she had a bath.

During interview on 11/30/17, at 7:24 a.m., licensed practical nurse (LPN)-A stated R16 had an order for Neosporin for areas on her face. LPN-A stated R16 was burnt from oil a long time ago and it started flaring up now, that is why R16 was getting the Neosporin to her face. When queried if R16 had an infection LPN-A stated no. LPN-A showed surveyor a tube mupirocin ointment 2%, which LPN-A stated was being applied to R16's face.

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21375	Continued From page 43 During observation on 11/30/17, at 8:45 a.m., trained medication aide (TMA)-A administered oral medications to R16. R16 was in the living room area doing an activity of folding clothes. At the time TMA-A stated R16 had a skin thing going on, I do not know if it is an infection. TMA-A stated R16 was getting an ointment and was not on any antibiotics, even though the PAC-D diagnosed it as impetigo and ordered an antibiotic ointment. TMA-A stated there was no precautions to follow for R16. During interview on 11/30/17, at 8:31 a.m., activity aide (AA)-A the clothing R16 was sorting was not four use by anyone else, just an activity for R16 to do. AA-A stated she was not aware R16 had any infections. During interview on 11/30/17, at 8:35 a.m., activity director (AD)-C stated she was aware R16 had had an infection, I do not know if currently active or not. AD-C reviewed notes from daily stand up meeting and stated I do not see anything in notes about an infection for R16. During interview on 11/30/17, at 9:02 a.m., nursing assistant (NA)-B verified she had given R16 a bath and trimmed and cleaned R16's fingernails. When queried if R16 had an infection NA-B stated I do not think so. During interview on 11/30/17, at 9:09 a.m., NA-A stated was not aware R16 had an infection. NA-A stated R16 had some sores on face, but was clear now. NA-A stated was not aware of any precautions to follow for R16. During interview on 11/30/17, at 9:48 a.m., PAC-D stated she ordered nails to be trimmed due to	21375		

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21375	Continued From page 44 R16 picking skin. PAC-D stated the diagnosis R16 had of impetigo was a staph or strep infection. Any draining lesions should be covered and was transmitted by contact, by touching face and then touching someone else. Proper handwashing hygiene needed. I guess she could touch lesions and spread infection, but after being on the antibiotic, not an issue. I would have hoped with the order to trim nails, that R16's fingernails would have been trimmed by later that night (12/27/17) at least. During interview on 11/30/17, at 2:37 p.m., the director of nursing (DON) stated she did not know R16 had an infection until today. The DON stated she would expect R16's fingernails to be trimmed the evening the PAC-D ordered nails to be trimmed (12/27/17) or the next morning as soon as we could get it done, depending on what is going on. The DON stated fingernails were to be trimmed on bath days, but I also think daily when doing other cares fingernails should be looked at and to encourage R16 to wash hands often. The facility policy Care of Fingernails/Toenails, dated revised 10/16, indicated the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. The facility policy Infection prevention Program Guidelines, dated effective 11/1/17, indicated the infection program exists to assure safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection.	21375		

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21375	Continued From page 45 R20 was observed during glucometer check on 12/01/17, at 11:01 a.m. when licensed practical nurse (LPN)-A was observed performing a blood glucose check for R20. LPN-A washed her hands and applied gloves prior to doing the procedure, LPN-A then wipe the glucometer with an alcohol pad prior to using the glucometer. After completing the blood sugar check, LPN-A placed the glucometer directly on the medication cart, removed her gloves, went to the sink and washed her hands, then went to the computer to chart the blood sugar reading, then reviewed order for insulin. Following this LPN-A went to medication cart picked up the soiled glucometer with ungloved hand, went into medication room opened treatment cart and placed soiled glucometer in a gray bin with 3 other glucometers machines. On asking about disinfecting the glucometer after testing blood sample, LPN-A said, "No, I don't think I did" LPN-A then proceeded to reopen the treatment cart and remove the glucometer used on R20. LPN-A then wiped the glucometer with an alcohol wipe and place it back into the bin with the other three glucometers. On asking about alcohol as a disinfectant, LPN-A stated, "That is what I usually clean it with." During interview with director of nursing (DON) on 12/1/17, at 11:28 a.m. the DON Stated, "We use alcohol wipe to clean the glucometer and each resident has their own machine." DON verified that even though each resident had their own machine they are stored in the same bin they have the potential of being contaminated by a glucometer that has not ben fully disinfected. During interview with registered nurse (RN)-B on 12/1/17, at 2:21 p.m. RN-B stated, "I would	21375		

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21375	Continued From page 46	21375		

accept alcohol wipes to disinfect the glucometers, though I like the Sani-wipes (disinfectant germicidal wipe) better. RN-B did confirm that the maintenance guideline states that alcohol is ok for cleaning but not disinfecting the glucometers.

Review of facility policy for Blood Glucose monitors, cleaning and disinfecting policy. Effective date 10/20/2016
Policy: Gunderson Tweeten Care Center will ensure that resident care items such as Blood Glucose Meters will be cleaned and disinfected according to current recommendations between each use.

Review for manufactures guidelines in section B on page 19,
MAINTENANCE Cleaning and Disinfecting Guidelines:
Healthcare professionals should wear gloves when cleaning and disinfecting the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use.

The policy to advise healthcare professionals to clean and disinfect meters between each patient test to avoid cross contamination issues. Out cleaning and disinfecting guidelines are as follows:

ARKRAY's Disinfecting Guidelines: to disinfect the meter, with a 1:10 bleach solution or wipe. Alternatively, if unable to use bleach solution use one of the following recommendations: Steris coverage spray HB, or Super Sani-Cloth, and Sani-Cloth HB Germicidal Disposable Wipes. These are pre-moistened towelettes manufactures by professional disposables

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21375	Continued From page 47 international, Inc. To use these products, remove wipe from container and follow product instructions to disinfect meter. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review infection control policies and procedures for infection control and physician orders with staff. The director of nursing or designee could then develop an auditing system as part of the facility's quality assurance program to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		1/12/18

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21426	Continued From page 48 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 employees (E)-A received tuberculin skin testing (TST) according to the Centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. Findings include: E-A whose date of hire was 10/03/17, had a first step TST administered on 10/3/17, at 1:35 p.m. This test was noted negative with 0 millimiters on 10/6/17, at 1:00 p.m. There was no evidence of a second TST haveing been completed. On 12/1/17, at 9:01 a.m., business office (BO)-F verified that E-A did not receive a second step tuberculin test. On 12/1/17, at 3:08 p.m., director of nursing (DON) verified second step TST was not completed for E-A. DON stated, "It is my expectation that all new hires receive a TB screening including a two-step TST at the time of hire per facility policy. Facility policy, "Tuberculin Test" dated 11/20/14, indicated at the time of hire a baseline TB screening is required. Consists of 2 components: assessing for current symptoms and testing for the presence of infection with mycobacterium tuberculosis by administering either a two-step TST or a single TBT blood test. The second TST should be done within 1-3 weeks. All records are maintained in the employees employee file.	21426	Corrected	

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21426	Continued From page 49 Health care worker is responsible along with HR for initiating mantoux testing. Healthcare worker is responsible for having test read in appropriate time frame as required or for repeat testing. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise the facility's TB policies and procedures to ensure appropriate symptom screening and first and second step tuberculin testing was completed. Pertinent personnel could be re-trained on TB screening and prevention. An auditing system of newly hired staff could be developed for on-going compliance, with the results of those audits being presented to the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Seven (7) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure a multi-use Aplisol (used to test for tuberculosis) was dated when opened and destroyed in a timely manner; this had the potential to affect all new admission or new staff hired after 11/3/17. Findings included On 11/30/17, at 8:40 a.m., during review of	21620	Gundersen Tweeten Care Center will continue to ensure that drugs and biological drugs used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Licensed Nursing staff were re-educated on 12/22/17 regarding open dates and expiration dates	1/12/18

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21620	Continued From page 50 medication refrigerator. An open vial of Aplisol solution (solution for testing for tuberculosis) was observed undated, with delivery date of 10/4/17, vial would have expired on 11/3/17, (30 days after delivery) since no open date on vial, Lot 301013 with manufacturer's expiration date of 2/2019. LPN-A was interviewed at this time and verified no open date was located on Aplisol vial. LPN-A also stated, Aplisol solution expires 30 days after opening or by manufacturer expiration date whichever comes first. LPN-A stated that the vial is about half-full. On 11/30/17, at 9:04 a.m. during an interview with the Director of nursing regarding the outdated Aplisol. The DON said, "I would expect vial is date when it is opened." Policy: Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Effective date 2/2015. Page 48 reads: D. When the original seal of a manufacturer's container or vial is broken, the container or vial will be dated. 1) The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a "date opened" and "expiration" notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating. E. Nurse will check the expiration date of each medication before administering it. F. No expired medication will be administered to a resident.	21620	for biological drugs and medications in multi-use vials. Compliance will be monitored weekly x12 weeks, by QA nurse auditor. Gundersen Tweeten Care Center Multi-Dose Vial Storage policy was reviewed and updated.	

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21620	Continued From page 51 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and	21800		1/12/18

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21800	Continued From page 52 local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure bed hold notification was provided for 1 of 1 resident (R50) reviewed for hospitalization. Findings include: R50's progress notes identified on 9/10/17, resident was out all shift with her husband. Nurse from Gunderson ER (emergency room) called at 8:30 p.m. that resident was going to be admitted to the hospital for work up due to shortness of breath. Resident's family had brought her to the ER. Review of R50's record identified no documentation a bed hold notification had been provided to R50 or R50's responsible party During interview on 12/04/17, at 11:45 a.m., the director of nursing (DON) stated the charge nurse was responsible for providing bed hold notification to the resident (if the resident was capable of signing) or the family before the resident leaves the facility, or by calling the family to talk over the phone. R50 was not in the building at the time, she was out for supper. The	21800	Gundersen Tweeten Care Center will continue to provide written information to the resident or resident representative in regards to the bed hold policy and return before transferring a resident to a hospital or the resident goes on therapeutic leave. This written notice specifies the duration of the bed-hold policy. R50 expired in the hospital and family notified the facility they no longer wanted the bed hold. All residents are given the Bed Hold Policy upon admission. Staff will be educated that any verbal conversations with resident representative/resident/hospital staff about bed hold status needs to be documented in the resident chart. This will be monitored by QA nurse with routine chart audits for all residents that are discharged with return anticipated.	

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21800	Continued From page 53 DON reviewed R50's record and stated she could not find any documentation a bed hold notification was provided to R50 or R50's responsible party. The DON stated we did not have contact with family, as the husband and R50 were out for the day. We received a call from the hospital informing R50 was admitted, so it was kind of a different case. When queried what the facility procedure would be for the circumstance when a resident was not in the facility and was taken to the hospital by the family, who would provide a bed hold notification, the DON stated the social worker would. During interview on 12/04/17, at 12:01 p.m., social worker (SW)-A sated R50 was provided a bed hold, I could not tell you whether it was verbal or not. R50's husband had stopped into the facility and talked to the staff on the floor about it. SW-A reviewed R50's record and stated there was no documentation in R50's record of a bed hold notification having been provided. SW-A stated I did not provide a bed hold notification to R50's husband. The hospital SW called and asked us about holding the bed and we said yes to saving a bed for R50. SW-A stated the staff on the floor provide the bed hold notification. If the bed hold notification does not occur with the staff on the floor then whoever would talk to the family would receive verbal notification and be responsible to fill out the bed hold notification paper work, then I would be responsible to let the hospital SW know we have a bed hold. The facility policy Bed Hold and Return to the Facility, dated effective 9/13/17, indicated Procedure: B. Bed Hold and Return notice upon transfer Gunderson Tweeten Care Center will provide the resident and resident representative a written notice which specifies the duration of the	21800		

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21800	Continued From page 54 bed-hold policy at the time of transfer for hospitalization or therapeutic leave. 5. In cases of emergency transfer, notice at the time of transfer means that the Gunderson Tweeten Care Center will send the notice along with the necessary paperwork to the receiving setting and the resident representative will receive a notice sent within 24 hours of transfer or next business day. 6. Documentation of bed hold notice will be completed in the individual medical record. Gunderson Tweeten Care Center Procedure: 3. The nurse will inform the resident representative , on the telephone if necessary, about the bed hold and return to facility policy and ask how best to provide a copy of the notice to the representative. b) The nurse will document the provision of the bed hold policy and return to the facility notice to the resident and information given to the representative in the resident's record. 4. The social service designee will contact the resident representative on the next working day to ensure that the representative understands the bed hold and return to facility information. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise the facility's resident advocacy group policies and procedures to ensure residents are given resident advocacy names, addresses, and telephone numbers for contact information. Pertinent personnel could be re-trained on these procedures. An auditing system could be developed for on-going compliance, with the results of those audits being presented to the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		

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21995	Continued From page 55	21995		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to submit a vulnerable adult report in a timely manner for 1 of 2 residents (R47) reviewed. Findings include: R47's quarterly Minimum Data Set (MDS) dated 10/3/17, included a diagnoses include Alzheimer's Disease and dementia, necessitating the need for placement in a secured environment. R47's event report dated 9/10/17, indicated that at 11:00 a.m., R47 was found on the floor by staff with another male resident standing over him and striking him. According to a witness statement by activity aide (AA)-B two sets of eyeglasses and a part of a hearing aid were noted to be on the floor as well. A witness statement by nursing assistant (NA)-G indicated R47 had been observed arguing 10-15 minutes prior to the altercation with the other male resident. Injuries to R47 included	21995	Gundersen Tweeten Care Center will continue to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Vulnerable Adult report that was filed on 9/11/17, Gundersen Tweeten Care Center was notified on 10/24/17 that the information was reviewed and it was determined that no further action was necessary at the time. Education was provided to all staff regarding the reporting requirement of vulnerable adults on 11/13/17. The charge nurses have been	1/12/18

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21995	Continued From page 56 bruising to his right knuckles and a cut on his right forehead. Progress note on 9/10/17 at 12:56 p.m., indicated the administrator had been notified of altercation. An incident report regarding R47's resident to resident altercation was reported to the Minnesota Department of Health (MDH) Office of Health Facility Complaints (OHFC) indicated R47's resident to resident abuse had been submitted on 9/11/17, at 2:39 p.m., more than 24 hours after the incident. The Plan for Abuse Prevention and the Reporting policy, revised 11/7/17, and received by the facility indicates the nursing home administrator or designee will report "abuse" to the state agency per state and federal requirements. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could create/update facility policy if needed. They could ensure all staff are aware of the importance of following the facility policy for Abuse/Neglect reporting. They could establish a system to audit to ensure all allegations are properly reported in accordance with the State of Minnesota- Vulnerable Adults Act and also facility policy. They could report that information gathered from those audits to the quality assurance performance improvement (QAPI) committee, for a determined amount of time set by the QAPI committee, to ensure correction and compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995	educated on the procedure for submitting the initial OHFC reports to ensure prompt reporting per state and federal regulation on VA reporting requirements. This will be monitored by the Director of Nursing and Social Service Designee with each reported incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Tweeten Lutheran Health Care) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Tweeten Lutheran Health Care Center is a 1-story building with a partial basements. The building was constructed at 3 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1967, addition was constructed to the South Wing that was determined to be of Type II(222) construction. The Activities/ Chapel was constructed in 1972 and was determined to be thype !! (222). Because the original building and the 2 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 43 at the time of the survey.	K 000		

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

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.