Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 13, 2025

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

RE: CCN: 245429
Cycle Start Date: November 21, 2024

Dear Administrator:

On December 13, 2024, we notified you a remedy was imposed.

On January 3, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 2, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 28, 2024, be discontinued as of January 2, 2025. (42 CFR 488.417 (b))

In our letter of December 13, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 28, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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January 13, 2025

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

Re: Reinspection Results
Event ID: QWQ212

Dear Administrator:

On January 3, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 2, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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December 13, 2024

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

RE: CCN: 245429
Cycle Start Date: December 13, 2024

Dear Administrator:

On December 2, 2024, we informed you that we may impose enforcement remedies.

Also on December 2, 2024, the Minnesota Department of Health completed a standard abbreviated survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 28, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 28, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 28, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Tweeten Lutheran Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 28, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 21, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
December 13, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: QWQ211

Dear Administrator:

The above facility was surveyed on November 26, 2024, through December 2, 2024, 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00285	A. BUILDING: _____ B. WING _____	C 12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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: On 11/26/24, 11/27/24 and 12/2/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54291663C (MN108504) with a licensing order issued at 0565, 0940 and 1540. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive care plan was developed to reflect 1 of 1 residents (R1) who had a diagnosis of acute respiratory failure with hypoxia. Findings include: R1's admission Minimum Data Set (MDS) dated 10/11/24, identified R1's cognition was intact and had diagnoses of acute respiratory failure with hypoxia. R1's care plan was reviewed, from 10/8/24 to 11/13/24 did not identify a respiratory plan of care with goals and individualized interventions to care and manage R1's respiratory condition(s). R1's hospital discharge summary dated 10/16/24,	2 565	Corrected	1/10/25

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2 565	Continued From page 3 identified R1 was hospitalized from 10/13/24 at 5:25 p.m. to 10/16/24,and returned to the facility at 2:45 p.m. R1 was hospitalized for severe hypotension (when blood pressure drops dangerously low), acute respiratory failure with hypoxia (when your lungs suddenly fail to adequately oxygenate the blood leading to a dangerously low level of oxygen in the blood) due to a choking/aspiration event and was discharged with new diet orders for nectar thickened liquids and soft and bite sized diet. During an interview on 11/27/24 at 12:54 p.m. LPN-A indicated R1 did have a diagnoses of acute respiratory failure with hypoxia upon admit and verified R1's care plan did not identify any interventions to assess and monitor for that. During an interview on 11/27/24 at 9:58 a.m., interim director of nursing (IDON) indicated R1 admitted on 10/8/24 with primary diagnosis of acute respiratory failure with hypoxia and verified this diagnosis was not on her care plan to provide interventions for respiratory assessment and monitoring. During a phone interview on 11/27/24 at 10:37 a.m. licensed practical nurse (LPN)-B indicated R1 was admitted with acute respiratory failure with hypoxia and verified the care plan did not identify interventions to assess and monitor for that routinely. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident with a diagnosis of acute respiratory failure with hypoxia, it should be care planned with person centered interventions to include a full respiratory assessment twice a day and as needed and monitor for changes.	2 565		

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2 565	Continued From page 4 Facility policy, Care Planning-Comprehensive Person-Centered Care dated 5/2024, identified a purpose statement: a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident ... Interventions" are actions, treatments, procedures, or activities designed to meet an objective ...The comprehensive person centered care plan will: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising their rights, including the right to refuse treatment;d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including the resident's desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program;	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 5 and o. Reflect currently recognized standards of practice for problem areas and conditions. p. Be culturally competent q. Reflect trauma-informed interventions. 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident's physician (or primary health care provider) is integral to this process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident ... 13. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine	2 565		

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

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2 565	Continued From page 6 compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive nutritional assessment was completed and further failed to identify, comprehensively assess and monitor for signs/symptoms of dehydration for 1 of 3 residents (R1) reviewed for change in condition. The facility's failures resulted in harm when R1 required a 3 day hospitalization for profound hypernatremia and hypovolemia. Findings include: R1's admission Minimum Data Set (MDS) dated 10/11/24, identified R1's cognition was intact and had diagnoses of congestive heart failure, hypernatremia (a condition where there is too much sodium in the blood that can be caused by diarrhea and not drinking enough fluids) and hyperosmolality (a condition where the blood has a high concentration of salt, glucose and other substances which draws water out of the body's organs). R1 was always continent of bowel and	2 940	Corrected	1/10/25

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	00285	A. BUILDING: _____ B. WING _____	C 12/02/2024

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2 940	Continued From page 7 bladder with no special diet. R1 received diuretics. R1's order summary dated 10/8/24, identified R1 had an order to receive torsemide 20 milligrams (mg) twice a day for heart failure. Additional orders to receive docusate sodium (emollient laxative that draws water and fat into your stool, making it softer and easier for stool to pass) give 100 mg twice a day for constipation. R1's Nutritional Therapy assessment dated 10/11/24 identified R1 was obese with no recent weight change, received a regular diet, used an adaptive divided plate with Dycem, mugs with lids and straws and built-up utensils. R1's food and fluid were adequate to meet estimated needs. Nutritional needs estimation did not identify how many calories, protein, or the amount of fluids R1 would need daily. R1's nutritional assessment did not identify R1 was on diuretics. R1's Bowel and Bladder Observation dated 10/11/24, identified R1 typically had a fluid intake of 501 to 1000 milliliters (ml)/daily. R1's discharge-return anticipated MDS assessment dated 10/23/24, identified R1 was frequently incontinent of bowel, received a mechanically altered diet and diuretics. Review of R1's record did not include a comprehensive assessment that identified R1's risk for dehydration, nor did the care plan address goals and interventions to prevent or mitigate R1's risk for dehydration related to (but not limited to) level of assistance, diuretic usage, change in diet to thickened liquids, and requiring assistance with eating.	2 940		

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2 940	Continued From page 8 R1's care plan identified a problem dated 10/15/24, nutritional status potential for significant wight change and malnutrition. Intervention dated 11/11/24 to provide a pureed diet with nectar thickened liquids, provide feeding assistance when in an upright position in the wheelchair, not in the bed or recliner and complete oral cares after meals due to observed residue in mouth. An additional problem dated 10/30/24, R1 was limited in the ability to toilet self-related to immobility, weakness, and deconditioning, was frequently incontinent of bowel and bladder with a long-term goal to have a Bowel Movement (BM) every 3 days. Interventions included to monitor and record BM every shift and administer docusate sodium, Citrucel (bulk-forming laxative), and Miralax (osmotic laxative) per provider orders and to monitor the effectiveness of the medication. An additional intervention was to encourage fluids and reminder to drink fluids in between meals. R1's Vital report for fluid intake identified total fluid intakes each day for October and November 2024 however, in review of R1's record between 10/8/24 through 10/28/24, revealed the record did not include assessments/evaluations to ensure appropriate fluid balance and/or evident R1 was monitored for signs/symptoms of dehydration. Documented intakes included: 10/8/24: 200 ml 10/9/24: 960 ml 10/10/24: 840 ml 10/11/24: 990 ml 10/12/24: 650 ml 10/13/24: 420 ml R1's hospital discharge summary identified R1 was hospitalized from 10/13/24 at 5:25 p.m. to 10/16/24,and returned to the facility at 2:45 p.m.	2 940		

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2 940	Continued From page 9 R1 was hospitalized for severe hypotension (when blood pressure drops dangerously low), acute respiratory failure with hypoxia (when your lungs suddenly fail to adequately oxygenate the blood leading to a dangerously low level of oxygen in the blood) due to a choking/aspiration event and was discharged with new diet orders for nectar thickened liquids and soft and bite sized diet. 10/16/24: 120 ml 10/17/24: 240 ml 10/18/24: 460 ml 10/19/24: 540 ml 10/20/24: 672 ml 10/21/24: 440 ml 10/22/24: 640 ml 10/23/23: 0 ml R1's hospital discharge summary identified R1 was hospitalized from 10/23/24 at 10:00 a.m. to 10/29/24 and returned to the facility at 1:00 p.m. R1 was hospitalized for profound hypernatremia and stupor secondary to poor oral intake and hypovolemia (a condition where the body loses too much fluid, such as blood or water which can lead to organ malfunction or failure), R1's torsemide was discontinued due to hypovolemia and may be restarted at a later date if needed. R1 will need to be offered water by staff every 4 to 6 hours, R1 may not ask for water so it needs to be offered. R1's Nutrition Reassessment dated 11/1/24 identified R1 received mechanical soft diet with thickened liquids. R1's current intake at meals was 50 to 74%. Food and fluid intake adequate to meet R1's needs was not identified and the assessment did not include an evaluation of R1's daily fluid consumption.	2 940		

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2 940	Continued From page 10 R1's bowel and bladder record reviewed between 11/2/24 through 11/13/24 identified R1 had 17 large loose stools. R1's Vital report for fluid intake identified total fluid intakes each day for October and November 2024 however, in review of R1's record between 10/29/24 through 11/13/24, revealed the record did not include assessments/evaluations to ensure appropriate fluid volume balance and/or evident R1 was monitored for signs/symptoms of dehydration. Additionally, the record did not include documentation R1 was offered fluids every 4-6 hours per the hospital discharge summary dated 10/29/24. Documented intakes included: 10/29/24: 0 ml 10/30/24: 1,150 ml 10/31/24: 300 ml 11/1/24: 240 ml 11/2/24: 950 ml 11/3/24: 0 ml 11/4/24: 0 ml 11/5/24: 320 ml 11/6/24: 520 ml 11/7/24: 605 ml 11/8/24: 0 ml 11/9/24: 350 ml 11/10/24: 320 ml 11/11/24: 0 ml 11/12/24: 580 ml 11/13/24: 560 ml R1's Speech therapy (ST) Evaluation and Plan of treatment dated 11/11/24 identified R1 had a diagnosis of dysphagia (difficulty swallowing) required assist with eating and recommendations were to receive nectar thickened liquids with pureed consistencies.	2 940		

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2 940	Continued From page 11 During a phone interview on 11/26/24 at 2:02 p.m., family member (FM)-A identified she was R1's guardian. FM-A indicated R1 had previously lived in a group home and had gotten COVID and had four hospitalizations since 9/25/24. FM-A stated the first and second time R1 had problems with her breathing, the third time she had high sodium levels and stated she didn't think R1 was getting enough to drink. FM-A stated after one of R1's hospitalizations she had to be on thickened liquids and didn't think the staff were offering the fluids like they should have been and R1 needed help with drinking fluids. During an interview on 11/26/24 at 4:26 p.m., nursing assistant (NA)-A identified R1 had a pureed diet and thickened liquids and needed assist with eating. NA-A stated she was not aware that fluids needed to be encouraged with R1 until the day she passed away on 11/13/24. NA-A stated the kitchen staff would pick up R1's lunch trays and document the fluids given. NA-A further stated R1 typically did not drink her fluids well. During an interview on 11/27/24 at 9:30 a.m., NA-B indicated R1 was on pureed foods and thickened liquids and stated R1 typically didn't eat much preferred desserts but would drink. NA-B stated initially R1 did not like thickened liquids but once we explained why she had to have thickened she would drink, she liked the thickened juice. During an interview on 11/27/24 at 1:51 p.m. licensed practical nurse (LPN)-B indicated low fluid intake along with loose stools can lead to dehydration and an electrolyte imbalance. LPN-B stated R1 was not drinking enough and was having several loose stools which can lead to	2 940		

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2 940	Continued From page 12 dehydration. LPN-B stated she was unsure they had a system in place to monitor fluid intake unless a resident was on a fluid restriction. LPN-B indicated R1 was not being monitored for dehydration. During an interview on 11/27/24 at 12:54 p.m., LPN-A stated R1's care plan did not identify R1 was at risk for dehydration and did not identify the amount of fluids R1 would need daily to prevent dehydration. LPN-A indicated from 11/3/24 to 11/10/24, R1 received less than 600 ml of fluids daily and and 15 large loose stools would place R1 at risk for dehydration. During an interview on 11/27/24 at 1:44 p.m., dietary aide (DA)-A stated the nursing staff are responsible to document flood and fluid intake for their residents. On unit 2 the kitchen staff are responsible to document the food and fluid intake in the resident medical record. The residents who ate in their rooms, dietary would pick up the resident trays and document how much they ate based on what was left on their tray. During an interview on 11/27/24 at 1:15 p.m., dietary manager (DM)-A stated R1's admission nutritional assessment was not comprehensive and did not include R1 was administered diuretic medications, also did not identify the amount of calories and fluids R1 would need daily. DM-A stated she would start getting worried if a resident was not drinking 400 ml per meal. DM-A explained from 11/3/24 to 11/13/24, R1's fluid intake was less than 600 ml daily along with over 15 loose stools during that time, she would worry about dehydration. DM-A was unsure if R1's intakes were being monitored or who would be responsible for that.	2 940		

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2 940	Continued From page 13 During a phone interview on 12/2/24 at 12:10 p.m., registered dietician (RD)-A stated a nutritional assessment was completed on all residents upon admit, with significant changes and annually. RD-A stated she did not comprehensively assess R1 for the amount of fluid intake she would need daily and did not develop a care plan for R1's risk for dehydration. RD-A stated typically the average resident would need 1500 ml per day to stay hydrated and verified that R1 was receiving less than 600 ml daily for 10 days prior to R1's death along with over 15 large loose stools. RD verified R1 was admitted with torsemide and taking this medication would put R1 at risk for dehydration and then was hospitalized from 10/23/24 to 10/29/24 for severe hypernatremia and was receiving thickened liquids due to difficulty swallowing, these factors put her at higher risk for dehydration. RD-A stated R1's body was losing fluids faster than she could take in and stated R1 should have been monitored for dehydration. During an interview on 11/27/24 at 2:03 p.m., interim director of nursing (IDON) indicated the facility did not currently have a system in place to monitor residents for fluid intake unless a resident was on a fluid restriction. IDON indicated R1's fluid intake was less than 600 ml daily for about 10 days along with over 15 large loose stools which had a high potential to lead to dehydration, the provider should have been notified right away. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident who had loose stools, bowel medications should be held, if loose stools continue for two days the provider should be notified to address this. PA-A further stated in conjunction with R1's lack of fluids and chronic loose stools could lead to	2 940		

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2 940	Continued From page 14 dehydration which can cause hypernatremia, which is a condition where the level of sodium in the blood is too high. PA-A stated R1 would be at high risk for dehydration with low fluid intake, loose stools and recent history of hypernatremia, facility should be closely monitoring residents like this a reporting it to the provider. Facility policy Dehydration Nutrition Interventions dated 9/2024, included Individuals at risk for dehydration will be identified and provided with sufficient fluid intake to maintain proper hydration and health. Implementation: Each individual will receive sufficient amounts of fluid based on individual need and personal preference to prevent dehydration and maintain health. 1. Risk factors for and/or clinical signs of dehydration will be identified through routine nursing assessments. 2. Adequate fluids should be offered based on a comprehensive nutrition assessment of factors affecting fluid needs and fluid intakes. 3. Fluids should be provided based on each individual's beverage preferences and physician's orders for fluid consistency. 4. If fluids intake is not adequate to meet needs, an IV or enteral feeding tube may be recommended. Facility policy Encouraging and Restricting Fluids dated 7/2024 included: The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. The policy directed staff on the protocol to encourage fluids and documentation requirements. The documentation requirements directed staff to record any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin.. Further directing staff to notify the supervisor if the resident refuses. Facility policy Comprehensive Medical Nutrition	2 940		

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2 940	Continued From page 15 Therapy Assessment dated 11/2024 included The RDN will complete a comprehensive medical nutrition therapy assessment for each individual that is referred or identified. The purpose of nutrition assessment is to obtain, verify, and interpret data needed to identify nutrition-related problems, their causes, and significance. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure residents are appropriately assessed for dehydration with fluid needs identified and implemented in a timely manner. The facility should create, review and/or update or policies and procedures, and educate all staff on specific requirements or interventions related to residents' weight, fluid status and nutrition to determine a method for communication within the facility. The administrator, registered dietician, or designee should perform audits to ensure fluids are given, offered, or consumed by residents are implemented as identified or ordered and residents are monitored appropriately for changes in weight, hydration and nutrition. The RD should also be part of the QAPI committee when food and nutrition services are involved. The facility should report results of those audits to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 940		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must	21540		1/10/25

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21540	Continued From page 16 monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to monitor and evaluate the necessity of a bowel medication for adequate monitoring for 1 of 1 resident (R1) who received scheduled bowel medications and had loose stools throughout her stay. Findings include: R1's admission Minimum Data Set (MDS) dated 10/11/24, identified R1's cognition was intact and had diagnoses of hypernatremia (a condition where there is too much sodium in the blood that can be caused by diarrhea and not drinking enough fluids) and hyperosmolality (a condition	21540	Corrected	

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21540	Continued From page 17 where the blood has a high concentration of salt, glucose and other substances which draws water out of the body's organs). R1 was always continent of bowel and bladder. R1's Bowel and Bladder Observation dated 10/11/24, identified R1 was always continent of bowel, had a bowel movement (BM) every 1 to 3 days and typically had a fluid intake to 501 to 1000 milliliters (ml)/daily. R1's discharge-return anticipated MDS assessment dated 10/23/24, identified R1 was frequently incontinent of bowel. R1's care plan dated 10/30/24 identified a problem, R1 was limited in the ability to toilet self-related to immobility, weakness, and deconditioning, was frequently incontinent of bowel and bladder with a long-term goal to have a Bowel Movement (BM) every 3 days. Interventions included to monitor and record BM every shift and administer docusate sodium, Citrucel (bulk-forming laxative), and Miralax (Osmotic Laxative) per provider orders and to monitor the effectiveness of the medication. R1's Order Summary dated 10/8/24, identified docusate sodium (emollient laxative that draws water and fat into your stool, making it softer and easier for stool to pass) give 100 milligrams (mg) twice a day for constipation. R1's Vital report for bowel movements identified the following: October 2024: 10/9/24 at 2:39 p.m., large loose stool 10/16/24 at 10:17 p.m., large incontinent loose stool x 2	21540		

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21540	Continued From page 18 10/18/24 at 8:28 a.m., large loose foamy stool with foul odor 10/19/24 at 1:30 p.m., large incontinent loose stool, at 3:09 p.m., medium incontinent loose stool 10/20/24 at 1:50 p.m., large liquid incontinent loose stool x 2 10/21/24 at 11:07 p.m., large loose stool 10/30/24 at 10:19 a.m., large loose stool 10/31/24 at 12:22 p.m., 1 large loose stool and 1 medium loose stool November 2024: 11/2/24 at 1:38 p.m., large loose stool x 2. 11/3/24 at 1:23 p.m., large loose incontinent stool, at 1:41 p.m., and large loose liquid incontinent stool x 2. 11/4/24 at 1:34 p.m., large loose incontinent stool 11/6/24 at 4:36 a.m., small continent liquid stool and at 9:37 p.m., large loose stool. 11/7/24 at 9:38 p.m., medium liquid stool 11/8/24at 1:36 p.m., large loose continent stool x 3. 11/9/24 at 7:43 a.m., large loose incontinent stool, at 11:43 a.m., small incontinent loose stool and at 9:26 p.m., large loose stool. 11/10/24 at 5:25 a.m., large loose incontinent stool, at 1:15 p.m., large loose incontinent stool, at 9:26 p.m., large loose incontinent stool and 10:57 p.m., large loose incontinent stool. 11/11/24 at 4:04 p.m., large loose incontinent stool 11/12/24 at 5:27 a.m., large loose incontinent stool 11/13/24 at 5:07 a.m., large loose stool R1's medication administration record (MAR) dated October 2024, identified that docusate sodium was given twice a day with the exception of the following dates and times:	21540		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 19 -10/14/24 am and pm due to hospitalization. -10/15/24 am and pm due to hospitalization. -10/16/24 am due to hospitalization. -10/21/24 am due to condition. -10/23/24 to 10/29/24 due to hospitalization R1's MAR dated November 2024, identified that docusate sodium was given twice a day with the exception of the following dates and times: -11/11/24 am due to loose stools. -11/13/24 am due to loose stools. R1's docusate sodium was given all other days from 10/8/24 to 11/13/24 even though the medical record identified R1 was having current loose stools. R1's progress note dated 10/19/24 at 2:33 p.m., ...identified that R1's docusate sodium was held due to loose stools. R1's progress note dated 10/20/24 at 12:18 p.m., ...identified that R1 had many loose stools ... R1's progress note dated 11/6/24 at 2:46 p.m., identified a request for med tech to hold bowel medications for this evening as R1 had been having loose stools. According to R1's MAR, bowel medications were not held on 11/6/24 and R1 had a large loose stool. R1's progress note dated 11/11/24 at 2:07 a.m., ... identified R1 had loose stools ... R1's progress note dated 11/12/24 at 1:20 p.m., ...identified R1 continued to have loose stools and stomach upset, will have med tech hold any bowel meds for now ...had a red raw bottom from	21540		

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21540	Continued From page 20 loose stools, Z-Guard (medicated cream or paste that works by forming a barrier on the skin to protect it from irritants/moisture) applied to this area ... According to R1's MAR, bowel medications were not held on 11/12/24 and R1 had a large loose stool. R1's progress note dated 11/12/24 at 11:43 p.m., identified R1 had loose stools ...rectal area raw. Z-Guard applied. R1's progress note dated 11/13/24 at 6:13 a.m., identified R1 had diarrhea ...had one more diarrhea after being given Loperamide at 10:30 p.m., ...had redness on buttocks, staff reminded to put on cream after cleansing. During an interview on 11/26/24 at 4:25 p.m., nursing assistant (NA)-A stated she had worked frequently with R1 the last week leading up to 11/13/24. NA-A stated R1 had loose stools daily sometimes several and that each loose stool was immediately reported to the nurse. NA-A stated R1 would complain of stomach pain and then have a loose stool. NA-A stated she asked the nurse if R1 was getting medications that could be causing diarrhea. During an interview on 11/27/24 at 9:30 a.m., NA-B stated she regularly performed cares for R1 and stated R1 had frequent large loose stools. NA-B stated she would report every time R1 had a loose stool to the nurse in charge. NA-B further stated, "anytime you would lay R1 down and roll her over it was projectile pooping." During an interview on 11/27/24 at 12:54 p.m., licensed practical nurse (LPN)-A indicated R1	21540		

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21540	Continued From page 21 was given docusate sodium twice a day most days even though R1 had several loose stools. LPN-A stated if a resident were to have a loose stool bowel medications should be held, if there were three or more large loose stools a provider would need to be notified. During an interview on 11/27/24 at 1:51 p.m. LPN-B stated when a resident who received bowel medications routinely, we would check the documentation to ensure the resident was not having loose stools. Nurses would also check in with the aides prior to giving the bowel medication. The provider should be notified of anything out of the normal. LPN-A stated R1 was having frequent loose stools since admission and docusate sodium was given most days in light of her having loose stools. LPN-A further stated loose stools can lead to dehydration and an electrolyte imbalance. During an interview on 11/27/24 at 2:03 p.m., interim director of nursing (IDON) verified R1 had loose stools on and off since admit and was given docusate sodium twice a day most of R1's stay when it should have been held, the provider should have been notified right away. IDON indicated the docusate sodium was an unnecessary medication for R1 and should have been given only as needed. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident who had loose stools, bowel medications should be held, if loose stools continue for two days the provider should be notified to address this. PA-A further stated chronic loose stools can lead to dehydration (when the body loses more fluids than it takes in) which can cause hypernatremia, which is a condition where the level of sodium in	21540		

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21540	Continued From page 22 the blood is too high. Facility policy Bowel Management dated 5/2024, identified Factors that may change the bowel routine. 1. Diarrhea is caused by intolerance of foods, taking certain medications (ie antibiotics), over-medication with laxatives, certain foods (spicy or greasy foods, or caffeinated beverages) the presence of a virus, food poisoning, etc. Attempt to determine the cause of diarrhea and treat accordingly ...Good habits to prevent bowel problems. 1. Dietary habits: a. Adequate fluid intake: 1500-2500 ml of non-caffeinated, nonalcoholic beverages, soups, and other liquids is required to replace urinary and fecal losses for older adults. Residents with a fever require more ...4. Good pharmacological habits: a. This requires the nurse to assess the resident for their individual needs and develop a plan of care. Pharmacological treatment should be used only after other measures have not worked. Because excessive use of laxatives can cause damage to the colon and increase the problem of constipation, the least harsh laxative should be used. 5. Pharmacological agents include: ...b. Stool Softeners: (DSS) These soften the stool by holding water and fat in the stool. Again, it is very important these residents receive adequate hydration ...Implementation ...3. Following admission assessment, a bowel assessment will be completed quarterly, annually and with significant change of condition. With this a 3-day bowel/bladder monitoring record with be completed annually and with significant change in condition. 1. if a resident becomes increasingly incontinent of bowel, a bowel assessment will be completed and if a pattern of incontinence is identified a toileting plan will be initiated for the resident to decrease incontinent episodes. Gundersen Tweeten Staff will ...2. Case	21540		

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21540	Continued From page 23 Managers develop and maintain the resident's plan of care including a bowel program if the resident is at risk or has an actual problem with diarrhea or constipation. Include preventive management for residents on constipating medications. For a detailed reference refer to "RNF Practice Guidelines for the Management of Constipation in Adultso.3. Nursing staff report to the Charge Nurse regarding any resident abdominal or rectal discomfort, or complaints of diarrhea or constipation. 4. Nursing staff document bowel movements in the BM book accurately for amount (S, M, L) and consistency (liquid, soft, formed, hard) and method (voluntary, involuntary). 5. Bowel Movement Monitoring: (unless the resident has a different plan of care) ... c. Diarrhea Control: 1. Ensure a high fluid intake to keep resident well hydrated. Clear liquid diet 24-48 hours when resident also has nausea/vomiting, as tolerated. 2. Begin BRAT diet (Bananas, rice cereal, applesauce, and toast). These are high in fiber, are easy on the stomach, and a bit constipating. To help absorb more fluid in the colon and minimize watery diarrhea, add Metamucil. This will also help minimize cramps (caused by fluid-filled colon). 3. Stop milk, cheese, and other milk products except for live culture yogurt. Live culture yogurt will replace lactobacillus which is needed to digest mild products. Restart milk products, along with the yogurt once the diarrhea has resolved. 4. Give Imodium after each loose stool (may be repeated four times within 24 hours per directions on package). If resident isn't having reasonable improvement in diarrhea in the next 1-2 days, or if diarrhea is getting worse, contact Physician/Physician Assistant. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and	21540		

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21540	Continued From page 24 consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		

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F 000	INITIAL COMMENTS On 11/26/24, 11/27/24 and 12/2/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H54291663C (MN108504) with a deficiency cited at F656, F692 and F757. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		1/2/25

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

Electronically Signed | 12/23/2024

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

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F 656	Continued From page 1 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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive care plan was developed to reflect 1 of 1 residents (R1) who had a diagnosis of acute respiratory failure with hypoxia.	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 and that includes	

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F 656	Continued From page 2 Findings include: R1's admission Minimum Data Set (MDS) dated 10/11/24, identified R1's cognition was intact and had diagnoses of acute respiratory failure with hypoxia. R1's care plan was reviewed, from 10/8/24 to 11/13/24 did not identify a respiratory plan of care with goals and individualized interventions to care and manage R1's respiratory condition(s). R1's hospital discharge summary dated 10/16/24, identified R1 was hospitalized from 10/13/24 at 5:25 p.m. to 10/16/24,and returned to the facility at 2:45 p.m. R1 was hospitalized for severe hypotension (when blood pressure drops dangerously low), acute respiratory failure with hypoxia (when your lungs suddenly fail to adequately oxygenate the blood leading to a dangerously low level of oxygen in the blood) due to a choking/aspiration event and was discharged with new diet orders for nectar thickened liquids and soft and bite sized diet. During an interview on 11/27/24 at 12:54 p.m. LPN-A indicated R1 did have a diagnoses of acute respiratory failure with hypoxia upon admit and verified R1's care plan did not identify any interventions to assess and monitor for that. During an interview on 11/27/24 at 9:58 a.m., interim director of nursing (IDON) indicated R1 admitted on 10/8/24 with primary diagnosis of acute respiratory failure with hypoxia and verified this diagnosis was not on her care plan to provide interventions for respiratory assessment and monitoring.	F 656	measurable objectives and timeframes to meet a resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Gundersen Tweeten Care Center completed the following: 1. Re-education of care plan development was completed 12/2/24 with the Interdisciplinary Team. 2. A review of the facility policy titled; Care Planning □ Comprehensive Person-Centered Care and Care Planning □ Goals and Objectives was completed, and no changes were made. 3. MDS Coordinator reviewed all resident care plans to ensure all diagnoses are reflected appropriately on 12/22/24. Care Plans will be reviewed Quarterly, with any significant change, and as needed following hospital discharge, provider visits by IDT. A weekly audit will be conducted by nursing management for four consecutive weeks, then every other week for 2 months and then monthly for 3 months. Results will be reported to the QAPI Committee monthly x6 months. Identify results will be reviewed by QAPI and QAPI will determine ongoing monitoring system for compliance. The Administrator is responsible for monitoring audits and ensuring compliance with the process.	

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F 656	Continued From page 3 During a phone interview on 11/27/24 at 10:37 a.m. licensed practical nurse (LPN)-B indicated R1 was admitted with acute respiratory failure with hypoxia and verified the care plan did not identify interventions to assess and monitor for that routinely. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident with a diagnosis of acute respiratory failure with hypoxia, it should be care planned with person centered interventions to include a full respiratory assessment twice a day and as needed and monitor for changes. Facility policy, Care Planning-Comprehensive Person-Centered Care dated 5/2024, identified a purpose statement: a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident ... Interventions" are actions, treatments, procedures, or activities designed to meet an objective ...The comprehensive person centered care plan will: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising their rights, including the right to refuse treatment;d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and	F 656		

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F 656	Continued From page 4 potential for future discharge, including the resident's desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions. p. Be culturally competent q. Reflect trauma-informed interventions. 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident's physician (or primary health care provider) is integral to this process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident ...	F 656		

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F 656	Continued From page 5 13. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).	F 656		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive nutritional assessment was completed and further failed to identify, comprehensively assess and monitor for signs/symptoms of dehydration for 1 of 3 residents (R1) reviewed for change in condition. The facility's failures resulted in harm when R1 required a 3 day hospitalization for	F 692	F692 Gundersen Tweeten Care Center will maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; is offered sufficient	1/2/25

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F 692	Continued From page 6 profound hypernatremia and hypovolemia. Findings include: R1's admission Minimum Data Set (MDS) dated 10/11/24, identified R1's cognition was intact and had diagnoses of congestive heart failure, hypernatremia (a condition where there is too much sodium in the blood that can be caused by diarrhea and not drinking enough fluids) and hyperosmolality (a condition where the blood has a high concentration of salt, glucose and other substances which draws water out of the body's organs). R1 was always continent of bowel and bladder with no special diet. R1 received diuretics. R1's order summary dated 10/8/24, identified R1 had an order to receive torsemide 20 milligrams (mg) twice a day for heart failure. Additional orders to receive docusate sodium (emollient laxative that draws water and fat into your stool, making it softer and easier for stool to pass) give 100 mg twice a day for constipation. R1's Nutritional Therapy assessment dated 10/11/24 identified R1 was obese with no recent weight change, received a regular diet, used an adaptive divided plate with Dycem, mugs with lids and straws and built-up utensils. R1's food and fluid were adequate to meet estimated needs. Nutritional needs estimation did not identify how many calories, protein, or the amount of fluids R1 would need daily. R1's nutritional assessment did not identify R1 was on diuretics. R1's Bowel and Bladder Observation dated 10/11/24, identified R1 typically had a fluid intake of 501 to 1000 milliliters (ml)/daily.	F 692	fluid intake to maintain proper hydration and health. Gundersen Tweeten Care Center completed the following: 1. A review of the facility policies titled; Hydration Clinical Protocol, Dehydration, Referrals to the Registered Dietitian Nutritionist was completed, and no changes were made. 2. Registered Dietician was educated by MDS Coordinator to assessment schedule, system for collecting fluid intakes and who is real time monitoring. 3. Nutritional Risk Indicator section has been added to the Nutritional Assessment to identify Nutritional intake & fluids that are needed. Nutritional needs (which include fluids) will be also noted on care plan and progress note. RD uses USDA DRI calculator to determine kcal, protein & fluid needs based on current weight. This will be completed by the RD on admission, annually, quarterly & significant change of condition. 3. RD will write a progress note that includes the above criteria for each resident for nutrition needs by 1/2/25 and then will continue to add on the observation, care plan & progress notes going forward. 4. Dehydration Observations/Assessments completed on all current residents and will be completed on all residents on admission, annually, quarterly & significant change of condition. Resident's at risk will have a problem added in their care plan. 5. An audit of all resident fluid intakes has been completed weekly since 12/2/24.	

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F 692	Continued From page 7 R1's discharge-return anticipated MDS assessment dated 10/23/24, identified R1 was frequently incontinent of bowel, received a mechanically altered diet and diuretics. Review of R1's record did not include a comprehensive assessment that identified R1's risk for dehydration, nor did the care plan address goals and interventions to prevent or mitigate R1's risk for dehydration related to (but not limited to) level of assistance, diuretic usage, change in diet to thickened liquids, and requiring assistance with eating. R1's care plan identified a problem dated 10/15/24, nutritional status potential for significant wight change and malnutrition. Intervention dated 11/11/24 to provide a pureed diet with nectar thickened liquids, provide feeding assistance when in an upright position in the wheelchair, not in the bed or recliner and complete oral cares after meals due to observed residue in mouth. An additional problem dated 10/30/24, R1 was limited in the ability to toilet self-related to immobility, weakness, and deconditioning, was frequently incontinent of bowel and bladder with a long-term goal to have a Bowel Movement (BM) every 3 days. Interventions included to monitor and record BM every shift and administer docusate sodium, Citrucel (bulk-forming laxative), and Miralax (osmotic laxative) per provider orders and to monitor the effectiveness of the medication. An additional intervention was to encourage fluids and reminder to drink fluids in between meals. R1's Vital report for fluid intake identified total fluid intakes each day for October and November	F 692	Residents at risk will have an order in place for documenting intakes and will be monitored by night charge nurse to identify if resident is receiving too much or not enough fluids. He/she will forward concerns to Case Manager, Dietary Manager and/or RD. Dietary Manager will report weekly at IDT meetings on resident food and fluid intakes, weights and any other concerns. RD will be notified to assess any residents that have new concerns with intakes. 6. Staff education was done regarding importance of providing fluids and accurate documentation. Activities, nursing and dietary was provided education as to each of their responsibilites with documenting fluids and how to document extra fluids. A weekly audit on Nutritional Observations, Dehydration Observations and fluid intakes will be conducted by nursing management and/or Dietary Manager for four consecutive weeks, then every other week for 2 months and then monthly for 3 months. Results will be reported to the QAPI Committee monthly x6 months. Identify results will be reviewed by QAPI and QAPI will determine ongoing monitoring system for compliance.	

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F 692	Continued From page 8 2024 however, in review of R1's record between 10/8/24 through 10/28/24, revealed the record did not include assessments/evaluations to ensure appropriate fluid balance and/or evident R1 was monitored for signs/symptoms of dehydration. Documented intakes included: 10/8/24: 200 ml 10/9/24: 960 ml 10/10/24: 840 ml 10/11/24: 990 ml 10/12/24: 650 ml 10/13/24: 420 ml R1's hospital discharge summary identified R1 was hospitalized from 10/13/24 at 5:25 p.m. to 10/16/24,and returned to the facility at 2:45 p.m. R1 was hospitalized for severe hypotension (when blood pressure drops dangerously low), acute respiratory failure with hypoxia (when your lungs suddenly fail to adequately oxygenate the blood leading to a dangerously low level of oxygen in the blood) due to a choking/aspiration event and was discharged with new diet orders for nectar thickened liquids and soft and bite sized diet. 10/16/24: 120 ml 10/17/24: 240 ml 10/18/24: 460 ml 10/19/24: 540 ml 10/20/24: 672 ml 10/21/24: 440 ml 10/22/24: 640 ml 10/23/23: 0 ml R1's hospital discharge summary identified R1 was hospitalized from 10/23/24 at 10:00 a.m. to 10/29/24 and returned to the facility at 1:00 p.m. R1 was hospitalized for profound hypernatremia	F 692		

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F 692	Continued From page 9 and stupor secondary to poor oral intake and hypovolemia (a condition where the body loses too much fluid, such as blood or water which can lead to organ malfunction or failure), R1's torsemide was discontinued due to hypovolemia and may be restarted at a later date if needed. R1 will need to be offered water by staff every 4 to 6 hours, R1 may not ask for water so it needs to be offered. R1's Nutrition Reassessment dated 11/1/24 identified R1 received mechanical soft diet with thickened liquids. R1's current intake at meals was 50 to 74%. Food and fluid intake adequate to meet R1's needs was not identified and the assessment did not include an evaluation of R1's daily fluid consumption. R1's bowel and bladder record reviewed between 11/2/24 through 11/13/24 identified R1 had 17 large loose stools. R1's Vital report for fluid intake identified total fluid intakes each day for October and November 2024 however, in review of R1's record between 10/29/24 through 11/13/24, revealed the record did not include assessments/evaluations to ensure appropriate fluid volume balance and/or evident R1 was monitored for signs/symptoms of dehydration. Additionally, the record did not include documentation R1 was offered fluids every 4-6 hours per the hospital discharge summary dated 10/29/24. Documented intakes included: 10/29/24: 0 ml 10/30/24: 1,150 ml 10/31/24: 300 ml 11/1/24: 240 ml 11/2/24: 950 ml	F 692		

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F 692	Continued From page 10 11/3/24: 0 ml 11/4/24: 0 ml 11/5/24: 320 ml 11/6/24: 520 ml 11/7/24: 605 ml 11/8/24: 0 ml 11/9/24: 350 ml 11/10/24: 320 ml 11/11/24: 0 ml 11/12/24: 580 ml 11/13/24: 560 ml R1's Speech therapy (ST) Evaluation and Plan of treatment dated 11/11/24 identified R1 had a diagnosis of dysphagia (difficulty swallowing) required assist with eating and recommendations were to receive nectar thickened liquids with pureed consistencies. During a phone interview on 11/26/24 at 2:02 p.m., family member (FM)-A identified she was R1's guardian. FM-A indicated R1 had previously lived in a group home and had gotten COVID and had four hospitalizations since 9/25/24. FM-A stated the first and second time R1 had problems with her breathing, the third time she had high sodium levels and stated she didn't think R1 was getting enough to drink. FM-A stated after one of R1's hospitalizations she had to be on thickened liquids and didn't think the staff were offering the fluids like they should have been and R1 needed help with drinking fluids. During an interview on 11/26/24 at 4:26 p.m., nursing assistant (NA)-A identified R1 had a pureed diet and thickened liquids and needed assist with eating. NA-A stated she was not aware that fluids needed to be encouraged with R1 until the day she passed away on 11/13/24. NA-A	F 692		

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F 692	Continued From page 11 stated the kitchen staff would pick up R1's lunch trays and document the fluids given. NA-A further stated R1 typically did not drink her fluids well. During an interview on 11/27/24 at 9:30 a.m., NA-B indicated R1 was on pureed foods and thickened liquids and stated R1 typically didn't eat much preferred desserts but would drink. NA-B stated initially R1 did not like thickened liquids but once we explained why she had to have thickened she would drink, she liked the thickened juice. During an interview on 11/27/24 at 1:51 p.m. licensed practical nurse (LPN)-B indicated low fluid intake along with loose stools can lead to dehydration and an electrolyte imbalance. LPN-B stated R1 was not drinking enough and was having several loose stools which can lead to dehydration. LPN-B stated she was unsure they had a system in place to monitor fluid intake unless a resident was on a fluid restriction. LPN-B indicated R1 was not being monitored for dehydration. During an interview on 11/27/24 at 12:54 p.m., LPN-A stated R1's care plan did not identify R1 was at risk for dehydration and did not identify the amount of fluids R1 would need daily to prevent dehydration. LPN-A indicated from 11/3/24 to 11/10/24, R1 received less than 600 ml of fluids daily and and 15 large loose stools would place R1 at risk for dehydration. During an interview on 11/27/24 at 1:44 p.m., dietary aide (DA)-A stated the nursing staff are responsible to document flood and fluid intake for their residents. On unit 2 the kitchen staff are responsible to document the food and fluid intake	F 692		

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F 692	Continued From page 12	F 692		

in the resident medical record. The residents who ate in their rooms, dietary would pick up the resident trays and document how much they ate based on what was left on their tray.

During an interview on 11/27/24 at 1:15 p.m., dietary manager (DM)-A stated R1's admission nutritional assessment was not comprehensive and did not include R1 was administered diuretic medications, also did not identify the amount of calories and fluids R1 would need daily. DM-A stated she would start getting worried if a resident was not drinking 400 ml per meal. DM-A explained from 11/3/24 to 11/13/24, R1's fluid intake was less than 600 ml daily along with over 15 loose stools during that time, she would worry about dehydration. DM-A was unsure if R1's intakes were being monitored or who would be responsible for that.

During a phone interview on 12/2/24 at 12:10 p.m., registered dietician (RD)-A stated a nutritional assessment was completed on all residents upon admit, with significant changes and annually. RD-A stated she did not comprehensively assess R1 for the amount of fluid intake she would need daily and did not develop a care plan for R1's risk for dehydration. RD-A stated typically the average resident would need 1500 ml per day to stay hydrated and verified that R1 was receiving less than 600 ml daily for 10 days prior to R1's death along with over 15 large loose stools. RD verified R1 was admitted with torsemide and taking this medication would put R1 at risk for dehydration and then was hospitalized from 10/23/24 to 10/29/24 for severe hypernatremia and was receiving thickened liquids due to difficulty swallowing, these factors put her at higher risk for

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F 692	Continued From page 13 dehydration. RD-A stated R1's body was losing fluids faster than she could take in and stated R1 should have been monitored for dehydration. During an interview on 11/27/24 at 2:03 p.m., interim director of nursing (IDON) indicated the facility did not currently have a system in place to monitor residents for fluid intake unless a resident was on a fluid restriction. IDON indicated R1's fluid intake was less than 600 ml daily for about 10 days along with over 15 large loose stools which had a high potential to lead to dehydration, the provider should have been notified right away. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident who had loose stools, bowel medications should be held, if loose stools continue for two days the provider should be notified to address this. PA-A further stated in conjunction with R1's lack of fluids and chronic loose stools could lead to dehydration which can cause hypernatremia, which is a condition where the level of sodium in the blood is too high. PA-A stated R1 would be at high risk for dehydration with low fluid intake, loose stools and recent history of hypernatremia, facility should be closely monitoring residents like this a reporting it to the provider. Facility policy Dehydration Nutrition Interventions dated 9/2024, included Individuals at risk for dehydration will be identified and provided with sufficient fluid intake to maintain proper hydration and health. Implementation: Each individual will receive sufficient amounts of fluid based on individual need and personal preference to prevent dehydration and maintain health. 1. Risk factors for and/or clinical signs of dehydration will be identified through routine nursing	F 692		

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F 692	Continued From page 14 assessments. 2. Adequate fluids should be offered based on a comprehensive nutrition assessment of factors affecting fluid needs and fluid intakes. 3. Fluids should be provided based on each individual's beverage preferences and physician's orders for fluid consistency. 4. If fluids intake is not adequate to meet needs, an IV or enteral feeding tube may be recommended. Facility policy Encouraging and Restricting Fluids dated 7/2024 included: The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. The policy directed staff on the protocol to encourage fluids and documentation requirements. The documentation requirements directed staff to record any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin.. Further directing staff to notify the supervisor if the resident refuses. Facility policy Comprehensive Medical Nutrition Therapy Assessment dated 11/2024 included The RDN will complete a comprehensive medical nutrition therapy assessment for each individual that is referred or identified. The purpose of nutrition assessment is to obtain, verify, and interpret data needed to identify nutrition-related problems, their causes, and significance.	F 692		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		1/2/25

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F 757	Continued From page 15 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor and evaluate the necessity of a bowel medication for adequate monitoring for 1 of 1 resident (R1) who received scheduled bowel medications and had loose stools throughout her stay. Findings include: R1's admission Minimum Data Set (MDS) dated 10/11/24, identified R1's cognition was intact and had diagnoses of hypernatremia (a condition where there is too much sodium in the blood that can be caused by diarrhea and not drinking enough fluids) and hyperosmolality (a condition where the blood has a high concentration of salt, glucose and other substances which draws water out of the body's organs). R1 was always continent of bowel and bladder. R1's Bowel and Bladder Observation dated	F 757	F757 Gundersen Tweeten Care Center will continue to ensure each resident□s drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used, a. in excessive dose or b. for excessive duration or c. without adequate monitoring or d. without adequate indications for its use or e. in the presence of adverse consequences which indicate the dose should be reduced or discontinued or any combinations for the previous 5 indicators. Gundersen Tweeten Care Center completed the following: 1. A review of the facility policy titled; Medication Management was completed, and no changes were made. 2. A current standing order was added to all resident existing orders that, may hold laxatives and stool softeners if loose stools are noted. This order will be part of	

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F 757	Continued From page 16 10/11/24, identified R1 was always continent of bowel, had a bowel movement (BM) every 1 to 3 days and typically had a fluid intake to 501 to 1000 milliliters (ml)/daily. R1's discharge-return anticipated MDS assessment dated 10/23/24, identified R1 was frequently incontinent of bowel. R1's care plan dated 10/30/24 identified a problem, R1 was limited in the ability to toilet self-related to immobility, weakness, and deconditioning, was frequently incontinent of bowel and bladder with a long-term goal to have a BM every 3 days. Interventions included to monitor and record BM every shift and administer docusate sodium, Citrucel (bulk-forming laxative), and Miralax (Osmotic Laxative) per provider orders and to monitor the effectiveness of the medication. R1's Order Summary dated 10/8/24, identified docusate sodium (emollient laxative that draws water and fat into your stool, making it softer and easier for stool to pass) give 100 milligrams (mg) twice a day for constipation. R1's Vital report for bowel movements identified the following: October 2024: 10/9/24 at 2:39 p.m., large loose stool 10/16/24 at 10:17 p.m., large incontinent loose stool x 2 10/18/24 at 8:28 a.m., large loose foamy stool with foul odor 10/19/24 at 1:30 p.m., large incontinent loose stool, at 3:09 p.m., medium incontinent loose stool	F 757	all new or returning residents standing orders. 3. Re-education was provided to all licensed nurses and TMAs on med administration. Education was provided to CNAs to notify charge nurse or med nurse right away when a resident is having loose stools. 4. During IDT meetings, bowel movements will be reviewed weekly and any changes in medications/orders will be a focus. The Director of Nursing Services will audit BM review, medication reviews monthly to ensure compliance. The results of the reviews will be reported to the QAPI committee monthly indefinitely.	

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F 757	Continued From page 17 10/20/24 at 1:50 p.m., large liquid incontinent loose stool x 2 10/21/24 at 11:07 p.m., large loose stool 10/30/24 at 10:19 a.m., large loose stool 10/31/24 at 12:22 p.m., 1 large loose stool and 1 medium loose stool November 2024: 11/2/24 at 1:38 p.m., large loose stool x 2. 11/3/24 at 1:23 p.m., large loose incontinent stool, at 1:41 p.m., and large loose liquid incontinent stool x 2. 11/4/24 at 1:34 p.m., large loose incontinent stool 11/6/24 at 4:36 a.m., small continent liquid stool and at 9:37 p.m., large loose stool. 11/7/24 at 9:38 p.m., medium liquid stool 11/8/24at 1:36 p.m., large loose continent stool x 3. 11/9/24 at 7:43 a.m., large loose incontinent stool, at 11:43 a.m., small incontinent loose stool and at 9:26 p.m., large loose stool. 11/10/24 at 5:25 a.m., large loose incontinent stool, at 1:15 p.m., large loose incontinent stool, at 9:26 p.m., large loose incontinent stool and 10:57 p.m., large loose incontinent stool. 11/11/24 at 4:04 p.m., large loose incontinent stool 11/12/24 at 5:27 a.m., large loose incontinent stool 11/13/24 at 5:07 a.m., large loose stool R1's medication administration record (MAR) dated October 2024, identified that docusate sodium was given twice a day with the exception of the following dates and times: -10/14/24 am and pm due to hospitalization. -10/15/24 am and pm due to hospitalization. -10/16/24 am due to hospitalization. -10/21/24 am due to condition.	F 757		

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	245429	A. BUILDING _____ B. WING _____	C 12/02/2024

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F 757	Continued From page 18 -10/23/24 to 10/29/24 due to hospitalization R1's MAR dated November 2024, identified that docusate sodium was given twice a day with the exception of the following dates and times: -11/11/24 am due to loose stools. -11/13/24 am due to loose stools. R1's docusate sodium was given all other days from 10/8/24 to 11/13/24 even though the medical record identified R1 was having current loose stools. R1's progress note dated 10/19/24 at 2:33 p.m., ...identified that R1's docusate sodium was held due to loose stools. R1's progress note dated 10/20/24 at 12:18 p.m., ...identified that R1 had many loose stools ... R1's progress note dated 11/6/24 at 2:46 p.m., identified a request for med tech to hold bowel medications for this evening as R1 had been having loose stools. According to R1's MAR, bowel medications were not held on 11/6/24 and R1 had a large loose stool. R1's progress note dated 11/11/24 at 2:07 a.m., ... identified R1 had loose stools ... R1's progress note dated 11/12/24 at 1:20 p.m., ...identified R1 continued to have loose stools and stomach upset, will have med tech hold any bowel meds for now ...had a red raw bottom from loose stools, Z-Guard (medicated cream or paste that works by forming a barrier on the skin to protect it from irritants/moisture) applied to this	F 757		

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F 757	Continued From page 19 area ... According to R1's MAR, bowel medications were not held on 11/12/24 and R1 had a large loose stool. R1's progress note dated 11/12/24 at 11:43 p.m., identified R1 had loose stools ...rectal area raw. Z-Guard applied. R1's progress note dated 11/13/24 at 6:13 a.m., identified R1 had diarrhea ...had one more diarrhea after being given Loperamide at 10:30 p.m., ...had redness on buttocks, staff reminded to put on cream after cleansing. During an interview on 11/26/24 at 4:25 p.m., nursing assistant (NA)-A stated she had worked frequently with R1 the last week leading up to 11/13/24. NA-A stated R1 had loose stools daily sometimes several and that each loose stool was immediately reported to the nurse. NA-A stated R1 would complain of stomach pain and then have a loose stool. NA-A stated she asked the nurse if R1 was getting medications that could be causing diarrhea. During an interview on 11/27/24 at 9:30 a.m., NA-B stated she regularly performed cares for R1 and stated R1 had frequent large loose stools. NA-B stated she would report every time R1 had a loose stool to the nurse in charge. NA-B further stated, "anytime you would lay R1 down and roll her over it was projectile pooping." During an interview on 11/27/24 at 12:54 p.m., licensed practical nurse (LPN)-A indicated R1 was given docusate sodium twice a day most days even though R1 had several loose stools.	F 757		

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F 757	Continued From page 20 LPN-A stated if a resident were to have a loose stool bowel medications should be held, if there were three or more large loose stools a provider would need to be notified. During an interview on 11/27/24 at 1:51 p.m. LPN-B stated when a resident who received bowel medications routinely, we would check the documentation to ensure the resident was not having loose stools. Nurses would also check in with the aides prior to giving the bowel medication. The provider should be notified of anything out of the normal. LPN-A stated R1 was having frequent loose stools since admission and docusate sodium was given most days in light of her having loose stools. LPN-A further stated loose stools can lead to dehydration and an electrolyte imbalance. During an interview on 11/27/24 at 2:03 p.m., interim director of nursing (IDON) verified R1 had loose stools on and off since admit and was given docusate sodium twice a day most of R1's stay when it should have been held, the provider should have been notified right away. IDON indicated the docusate sodium was an unnecessary medication for R1 and should have been given only as needed. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident who had loose stools, bowel medications should be held, if loose stools continue for two days the provider should be notified to address this. PA-A further stated chronic loose stools can lead to dehydration (when the body loses more fluids than it takes in) which can cause hypernatremia, which is a condition where the level of sodium in the blood is too high.	F 757		

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F 757	Continued From page 21 Facility policy Bowel Management dated 5/2024, identified Factors that may change the bowel routine. 1. Diarrhea is caused by intolerance of foods, taking certain medications (ie antibiotics), over-medication with laxatives, certain foods (spicy or greasy foods, or caffeinated beverages) the presence of a virus, food poisoning, etc. Attempt to determine the cause of diarrhea and treat accordingly ...Good habits to prevent bowel problems. 1. Dietary habits: a. Adequate fluid intake: 1500-2500 ml of non-caffeinated, nonalcoholic beverages, soups, and other liquids is required to replace urinary and fecal losses for older adults. Residents with a fever require more ...4. Good pharmacological habits: a. This requires the nurse to assess the resident for their individual needs and develop a plan of care. Pharmacological treatment should be used only after other measures have not worked. Because excessive use of laxatives can cause damage to the colon and increase the problem of constipation, the least harsh laxative should be used. 5. Pharmacological agents include: ...b. Stool Softeners: (DSS) These soften the stool by holding water and fat in the stool. Again, it is very important these residents receive adequate hydration ...Implementation ...3. Following admission assessment, a bowel assessment will be completed quarterly, annually and with significant change of condition. With this a 3-day bowel/bladder monitoring record with be completed annually and with significant change in condition. 1. if a resident becomes increasingly incontinent of bowel, a bowel assessment will be completed and if a pattern of incontinence is identified a toileting plan will be initiated for the resident to decrease incontinent episodes. Gundersen Tweeten Staff will ...2. Case	F 757		

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F 757	Continued From page 22 Managers develop and maintain the resident's plan of care including a bowel program if the resident is at risk or has an actual problem with diarrhea or constipation. Include preventive management for residents on constipating medications. For a detailed reference refer to "RNF Practice Guidelines for the Management of Constipation in Adultso.3. Nursing staff report to the Charge Nurse regarding any resident abdominal or rectal discomfort, or complaints of diarrhea or constipation. 4. Nursing staff document bowel movements in the BM book accurately for amount (S, M, L) and consistency (liquid, soft, formed, hard) and method (voluntary, involuntary). 5. Bowel Movement Monitoring: (unless the resident has a different plan of care) ... c. Diarrhea Control: 1. Ensure a high fluid intake to keep resident well hydrated. Clear liquid diet 24-48 hours when resident also has nausea/vomiting, as tolerated. 2. Begin BRAT diet (Bananas, rice cereal, applesauce, and toast). These are high in fiber, are easy on the stomach, and a bit constipating. To help absorb more fluid in the colon and minimize watery diarrhea, add Metamucil. This will also help minimize cramps (caused by fluid-filled colon). 3. Stop milk, cheese, and other milk products except for live culture yogurt. Live culture yogurt will replace lactobacillus which is needed to digest mild products. Restart milk products, along with the yogurt once the diarrhea has resolved. 4. Give Imodium after each loose stool (may be repeated four times within 24 hours per directions on package). If resident isn't having reasonable improvement in diarrhea in the next 1-2 days, or if diarrhea is getting worse, contact Physician/Physician Assistant.	F 757		