Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2023

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

RE: CCN: 245429
Cycle Start Date: May 25, 2023

Dear Administrator:

On June 1, 2023, we notified you a remedy was imposed. On June 12, 2023 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 June 6, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 16, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 1, 2023, 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 May 25, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 29, 2023

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

Re: Reinspection Results
Event ID: FPWZ12

Dear Administrator:

On June 12, 2023 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 May 25, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 1, 2023

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

RE: CCN: 245429
Cycle Start Date: May 25, 2023

Dear Administrator:

On May 25, 2023, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On May 25, 2023, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office 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 June 16, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 16, 2023 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 16, 2023 (42 CFR 488.417 (b)).

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.

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 $11,995; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 25, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Tweeten Lutheran Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 25, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 November 25, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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) 565-9462

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health & 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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period

allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 1, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: FPWZ11

Dear Administrator:

The above facility was surveyed on May 24, 2023 through May 25, 2023 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	C 05/25/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/24/23 and 5/25/23, 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 complaints were reviewed: H54292278C (MN93643). The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F689 began on 5/1/23, when the facility failed to transcribe a physician ordered pureed diet for R1 which resulted in R1 receiving the wrong textured diet resulting in hospitalization with aspiration pneumonia, lung abscess sepsis and hospice care. The administrator and director of nursing (DON) were notified of the IJ on 5/24/23 at 4:47 p.m. The IJ was removed on 5/25/23 at 11:30 a.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/25/23 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/06/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	C 05/25/2023

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

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify and implement physician orders for a therapeutic textured diet with interventions for safe swallowing for 1 of 3 residents (R1) who received the wrong textured diet for seventeen days, resulting in hospitalization with aspiration pneumonia, lung abscess, sepsis, and hospice care for one of one resident (R1). The immediate jeopardy (IJ) began on 5/1/23, when R1 had a provider visit and R1 was diagnosed with dysphagia and required a pureed diet with thickened liquids, the order was not acknowledged or implemented by the facility resulting in R1's transfer to emergency room (ER) and hospitalization from 5/11/23 to 5/16/23. The administrator and director of nursing (DON) were notified of the IJ on 5/24/23, at 4:47 p.m. The immediacy was removed on 5/25/23, at 11:30 a.m. but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include:	F 689	F689: Gundersen Tweeten Care Center will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. On 5/24/23 Gundersen Tweeten Care Center verified that resident R1 was on the correct diet order for her diagnosis. Resident R1□s care plan was reviewed and found to be correct as well regarding dietary restrictions. Gundersen Tweeten Care Centered completed the following through the night of 5/24/23 and day of 5/25/23: 1. All licensed nurses were reeducated and tested for competency on transcribing orders and clarifying any discrepancies in orders received during physician visits, clinic visits and upon admission and readmission. This training included writing a progress note summarizing the visit and any order changes as well as updating care plan if needed. Those that were unable to be reeducated on 5/24/23 will be notified by phone and email that they will not be able to work until they have	6/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTER	125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974

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F 689	Continued From page 2 R1's hospital,Speech Pathology Inpatient Evaluation, dated 4/19/23, identified R1 was referred for a bedside swallow evaluation nursing requested due to poor oral intake. The evaluation identified R1 had four trials given for thin liquids, one trial of bite size solids and easy to chew solids; R1 had delayed throat clearing, change in vital signs, and wet vocal quality. Suspect pharyngeal stasis (residue in the throat after swallowing) and suspected delayed initiation of swallow. After three trials of pureed food and mildly thicken liquids resulting in normal limited speech therapy recommendations were mildly thick liquids, pureed foods, crush medications with puree, upright with all oral intake and remain upright for 30 - 60 minutes after meals, eat/feed slowly, small bites/sips, nursing to provide assistance as needed. Plan: A Video fluoroscopic Swallow Study (VFSS) will need to be performed prior to diet consistency upgrades to rule out aspiration or if a decline in swallowing status observed by medical staff. R1's admission provider visit dated 4/25/23, indicated R1 was admitted to the facility for rehab following a hospitalization with a right sided pleural effusion that was thought to be secondary to an autoimmune disease. The visit note did not address R1's diagnoses of dysphagia or diet texture recommendations from her hospitalization and not evident the facility identified or provided R1 required a textured therapeutic diet upon admission to the facility. R1's physician order dated 4/24/23, included regular carb-controlled diet. Further clarified to include low sodium according to the Dietary Communication Order dated 4/25/23.	F 689	completed their mandatory training. All training will be completed by 5/31/23 for all licensed nurses. 2. A comprehensive review of all physician visits, clinic visits, and discharge summaries that occurred between 4/24/23 to 5/24/23 was conducted to identify any discrepancies or missed physician orders. No discrepancies or missed orders were found. 3. A review of the following policies and procedures was completed, and no changes were made: " Nursing Admission/Readmission Policy & Guidelines " Physician Services " Medication and Treatment Orders 4. A review of the Transcription of Orders policy was completed, and policy was revised to include if orders are not legible or understood, the nurse is to call ordering physician for clarification. Along with this, policy was revised to include adding a progress note to ensure that the physician visit was reviewed. 5. An audit of all other residents was completed by our Dietitian to review residents identified to be at risk for aspiration. All residents identified to be at risk for aspiration were found to have the appropriate diet modifications. 6. Training that was completed for transcribing orders and clarifying any discrepancies in orders will be added to orientation for all new licensed nurses that are hired moving forward. Along with this, The Director of Nursing reviewed current systems and made the following changes around doctor visits:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWEETEN LUTHERAN HEALTH CARE CENTER	125 5TH AVENUE SOUTHEAST SPRING GROVE, MN 55974

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F 689	Continued From page 3 R1's admission, Minimum Data Set (MDS), dated 4/27/23, identified R1 had diagnoses of downs syndrome, acute respiratory failure with hypoxemia (lower than normal oxygen levels) and gastroesophageal reflux disease (GERD). R1 had severe cognitive impairment and required supervision with eating. MDS identified R1 did not have any issues with swallowing/choking and did not identify R1's diagnosis of dysphagia. R1's physician visit dated 5/1/23, indicated during R1's hospital stay from 4/12/23 to 4/24/23, R1 had a speech therapy eval completed to rule out aspiration. Evaluation included findings of moderate oral pharyngeal dysphagia. Recommendations included level 2 mildly thickened liquids and level 4 pureed solids. Meds should be taken crushed with pureed foods. Remain upright as possible for all oral intake and remain upright for 30-60 minutes after meals, eat slowly, and take small bites and sips. Good potential for rehab and SLP (speech language pathologist) re-evaluation can be completed to see if we can advance diet if R1 continues to do well. In review of R1's physician orders, progress notes, and dietary documentation after the physician acknowledged R1's dysphagia diagnosis, dietary requirements for pureed diet, and interventions were transcribed into the facilities EMR (electronic medical record). Between 5/1/23 to 5/11/23, R1 did not receive the correct diet nor safe swallowing interventions to prevent or mitigate risk of aspiration according to the 5/1/23 physician visit note. During an interview on 5/24/23, at 12:55 p.m. the	F 689	1. Leadership nurses will review clinic notes from providers when they become available to the nursing home. The nurses will sign off when reviewed and scan into chart. Educated to this system on 6/6/23. The DON will audit this weekly for 4 weeks, bi-weekly for 2 months, monthly for 3 months and results of audit will be reported off to the QAA committee monthly	

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F 689	Continued From page 4 director of nursing (DON) was not aware R1 had a diagnosis of dysphagia nor the orders that had been identified in the 5/1/23 physician visit note. When R1 was admitted, the hospital discharge paperwork did not identify R1's diagnosis of dysphagia or include R1's speech evaluation and recommendations. DON stated "I didn't know anything about it [5/1/23 physician acknowledgement of dysphagia diagnoses and textured diet order] until you [surveyor] brought it to my attention." DON explained the charge nurse would usually bring the residents visit notes/orders back for her to look at. DON was not sure what happened with R1's 5/1/23, visit or who reviewed it. R1's progress notes dated 5/11/23, at 6:45 a.m. indicated R1 was having diarrhea and nausea. At 11:30 p.m. R1's entire bed was wet from perspiration. R1's blood sugar was elevated, the physician was notified with orders to give insulin. At 11:36 p.m. R1 began to complain of chest pain and stated, "my heart hurts." Family and physician notified and R1 was sent to the emergency department. R1's hospital palliative care visit note dated 5/12/23, identified visit diagnosis as abscess of lung with sepsis. R1 had a large right lung abscess that had not responded to antibiotics nor intervention, had progressed, and was very high risk for a surgical candidate. Shared concerns with family members that R1 was nearing the end of life and could not tolerate any aggressive treatments. Family was supportive of hospice. R1's after visit summary (AVS) dated 5/16/23, indicated R1 had a hospitalization from 5/12/23 to 5/16/23, with diagnoses of right lung abscess with	F 689		

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F 689	Continued From page 5 aspiration pneumonia with a fluid collection measuring 7.4 centimeters (cm) x 4.3 cm x 5.5 cm. R1 was placed on end-of-life comfort cares. R1's Dietary Communication Order dated 5/16/23, included pureed diet with nectar thickened liquids. During an interview on 5/24/23, at 10:09 a.m. cook (C)-A, confirmed through documentation that R1 was on a low sodium diet with regular texture when she was first admitted. R1 did not receive pureed diet until 5/16/23, according to our kitchen records During an interview on 5/24/23, at 9:44 a.m. nursing assistant (NA)-A stated when R1 first got here she was a on a regular diet, then she went to the hospital, and currently on a pureed diet with thickened liquids. During an interview on 5/24/23, at 9:46 a.m. NA-B stated when R1 first got here she was a on a regular diet, then one day she was weak and shaky. R1 was sent to the hospital, she was diagnosed with aspiration pneumonia. When R1 returned from the hospital she was on hospice and needed a pureed diet with thickened liquids. During an interview on 5/24/23, at 9:48 a.m. NA-C stated when R1 first got here she was a on a regular diet, then she got aspiration pneumonia and went to the hospital. R1 came back from the hospital on hospice and was on pureed diet. During an interview 5/24/23, at 12:35 p.m. licensed practical nurse (LPN)-A indicated when we have new admissions the case manager reviews all of the admission paperwork and	F 689		

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F 689	Continued From page 6 enters the orders into the EHR. The floor nurses were responsible for the assessments. Following a physician visit/appointment, a nurse needed to go through the visit notes and transcribe the orders and any care plan changes into EHR (electronic health record). LPN-A was not aware why R1's orders for pureed diet and thickened liquids were missed from the 5/1/23 appointment. During an interview on 5/24/23, at 12:46 p.m. speech therapist (ST)-A, stated she never received referral for R1 upon her initial admission date. ST-A stated if textured diets were not followed, it could result in aspiration pneumonia which could lead to sepsis and death. Aspiration can occur when pharyngeal (throat) secretions, food, or gastric (stomach) secretions enter the larynx (tube that leads to the lungs) and trachea and can descend into the lungs, having a diagnosis of GERD can play a role in this as well increasing the risk of aspiration. When the secretions are trapped in the lungs bacteria starts to form which leads to pneumonia. Silent aspiration happens when the cough reflex is not present. During an interview on 5/24/23 at 3:53 p.m. DON confirmed R1 should have been on a pureed diet and thickened liquid diet on her admit date of 4/24/23. DON acknowledged R1 started declining on 5/11/23, was sent to the ER and was hospitalized for aspiration pneumonia with sepsis and returned to the facility with hospice 5/16/23, as a result of further decline related to aspiration pneumonia. Facility policy, undated, National Dysphagia Level 1: Pureed Nutritional Therapy, indicated this diet is designed for people who have moderate to	F 689		

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F 689	Continued From page 7 severe dysphagia, with poor oral phase abilities and reduced ability to protect their airway. Close to complete supervision and alternate feeding methods may be required. Facility policy, Physician services, revised 10/2022, indicated the medical care of each resident is under the supervision of a Licensed physician. Physician visits the physician will review the residents total program of care, including medications and treatments at each visit. Facility policy, Nursing admission/Readmission Policy and Guidelines, revised 10/2022, indicated 4. Assure the facility receives appropriate medical records prior to or upon the resident admission. Preadmission/Preadmission: 1. Prior to the admission or readmission, the referring entity and/or attending physician must provide the facility with information related to the immediate care of the resident. An interdisciplinary discussion will occur in the facility involving no less than the social security designee (SSD) and nursing leadership team, but may include the medical director, pharmacy, or any other appropriate entity to best decide if the facility can safely and effectively meet the needs of the potential admission based on the information received. If needed a nurse-to-nurse call may be made to assist in the decision to take the individual as a resident of the facility. The immediate jeopardy that began on 5/1/23, was removed on 5/25/23, when it was verified, the facility implemented the following: -identified residents at risk for aspiration to ensure appropriate diets were given -reviewed physician visit notes for any missed	F 689		

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F 689	Continued From page 8 orders for textured diets -Review and revised policies and procedures -Reviewed/revised care plans as appropriate -Educated all nursing staff on reading physician visits and transcribing orders from provider visits	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/24/23 and 5/25/23, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H54292278C (MN93643) with a licensing order issued at 0830. 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 state form.	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to identify and implement physician orders for a therapeutic textured diet with interventions for safe swallowing for 1 of 3 residents (R1) who received the wrong textured diet for seventeen days, resulting in hospitalization with aspiration pneumonia, lung abscess, sepsis, and hospice care for one of one resident (R1). The immediate jeopardy (IJ) began on 5/1/23, when R1 had a provider visit and R1 was	2 830	F689: Gundersen Tweeten Care Center will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. On 5/24/23 Gundersen Tweeten Care Center verified that resident R1 was on the correct diet order for her diagnosis. Resident R1□s care plan was reviewed and found to be correct as well regarding dietary restrictions.	6/6/23

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2 830	Continued From page 3 diagnosed with dysphagia and required a pureed diet with thickened liquids, the order was not acknowledged or implemented by the facility resulting in R1's transfer to emergency room (ER) and hospitalization from 5/11/23 to 5/16/23. The administrator and director of nursing (DON) were notified of the IJ on 5/24/23, at 4:47 p.m. The immediacy was removed on 5/25/23, at 11:30 a.m. but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1's hospital,Speech Pathology Inpatient Evaluation, dated 4/19/23, identified R1 was referred for a bedside swallow evaluation nursing requested due to poor oral intake. The evaluation identified R1 had four trials given for thin liquids, one trial of bite size solids and easy to chew solids; R1 had delayed throat clearing, change in vital signs, and wet vocal quality. Suspect pharyngeal stasis (residue in the throat after swallowing) and suspected delayed initiation of swallow. After three trials of pureed food and mildly thicken liquids resulting in normal limited speech therapy recommendations were mildly thick liquids, pureed foods, crush medications with puree, upright with all oral intake and remain upright for 30 - 60 minutes after meals, eat/feed slowly, small bites/sips, nursing to provide assistance as needed. Plan: A Video fluoroscopic Swallow Study (VFSS) will need to be performed prior to diet consistency upgrades to rule out aspiration or if a decline in swallowing status observed by medical staff. R1's admission provider visit dated 4/25/23, indicated R1 was admitted to the facility for rehab	2 830	Gundersen Tweeten Care Centered completed the following through the night of 5/24/23 and day of 5/25/23: 1. All licensed nurses were reeducated and tested for competency on transcribing orders and clarifying any discrepancies in orders received during physician visits, clinic visits and upon admission and readmission. This training included writing a progress note summarizing the visit and any order changes as well as updating care plan if needed. Those that were unable to be reeducated on 5/24/23 will be notified by phone and email that they will not be able to work until they have completed their mandatory training. All training will be completed by 5/31/23 for all licensed nurses. 2. A comprehensive review of all physician visits, clinic visits, and discharge summaries that occurred between 4/24/23 to 5/24/23 was conducted to identify any discrepancies or missed physician orders. No discrepancies or missed orders were found. 3. A review of the following policies and procedures was completed, and no changes were made: " Nursing Admission/Readmission Policy & Guidelines " Physician Services " Medication and Treatment Orders 4. A review of the Transcription of Orders policy was completed, and policy was revised to include if orders are not legible or understood, the nurse is to call ordering physician for clarification. Along with this, policy was revised to include adding a progress note to ensure that the physician visit was reviewed.	

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2 830	Continued From page 4 following a hospitalization with a right sided pleural effusion that was thought to be secondary to an autoimmune disease. The visit note did not address R1's diagnoses of dysphagia or diet texture recommendations from her hospitalization and not evident the facility identified or provided R1 required a textured therapeutic diet upon admission to the facility. R1's physician order dated 4/24/23, included regular carb-controlled diet. Further clarified to include low sodium according to the Dietary Communication Order dated 4/25/23. R1's admission, Minimum Data Set (MDS), dated 4/27/23, identified R1 had diagnoses of downs syndrome, acute respiratory failure with hypoxemia (lower than normal oxygen levels) and gastroesophageal reflux disease (GERD). R1 had severe cognitive impairment and required supervision with eating. MDS identified R1 did not have any issues with swallowing/choking and did not identify R1's diagnosis of dysphagia. R1's physician visit dated 5/1/23, indicated during R1's hospital stay from 4/12/23 to 4/24/23, R1 had a speech therapy eval completed to rule out aspiration. Evaluation included findings of moderate oral pharyngeal dysphagia. Recommendations included level 2 mildly thickened liquids and level 4 pureed solids. Meds should be taken crushed with pureed foods. Remain upright as possible for all oral intake and remain upright for 30-60 minutes after meals, eat slowly, and take small bites and sips. Good potential for rehab and SLP (speech language pathologist) re-evaluation can be completed to see if we can advance diet if R1 continues to do well.	2 830	5. An audit of all other residents was completed by our Dietitian to review residents identified to be at risk for aspiration. All residents identified to be at risk for aspiration were found to have the appropriate diet modifications. 6. Training that was completed for transcribing orders and clarifying any discrepancies in orders will be added to orientation for all new licensed nurses that are hired moving forward. Along with this, The Director of Nursing reviewed current systems and made the following changes around doctor visits: 1. Leadership nurses will review clinic notes from providers when they become available to the nursing home. The nurses will sign off when reviewed and scan into chart. Educated to this system on 6/6/23. The DON will audit this weekly for 4 weeks, bi-weekly for 2 months, monthly for 3 months and results of audit will be reported off to the QAA committee monthly	

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2 830	Continued From page 5 In review of R1's physician orders, progress notes, and dietary documentation after the physician acknowledged R1's dysphagia diagnosis, dietary requirements for pureed diet, and interventions were transcribed into the facilities EMR (electronic medical record). Between 5/1/23 to 5/11/23, R1 did not receive the correct diet nor safe swallowing interventions to prevent or mitigate risk of aspiration according to the 5/1/23 physician visit note. During an interview on 5/24/23, at 12:55 p.m. the director of nursing (DON) was not aware R1 had a diagnosis of dysphagia nor the orders that had been identified in the 5/1/23 physician visit note. When R1 was admitted, the hospital discharge paperwork did not identify R1's diagnosis of dysphagia or include R1's speech evaluation and recommendations. DON stated "I didn't know anything about it [5/1/23 physician acknowledgement of dysphagia diagnoses and textured diet order] until you [surveyor] brought it to my attention." DON explained the charge nurse would usually bring the residents visit notes/orders back for her to look at. DON was not sure what happened with R1's 5/1/23, visit or who reviewed it. R1's progress notes dated 5/11/23, at 6:45 a.m. indicated R1 was having diarrhea and nausea. At 11:30 p.m. R1's entire bed was wet from perspiration. R1's blood sugar was elevated, the physician was notified with orders to give insulin. At 11:36 p.m. R1 began to complain of chest pain and stated, "my heart hurts." Family and physician notified and R1 was sent to the emergency department. R1's hospital palliative care visit note dated	2 830		

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2 830	Continued From page 6 5/12/23, identified visit diagnosis as abscess of lung with sepsis. R1 had a large right lung abscess that had not responded to antibiotics nor intervention, had progressed, and was very high risk for a surgical candidate. Shared concerns with family members that R1 was nearing the end of life and could not tolerate any aggressive treatments. Family was supportive of hospice. R1's after visit summary (AVS) dated 5/16/23, indicated R1 had a hospitalization from 5/12/23 to 5/16/23, with diagnoses of right lung abscess with aspiration pneumonia with a fluid collection measuring 7.4 centimeters (cm) x 4.3 cm x 5.5 cm. R1 was placed on end-of-life comfort cares. R1's Dietary Communication Order dated 5/16/23, included pureed diet with nectar thickened liquids. During an interview on 5/24/23, at 10:09 a.m. cook (C)-A, confirmed through documentation that R1 was on a low sodium diet with regular texture when she was first admitted. R1 did not receive pureed diet until 5/16/23, according to our kitchen records During an interview on 5/24/23, at 9:44 a.m. nursing assistant (NA)-A stated when R1 first got here she was a on a regular diet, then she went to the hospital, and currently on a pureed diet with thickened liquids. During an interview on 5/24/23, at 9:46 a.m. NA-B stated when R1 first got here she was a on a regular diet, then one day she was weak and shaky. R1 was sent to the hospital, she was diagnosed with aspiration pneumonia. When R1 returned from the hospital she was on hospice and needed a pureed diet with thickened liquids.	2 830		

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	00285	A. BUILDING: _____ B. WING _____	05/25/2023

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2 830	Continued From page 7 During an interview on 5/24/23, at 9:48 a.m. NA-C stated when R1 first got here she was a on a regular diet, then she got aspiration pneumonia and went to the hospital. R1 came back from the hospital on hospice and was on pureed diet. During an interview 5/24/23, at 12:35 p.m. licensed practical nurse (LPN)-A indicated when we have new admissions the case manager reviews all of the admission paperwork and enters the orders into the EHR. The floor nurses were responsible for the assessments. Following a physician visit/appointment, a nurse needed to go through the visit notes and transcribe the orders and any care plan changes into EHR (electronic health record). LPN-A was not aware why R1's orders for pureed diet and thickened liquids were missed from the 5/1/23 appointment. During an interview on 5/24/23, at 12:46 p.m. speech therapist (ST)-A, stated she never received referral for R1 upon her initial admission date. ST-A stated if textured diets were not followed, it could result in aspiration pneumonia which could lead to sepsis and death. Aspiration can occur when pharyngeal (throat) secretions, food, or gastric (stomach) secretions enter the larynx (tube that leads to the lungs) and trachea and can descend into the lungs, having a diagnosis of GERD can play a role in this as well increasing the risk of aspiration. When the secretions are trapped in the lungs bacteria starts to form which leads to pneumonia. Silent aspiration happens when the cough reflex is not present. During an interview on 5/24/23 at 3:53 p.m. DON confirmed R1 should have been on a pureed diet and thickened liquid diet on her admit date of	2 830		

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2 830	Continued From page 8 4/24/23. DON acknowledged R1 started declining on 5/11/23, was sent to the ER and was hospitalized for aspiration pneumonia with sepsis and returned to the facility with hospice 5/16/23, as a result of further decline related to aspiration pneumonia. Facility policy, undated, National Dysphagia Level 1: Pureed Nutritional Therapy, indicated this diet is designed for people who have moderate to severe dysphagia, with poor oral phase abilities and reduced ability to protect their airway. Close to complete supervision and alternate feeding methods may be required. Facility policy, Physician services, revised 10/2022, indicated the medical care of each resident is under the supervision of a Licensed physician. Physician visits the physician will review the residents total program of care, including medications and treatments at each visit. Facility policy, Nursing admission/Readmission Policy and Guidelines, revised 10/2022, indicated 4. Assure the facility receives appropriate medical records prior to or upon the resident admission. Preadmission/Preadmission: 1. Prior to the admission or readmission, the referring entity and/or attending physician must provide the facility with information related to the immediate care of the resident. An interdisciplinary discussion will occur in the facility involving no less than the social security designee (SSD) and nursing leadership team, but may include the medical director, pharmacy, or any other appropriate entity to best decide if the facility can safely and effectively meet the needs of the potential admission based on the information received. If needed a nurse-to-nurse call may be	2 830		

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2 830	Continued From page 9 made to assist in the decision to take the individual as a resident of the facility. The immediate jeopardy that began on 5/1/23, was removed on 5/25/23, when it was verified, the facility implemented the following: -identified residents at risk for aspiration to ensure appropriate diets were given -reviewed physician visit notes for any missed orders for textured diets -Review and revised policies and procedures -Reviewed/revised care plans as appropriate -Educated all nursing staff on reading physician visits and transcribing orders from provider visits SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to physician orders and transcription policies, to ensure appropriate texture diet orders are being implemented are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		