Electronically delivered

August 12, 2019

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

RE: Project Number H5429021C

Dear Administrator:

On July 26, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is September 4, 2019.

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.

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.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 26, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 26, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 07/26/2019

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 000	INITIAL COMMENTS On 7/26/19 abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5429021C with deficiencies issued at F600 and F741. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		9/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2019

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 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 6 of 6 residents (R1, R2, R3, R4, R5, R6) were free from physical abuse from resident-to-resident altercations where in 9 separate incidences R1 was either the aggressor or the victim. Findings include: A review of facility reported incidents from 5/1/19 to 7/26/19, indicated R1 was involved in 9 separate resident-to-resident physical altercations with R2, R3, R4, R5, and R6 in the facilities locked dementia care unit. During an continuous observation and interview on 7/26/19, at 1:03 p.m. trained medication assistant (TMA-A) was at the medication cart with R4 along the side of her, R1 was grabbing onto the arm of R4's wheelchair attempting to move it. At 1:04 p.m. TMA-A called for assistance once she got R1 to let go of R4's wheelchair. TMA-A stated she had been at the medication cart getting medications ready to pass, when TMA-A observed R1 pushing R4's wheelchair down the hallway from dining room/kitchen area. TM-A stated she was not able to supervise the residents during that time. TMA-A continued by stating when she saw R1 pushing R4, she stopped and pushed R4 next to her. While TMA-A was attempting to redirect R1 and relocate R4, R3 was continuously stating "[R1] has bullets and kills people". TMA-A stated when	F 600	GTCC will continue to ensure that all residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The facility will continue to ensure it does not use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. Nursing and activities staff were educated on 8/1/19 on all resident's being free from abuse and neglect and sufficient staffing regarding resident behavioral needs and action necessary to correct and prevent further altercations between residents on The Woodland's Dementia Care Household. Actions include: 1) Staffing changes were implemented on 7/26/19 to prevent resident to resident abuse. Staffing adjustments are designed to provide adequate supervision to prevent further altercation. 2) Resident #1 who was involved as aggressor or victim in multiple altercations has been evaluated by his physician and medications have been adjusted. 3) Review of resident preferences, life history and behavioral health needs was done and person-centered activity items were	

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F 600	Continued From page 2 she turned around to attempt de-escalate R3, who was in near proximity of the medication cart, R1 walked by R4 and started hitting him over the head with a stuffed turtle. TMA-A then went over and moved R4 and attempted to redirect R1 again however, he persisted to hold onto R4's wheelchair arm attempting to move it. At 1:07 p.m. LPN-A arrived in the unit and took TMA-A's report of the incident. R4 stated when R1 hit him on top of the head it hurt, but did not hurt anymore. R1 left the area and walked down the hallway. At 1:12 p.m. R1 again grabbed onto the arm of R4's wheelchair and attempted to move it while LPN-A and TMA-A stood on the other side of R4. R1 was redirected by TMA-A and then registered nurse (RN)-B who arrived on the unit, redirected and lead R1 away from R4. R1's facility Face Sheet dated 7/26/19, included diagnosis of dementia with behavioral disturbance, Alzheimer's disease, and anxiety disorder. R1's annual Minimum Data Set (MDS) dated 6/25/19, indicated R1 had severe cognitive impairment, had behaviors of wandering 4-6 days of the assessment period and had physical behaviors directed towards others 1 to 3 days during the assessment period. The MDS also indicated R1 required extensive assistance from 2 or more staff for bed mobility and transfers and required supervision with ambulation and locomotion. R1's care plan dated 6/26/19, indicated R1 is incapable of discerning safety needs and directed staff to assist to safe area and calmly keep safe, and one staff to monitor/supervise ambulation redirecting if in an unsafe area. The care plan also included, R1 sometimes became frustrated with being at the facility and didn't understand why he couldn't go home, sometimes that lead to verbal and physical	F 600	purchased to provide tactile stimulation. 4) The DON will monitor daily to ensure sufficient staffing. SSD, DON and QAPI Nurse to monitor each reported alleged violation involving abuse, neglect, exploitation or mistreatment, including misappropriation of resident property at the time of submission for trends. If trends are noted, IDT team to be notified and review completed reports to look for gaps in the systems that need addressing to prevent further incidents. QAPI nurse to audit investigations for strong interventions and trends monthly x6 months and report to QAPI committee findings and actions taken.	

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F 600	Continued From page 3	F 600		

aggression. The care plan also indicated R1 had wandering behaviors and directed staff to provide redirection to another area on the unit when other residents became irritated with R1's interaction with them, and engage in activity of interest. The care plan also directed staff to assess whether the behavior endangers the resident and/or other, intervene when necessary, avoid over stimulation and indicated R1 preferred to do activity of interest in his own room over group activities, and is easily redirected when wandering the halls or anxious keep busy with tasks. When resident becomes physically abuse, keep distance between resident and others and when resident becomes physically aggressive, encourage resident to move to a quiet calm environment.

R2's facility face sheet dated 7/26/19, included diagnoses of Alzheimer's disease and dementia without behavioral disturbance. R2's quarterly MDS dated 5/14/19, indicated R2 had moderate cognitive impairment, required limited assistance of one staff for bed mobility, and supervision with transfers, ambulation, and locomotion. R2's care plan dated 4/21/16 included, "has a history of aggressive behaviors directed at other residents who are verbally abusive toward him." The care plan directed staff to offer interactions away from disruptive or loud others, maintain space apart, avoid over-stimulation, maintain calm environment, observe closely when other resident in household are loud/disruptive or swearing at staff, when resident becomes annoyed/irritated with another resident move to a quiet, calm environment.

R3's facility Face Sheet dated 7/26/19, included diagnoses of Alzheimer's disease and dementia without behavioral disturbance. R3's quarterly

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F 600	Continued From page 4 MDS dated 7/16/19, indicated R3 had moderate cognitive impairment, required extensive assistant of one staff for bed mobility, extensive assistance of two or more staff for transfers, and limited assistance with ambulation, and supervision with locomotion on and off the unit. R3's care plan dated 5/10/19, included "resident has dementia with periods of disorientation and be physically aggressive/abusive toward others." The care plan directed staff to allow distance in seating other residents around resident, assess whether behavior endangers the resident and/or others, maintain calm environment, seat resident where constant/near constant observation is possible, when resident becomes physically abusive, keep distance between resident and others and move to quiet calm environment. R4's facility Face sheet dated 7/26/19, included diagnoses of dementia due to Parkinson's, dementia with behavioral disturbance, restlessness and agitation, and major depressive disorder. R4's quarterly MDS dated 7/9/19, indicated R4 had moderate cognitive impairment, required extensive assistance of two or more staff for bed mobility and transfers, and was totally dependent on staff for locomotion. R4's care plan dated 7/23/19, indicated R4 had hallucinations and periods of agitation. The care plan also indicated R4 was vulnerable related to cognition and physical limitations he would require assist to safety in the event of harmful situation. The care plan directed staff to assist to safety in the event of a harmful situation. R5's facility Face Sheet dated 7/26/19, included diagnosis of dementia with behavioral disturbance, Alzheimer's disease, anxiety disorder, and major depressive disorder. R5's	F 600		

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F 600	Continued From page 5 MDS dated 7/2/19, indicated R5 had moderate cognitive impairment, required extensive assistance of two or more staff for bed mobility, and extensive of assistance of one staff for transfers, walking in room and corridor, and locomotion on and off the unit. R5's care plan dated 3/26/19, included "Resident becomes irritated with others at times when they are too close in his personal space." The care plan indicated and directed staff to avoid chaotic environment and reduce stimulation, allow distance in seating other residents around resident, and when resident becomes irritated with other residents keep distance between resident and others, assess whether the behaviors endangers the resident and/or others, and maintain calm environment. R6's facility Face Sheet dated 7/26/19, included diagnosis of Alzheimer's disease and dementia with behavioral disturbance. R6's quarterly MDS dated 4/2/19, indicated R6 had severe cognitive impairment, required extensive of assistance from two or more staff members for bed mobility, transfers, and toileting, and required supervision with locomotion on and off the unit. R6's care plan dated 6/7/19, indicated R6 was incapable of discerning safety needs and would need full staff assistance to safety. The care plan also indicated R6 was forgetful and got agitated when she didn't understand what she should do, had periods of aggression and paranoia, and became irritated with others at times when they are too close in personal space. The care plan directed staff to allow distance in seating of other residents around resident to optimize functioning, avoid over stimulating environment, could become irritated with other residents, monitor signs and symptoms when identified help resident to	F 600		

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F 600	Continued From page 6 maintain personal space between herself and others. A facility reported incident to the State Agency dated 5/5/19, indicated the incident happened on 5/5/19, at 9:00 p.m. when R1 walked into R2's room and hit R2 on his shoulder with a shoe. The investigative summary dated 5/10/19, indicated staff were not aware R1 had wandered into R2's room; staff heard R2 yelling at R1 from his room and then observed R2 exiting his bed. R2 had a shoe in his hand and stated R1 had hit his shoulder with his shoe. The actions taken to prevent reoccurrence to either residents included, R1 was removed from R2's room, and staff continued to monitor whereabouts and redirected R1 to another area. A facility reported incident to the State Agency dated 5/10/19, indicated the incident happened on 5/10/19, at 11:45 a.m. stating R5 was sitting on the couch when R1 walked by and put his hand down on the arm of the couch to steady himself next to R5. R5 grabbed R1's wrist and squeezed, stated "Go away, get out of here you dumb ass" as R1 tried to pull away and stated "ouch" repeatedly in the process. The report indicated staff did not directly observe the incident when it started, rather overheard the altercation, responded, and got R1 "free from [R5's] grasp". The investigative summary dated 5/14/19, indicated the action taken to prevent reoccurrence to either of the residents included the two residents involved were physically separated and engaged in activities with staff present on the unit and monitored involved residents to ensure safety and to maintain milieu of the unit.	F 600		

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F 600	Continued From page 7	F 600		

A facility reported incident submitted to the State Agency on 5/10/19, indicated the incident happened on 5/10/19, at 7:36 p.m. The report indicated R6 started yelling in a harsh voice at R1 and was banging on something in the dining room area. Staff member witnessed R1 irritated with R6's behavior and observed R1 grab R6's sweater on upper right side aggressively and pull it. The staff member redirected R1 out of the living room area. The report indicated although staff were in the unit, the residents were not being supervised when the incident began. The investigative summary dated 5/14/19, indicated the unit was calm prior to the incident and the two staff members in the unit were down the resident hallway assisting another resident at the time. The intervention to prevent reoccurrence to either residents included, "residents monitored to maintain physical separation and therapeutic milieu of the unit."

A facility reported incident submitted to the State Agency on 5/20/19, indicated the incident occurred on 5/20/19, at 5:50 p.m. when R1 leaned over to pick up a pillow off the floor and R6 came behind him, and slapped him on his back. The investigative report dated 5/21/19, indicated R1 was walking into the dining room holding a pillow and blanket, dropped the pillow on the floor, R6 saw pillow on the floor, became upset, and tried to grab pillow from R1. R1 grabbed pillow tight so R6 could not take it, R6 then hit R1 on the back. The report indicated the nursing assistant (NA) stepped between the residents and redirected R6 away from R1. The report indicated R1 had medication adjusted by the physician and distracted with activities following the incident. Action taken to prevent reoccurrence to either resident included, observe

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F 600	Continued From page 8	F 600		

residents in group areas, monitor for increased agitation, anticipate mood and triggers, keep space between residents as appropriate, and engage residents in activities.

A facility reported incident submitted to the State Agency on 5/27/19, indicated the incident occurred on 5/27/19, at 11:15 a.m. when R1 took R6's baby doll off the table, R6 got upset and hit R1's hand 3 times, R1 then slapped R6's cheek three times. The investigative report dated 5/29/19, indicated staff witnessed the incident, separated the residents, and de-escalated the situation. Action take to prevent re-occurrence to either residents included encourage staff to engage resident in activities, provide baby doll to both residents, try to keep space between them, monitor for triggers when residents area mobile.

A facility reported incident to the State Agency on 6/4/19, indicated the incident happened on 6/4/19, at 1:45 p.m. when R3 was pushing his wheelchair and trying to hit R1 who was walking in the hall with his wheelchair, NA intervened with R1 having his hands on R3's arm. The investigative summary dated 6/7/19, indicated R3 had tried to push his wheelchair into R1 in May 2019, and R3's care plan was not followed at the time of occurrence; R3 was supposed to be contact guard assist with ambulation. The report also included the aforementioned incident report information; in addition to NA staff attempted to move R1 out of the way but R3 continued trying to push his wheelchair into R1 so he could not move. Another staff member entered the unit and helped separate the 2 residents, R3 grabbed R1's arm when staff attempted to move R1 out of the way. The report included, "no injuries noted on [R1's] arm. Action taken to prevent re-occurrence

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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to either resident included staff were educated to replace R3's wheelchair with walker when resident is pushing wheelchair and should be accompanied by staff and staff would intervene if found pushing wheelchair.

A facility reported incident submitted to the State Agency on 7/16/19, indicated the incident happened on 7/16/19, at 11:36 a.m. R1 was passing by R5 and punched him on the legs without being provoked. R1 was removed by staff member, at that time R1 reached for R2's foot, grabbed it, and R2 slapped R1. The report indicated R1 sustained red/purple bruise on the left had that measured 0.9 x 1.0 centimeters and that bruise had appeared around noon. The investigative report dated 7/18/19, indicated staff were not supervising the resident at the time, "staff heard a commotion coming from the living room. When staff entered area [R1] was grabbing and hitting [R5]. R5 was striking back and hitting.

A facility reported incident submitted to the State Agency on 7/23/19, indicated the incident happened on 7/23/19, at 7:00 a.m. when R1 walked past R5 with a piece of paper in his hand. R5 swatted at R1's hand and R1's hand hit the table. The incident was witnessed by a staff member.

During an interview on 7/25/19 at 3:49 p.m. local sheriff indicated concern on the number of resident-to-resident altercations at the facility and they seemed constant. Sheriff indicated he had responded to a number of incidents and has to follow-up with family members, it had gotten to the point where some families have told him not to call unless the injury was significant and/or unusual occurrence. Sheriff stated they have one

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guy that roams the hallways 24 hours a day, "why is he wandering the halls at 4:00 in the morning?" Sheriff stated he had no problem with the staff and it could be that there isn't enough staff available.

During an interview on 7/26/19, at 10:41 a.m. nursing assistant TMA-A stated there was not enough staff in the unit to make sure all the residents were safe. TMA-A stated R1 needed constant supervision when he's up, he continuously wanders, moves furniture around, and gets into other residents personal spaces, R2 and R3 get very irritated with him and they have shown aggressive behaviors toward him. R1 had aggressive behaviors toward other residents, but was also at high risk for being abused because of his behaviors. TMA-A stated she couldn't provide continuous supervision if she had to take someone to the bathroom or redirect a resident, there wasn't time to call someone for help. TMA-A stated she could not prevent and/or intervene if she couldn't continuously watch them. TMA-A indicated recently administration had cut nursing hours in the unit because census had changed from seven residents to five residents.

During an interview on 7/26/19, at 11:00 a.m. licensed practical nurse (LPN)-A stated staffing levels had changed lately in the unit, and now only one NA was scheduled back there for days and evenings with a float person that would go between the units. LPN-A indicated the reason for this was because the census had changed, however felt the acuity of the residents had not. LPN-A stated one person is not enough in the unit to keep residents safe because of some of the aggressive behaviors that required de-escalation in that moment. LPN-A stated

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residents are at risk for injury and harm because staff could directly supervise and/or redirect to prevent an incident when they have to attend to someone's toileting needs, do checks, pass medications, ect.

During an interview on 7/26/19, at 12:31 p.m. NA-C stated there had been staffing changes related to the census. NA-C stated "you can't possibly supervise residents with only one person, if somebody [resident] is having a bad day, you can't do it by yourself. Supposed to call to get help but sometimes didn't have enough time to make the phone call." NA-C indicated it was very hard and very frustrating, cannot be everywhere at the same time, residents were not safe and more at risk for injury. NA-C stated R1 wonders all over and agitates other residents, "I don't know what is happening if I'm not right there when he gets up."

During an interview on 7/26/19, at 12:45 p.m. interim director of nursing (DON), confirmed staffing had been changed on the unit because the census had gone down to five residents at the beginning of July. DON indicated staff that work in the unit have voiced concern about the level of staffing. DON stated, potentially residents safety is at risk because of the lack of staffing. DON also indicated R1 wandered and had a tendency to get into other residents' personal spaces, which irritated/agitated other residents. DON also indicated that one staff member could not move resident away from R1 and/or provide de-escalation techniques if they were not present and watching.

During an interview on 7/26/19, at 1:54 p.m. registered nurse (RN)-A stated she often times

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worked the unit in the evening. RN-A stated there was not adequate staffing levels to provide appropriate levels of supervision. RN-A indicated when she assisting a resident is one area of the unit, she couldn't see what was going on in another area, and didn't have time to call for assistance all the time. "I can't keep track of everybody, it's not safe".

During an interview on 7/26/19, at 3:51 p.m. RN-B indicated that staffing was reduced in the unit, if staff feel unsafe in the unit they could call the other unit for assistance. RN-B indicated it was difficult to provide the level of care the residents in the unit require and be cost effective at the same time. RN-B indicated it would be difficult for one person to provide all the necessary dementia related interventions in order to prevent altercations from occurring.

During an interview on 7/26/19, at 4:23 p.m. administrator confirmed staffing hours were changed based on the acuity of the unit and used the MDS and CMS time study report. Administrator stated the most recent change to scheduling happened this week where staffing in the unit was reduced to one staff in the unit during the day with a float between the units, and on the evening shift staff member and a four hour shift from 4:00 p.m. to 8:00 p.m. during high care times. Administrator indicated that staffing pattern equaled out to be an average of 7.77 hours of nursing hours per resident day, and indicated according to the acuity level of 3.05, staffing should be sufficient. Administrator stated that the facility had a meeting planned for 8/6/19, to review and evaluate the change that was made to the staffing patterns.

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F 600	Continued From page 13 Facility's Plan for Abuse Prevention and Reporting dated 7/12/19, included it is the policy of Gunderson Tweeten Care Center to maintain an environment where residents are free from abuse, neglect, exploitation, and misappropriation of resident property and all residents, staff, families, visitors, volunteers, students, and resident representative are encouraged and supported in reporting any suspected acts of abuse. -F600 Each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone. -physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. -Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse Policy: Residents will be protected from abuse, neglect, and harm while they reside at Gunderson Tweeten Care Center. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection.	F 600		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These	F 741		9/3/19

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F 741	Continued From page 14 competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure sufficient staffing in locked unit to supervise to prevent and/or reduce the risk of resident to resident physical abuse for 5 of 5 residents (R1, R2, R3, R4,R5) who had a history of dementia related behaviors that included physical abuse and wandering. Findings include: A facility reported incident submitted to the State Agency on 7/16/19, indicated the incident happened on 7/16/19, at 11:36 a.m. R1 was passing by R5 and punched him on the legs without being provoked. R1 was removed by staff member, at that time R1 reached for R2's foot, grabbed it, and R2 slapped R1. The report indicated R1 sustained red/purple bruise on the left had that measured 0.9 x 1.0 centimeters and	F 741	GTCC will continue to have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering number, acuity and diagnoses of the facility's resident population in accordance with 483.70(e). Gundersen Tweeten Care Center continues to staff above the 5-Star standard based on acuity on the dementia household. Resident #1 had been provided with 1:1 monitoring during waking hours and when in groups of residents. Resident #1 expired on 8/19/19. The DON will continue	

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F 741	Continued From page 15 that bruise had appeared around noon. The investigative report dated 7/18/19, indicated staff were not supervising the resident at the time, "staff heard a commotion coming from the living room. When staff entered area [R1] was grabbing and hitting [R5]. R5 was striking back and hitting. A facility reported incident submitted to the State Agency on 7/23/19, indicated the incident happened on 7/23/19, at 7:00 a.m. when R1 walked past R5 with a piece of paper in his hand. R5 swatted at R1's hand and R1's hand hit the table. The incident was witnessed by a staff member. R1's facility Face Sheet dated 7/26/19, included diagnosis of dementia with behavioral disturbance, Alzheimer's disease, and anxiety disorder. R1's annual Minimum Data Set (MDS) dated 6/25/19, indicated R1 had severe cognitive impairment, had behaviors of wandering 4-6 days of the assessment period and had physical behaviors directed towards others 1 to 3 days during the assessment period. R1's care plan dated 6/26/19, indicated R1 sometimes became frustrated with being at the facility and didn't understand why he couldn't go home, sometimes that lead to verbal and physical aggression. The care plan also indicated R1 had wandering behaviors and directed staff to provide redirection to another area on the unit when other residents are becoming irritated with R1's interaction with them, and engage in activity. R2's facility face sheet dated 7/26/19, included diagnoses of Alzheimer's disease and dementia without behavioral disturbance. R2's quarterly MDS dated 5/14/19, indicated R2 had moderate cognitive impairment. R2's care plan dated	F 741	to monitor daily to ensure sufficient staffing to meet resident needs. Acuity levels will be monitored monthly by the Administrator and Director of Nursing. DON will monitor special treatments and Activities of Daily Living scores along with acuity levels monthly to determine staffing levels are adequate. Results of monitoring will be reported to quarterly QAA meeting.	

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4/21/16 included, "has a history of aggressive behaviors directed at other residents who are verbally abusive toward him."

R3's facility Face Sheet dated 7/26/19, included diagnoses of Alzheimer's disease and dementia without behavioral disturbance. R3's quarterly MDS dated 7/16/19, indicated R3 had moderate cognitive impairment. R3's care plan dated 5/10/19, included "resident has dementia with periods of disorientation and be physically aggressive/abusive toward others.

R4's facility Face sheet dated 7/26/19, included diagnoses of dementia due to Parkinson's, dementia with behavioral disturbance, restlessness and agitation, and major depressive disorder. R4's quarterly MDS dated 7/9/19, indicated R4 had moderate cognitive impairment. R4's care plan dated 7/23/19, indicated R4 had hallucinations and periods of agitation.

R5's facility Face Sheet dated 7/26/19, included diagnosis of dementia with behavioral disturbance, Alzheimer's disease, anxiety disorder, and major depressive disorder. R5's MDS dated 7/2/19, indicated R5 had moderate cognitive impairment. R5's care plan dated 3/26/19, included "Resident becomes irritated with others at times when they are too close in his personal space."

During a continuous observation that began on 7/26/19, at 8:12 a.m. trained medication assistant (TMA)-A was the only staff member on the unit. R1 was sleeping in bed. R3 was in the kitchen drinking coffee, R4 sat in a Broda wheelchair at the dining room table. R2 was initially in his room, and then walked to the table in living room area

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and sat down. R3 joined the other's at the table, and R5 wheeled himself down the hallway. For 4 minutes TMA-A walked to activity closet to gather supplies for activity, residents were not supervised during that time, R3 wheeled himself away from the table into the kitchen, TMA-A then provided redirection to R3 to go back to table for activity.

-At 8:26 a.m. to 8:47 a.m. TMA-A engaged the three residents in an activity; residents were actively engaged in the activity. At 8:48 a.m. an unidentified staff member walked into the unit to check to see how things were going and then exited the unit.

-At 8:54 a.m. TMA-A went to the kitchen area, left the 3 residents alone at the table and was out of view for 4 minutes. At 8:58 a.m. registered nurse (RN)-B walked into the unit to see how things were going and then exited the unit. At 9:02 a.m. NA-C came into the unit, asked if TMA-A need anything, TMA-A responded no, NA-C left the unit.
-At 9:00 a.m. the activity ended.
-At 9:10 a.m. R1 was walking up the hallway towards the living room area, at 9:24 a.m. TMA-A asked R1 to come down to living room area.
-At 9:30 a.m. R1 was wandering up and down the hallway, R3 is in the bathroom, TMA-A assisted R2, R1 continued to wander and pushed/moved chairs in the dining. R1 wandered down the hallways and started to push on the exit door. TMA-A continued to assist R3.
-At 9:39 a.m. R2 returned to the unit from restorative, R1 was observed wandering around the unit. R1 was attempting to get into the bathroom, TMA-A noticed and successfully redirected R1.

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F 741	Continued From page 18 -At 9:47 a.m. R1 continued to wander up and down the hallways, walked close to other residents, TMA-A was at the medication cart not in direct view of residents in the living room area. -At 9:54 a.m. R2 sat next to TMA-A in living room area. R1 took a large painting off the wall, R2 became visibly annoyed, started to move to stand up and stated "oh God!! I hate him!". TMA-A successfully de-escalated and returned to conversation about animals with TMA-A. -At 9:56 a.m. TMA-A was 1:1 with R1, to move him away from R2, TMA-A then sat in a chair next to R2. R1 walked over to TMA-A and attempted to move the chair TMA-A was sitting in. R2 again became visibly upset, turned his head to R1, in an elevated voice stated, "HEY, LEAVE HER ALONE!" TMA-A, successfully de-escalated R2 again. R1 then walked in very close proximity to R2, TMA-A distracted R2 while R1 walked in front of him. -At 10:05 a.m. R3 returned to the unit from restorative therapy. R1 continued to wander the unit. -At 10:23 a.m. NA-C had taken over for TMA-A for a break. R1 continued to wander and was in the kitchen/dining room area and in very close proximity to R3, NA-C removed R3 from the area and took him to the adjacent room to watch the tractor bailing hay. -At 10:26 a.m. NA-C took R3 to the bathroom, R1 attempted to go into the bathroom and was redirected. -At 10:27 a.m. all five residents were back in the unit and in different locations, R1 continued to wander intermittently stopped attempted to move furniture. NA-C could not visualize all of the residents at the same time based on the location of the residents.	F 741		

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F 741	Continued From page 19 During an continuous observation and interview on 7/26/19, at 1:03 p.m. trained medication assistant (TMA-A) was at the medication cart with R4 along the side of her, R1 was grabbing onto the arm of R4's wheelchair attempting to move it. At 1:04 p.m. TMA-A called for assistance once she got R1 to let go of R4's wheelchair. TMA-A stated she had been at the medication cart getting medications ready to pass, when TMA-A observed R1 pushing R4's wheelchair down the hallway from dining room/kitchen area. TM-A stated she was not able to supervise the residents during that time. TMA-A continued by stating when she saw R1 pushing R4, she stopped and pushed R4 next to her. While TMA-A was attempting to redirect R1 and relocate R4, R3 was continuously stating "[R1] has bullets and kills people". TMA-A stated when she turned around to attempt de-escalate R3, who was in near proximity of the medication cart, R1 walked by R4 and started hitting him over the head with a stuffed turtle. TMA-A then went over and moved R4 and attempted to redirect R1 again however, he persisted to hold onto R4's wheelchair arm attempting to move it. At 1:07 p.m. LPN-A arrived in the unit and took TMA-A's report of the incident. R4 stated when R1 hit him on top of the head it hurt, but did not hurt anymore. R1 left the area and walked down the hallway. At 1:12 p.m. R1 again grabbed onto the arm of R4's wheelchair and attempted to move it while LPN-A and TMA-A stood on the other side of R4. R1 was redirected by TMA-A and then registered nurse (RN)-B who arrived on the unit, redirected and lead R1 away from R4. During an interview on 7/25/19 at 3:49 p.m. local sheriff indicated concern on the number of resident-to-resident altercations at the facility and they seemed constant. Sheriff indicated he had	F 741		

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responded to a number of incidents and has to follow-up with family members, it had gotten to the point where some families have told him not to call unless the injury was significant and/or unusual occurrence. Sheriff stated they have one guy that roams the hallways 24 hours a day, "why is he wandering the halls at 4:00 in the morning?" Sheriff indicated he had no problem with the staff and it could be that there isn't enough staff available.

During an interview on 7/26/19, at 10:41 a.m. trained medicaiton assistant (TMA)-A stated there was not enough staff in the unit to make sure all the residents were safe. TMA-A stated R1 needed constant supervision when he's up, he continuously wanders, moves furniture around, and gets into other residents personal spaces, R2 and R3 get very irritated with him. R1 had aggressive behaviors toward other residents, but was also at high risk for being abused because of his behaviors. TMA-A indicated she feels like there are more incidents of resident to resident altercations since staffing was reduced. TMA-A stated she couldn't provide continuous supervision if she had to take someone to the bathroom or redirect a resident, there wasn't time to call someone for help. TMA-A stated she could not prevent and/or intervene if she couldn't continuously watch them. TMA-A also stated she could not possibly provide group activities and individualized activities when R1 was wondering around and had to continuously redirect to keep him safe and other residents safe from him. TMA-A indicated recently administration had cut nursing hours in the unit because census had changed from seven residents to five residents. TMA-A stated that there was only one staff member scheduled during the day shift, and a

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	245429	A. BUILDING _____ B. WING _____	C 07/26/2019

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 741	Continued From page 21	F 741		

float person until 10:00 a.m. that would work between the units. TMA-A then stated from 10:00 a.m. until 2:00 p.m. there was only one staff member in the unit. On the evening shift, there is one NA scheduled then a float, and the nurse comes in and passes the medications. TMA-A stated we used to have someone from 4:00 p.m. to 8:00 p.m. Night shift has one staff member and that had not changed. TMA-A indicated that since she was a trained medication assistant (TMA) she was responsible for passing medications, conducting activities, and housekeeping tasks as well as routine toileting and personal cares.

During an interview on 7/26/19, at 11:00 a.m. licensed practical nurse (LPN)-A stated staffing levels had changed lately in the unit, and now only one NA was scheduled back there for days and evenings with a float person that would go between the units. LPN-A indicated the reason for this was because the census had changed, however felt the acuity of the residents had not. LPN-A stated one person is not enough in the unit to keep residents safe because of the behaviors. LPN-A stated residents are at risk for injury and harm because staff could directly supervise and/or redirect to prevent an incident they have to attend to someone's toileting needs, do checks, pass medications, ect.

During an interview on 7/26/19, at 12:31 p.m. NA-C stated there had been staffing changes related to the census. NA-C stated "you can't possibly supervise residents with only one person, if somebody [resident] is having a bad day, you can't do it by yourself. Supposed to call to get help but sometimes you don't have enough time to make the phone call." NA-C indicated it was very hard and very frustrating, cannot be

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F 741	Continued From page 22	F 741		

everywhere at the same time, residents were not safe and more at risk for injury. NA-C stated R1 wonders all over and agitates other residents, "I don't know what is happening if I'm not right there when he gets up." NA-C stated if there was more staff the unit would be safer because we could provide activities and keep them more occupied. NA-C stated she feels like since staffing changed in the unit, felt like there were more altercations.

During an interview on 7/26/19, at 12:45 p.m. interim director of nursing (DON), confirmed staffing had been changed on the unit because the census had gone down to five residents at the beginning of July. DON indicated the staffing levels were based on acuity level of the residents, acuity was based on the Minimum Data Set, and was not sure if the acuity level took into consideration the number of behaviors and level of supervision required. DON indicated staff that work in the unit have voiced concern about the level of staffing. DON stated, potentially residents safety is at risk because of the lack of staffing. DON indicated when the interdisciplinary team reviewed the resident to resident incident reports it was determined that the increased staff levels would not have prevented all of the incidents from occurring.

During an interview on 7/26/19, at 1:54 p.m. registered nurse (RN)-A stated she often times worked the unit in the evening. RN-A stated there was not adequate staffing levels to provide appropriate levels of supervision. RN-A indicated when she assisting a resident is one area of the unit, she couldn't see what was going on in another area, and didn't have time to call for assistance all the time. "I can't keep track of everybody, it's not safe".

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F 741	Continued From page 23 During an interview on 7/26/19, at 3:51 p.m. RN-B indicated that staffing was reduced in the unit, if staff feel unsafe in the unit they could call the other unit for assistance. RN-B indicated it was difficult to provide the level of care the residents in the unit require and be cost effective at the same time. RN-B indicated it would be difficult for one person to provide all the necessary dementia related interventions. During an interview on 7/26/19, at 4:23 p.m. administrator confirmed staffing hours were changed based on the acuity of the unit and used the MDS and CMS time study report. Administrator stated the most recent change to scheduling happened this week where staffing in the unit was reduced to one staff in the unit during the day with a float between the units, and on the evening shift staff member and a four hour shift from 4:00 p.m. to 8:00 p.m. during high care times. Administrator indicated that staffing pattern equaled out to be an average of 7.77 hours of nursing hours per resident day, and indicated according to the acuity level of 3.05, staffing should be sufficient. Administrator stated that the facility had a meeting planned for 8/6/19, to review and evaluate the change that was made to the staffing patterns. Facility Assessment last 6/30/19, included the following: Acuity 1.5: Gunderson Tweeten Care Center utilized their electronic health record reports that pull acuity information from each resident's MDS to consider RUG levels as well as how much assistance our residents are requiring with activities of daily living. We also evaluate what and how many special treatments and conditions are occurring within our resident	F 741		

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F 741	Continued From page 24 population. The assessment indicated the number/average range of residents that had behavioral symptoms and cognitive impairment as 4-5. -1.7: Interdisciplinary Team also considers other facts such as resident's preferences for getting up and going to bed, preferences around bathing schedules, personal lift histories to include meaningful activities that resident enjoys, preferences for nap schedules, and food likes/dislikes and utilizes this information to enhance a more person centered approach to caring for each individual resident. -Staffing Plan 3.2 included staffing plan for Woodlands household: RN/LPN/TMA: one for day shift and one for overnight shift on Woodlands Memory Care Household (12 beds). Direct care staff for Woodlands: one shared NA 4 hour float with unit 2 for day shift and for evenings one 4 hour NA on evening shift and occasionally as needed night shift. Restorative assistant 6 days a week for 8 hours; RA shared between units. One activity aide evening for 4 hours	F 741		

Electronically Delivered

August 12, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5429021C

Dear Administrator:

A complaint investigation was completed on July 26, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/26/19, surveyors of this Department's staff conducted an investigation of complaint H5429021C . As a result, correction orders were issued at 0800 (MN Rule 4685.0510 Subp 1.) Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure sufficient staffing in locked unit to supervise to prevent and/or reduce the risk of resident to resident physical abuse for 5 of 5 residents (R1, R2, R3, R4,R5) who had a history of dementia related behaviors that included physical abuse and wandering. Findings include: A facility reported incident submitted to the State Agency on 7/16/19, indicated the incident happened on 7/16/19, at 11:36 a.m. R1 was passing by R5 and punched him on the legs without being provoked. R1 was removed by staff member, at that time R1 reached for R2's foot,	2 800	GTCC will continue to have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering number, acuity and diagnoses of the facility's resident population in accordance with 483.70(e). Gundersen Tweeten Care Center continues to staff above the 5-Star standard based on acuity on the dementia household. Resident #1 had been provided with 1:1 monitoring during	9/3/19

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2 800	Continued From page 3 grabbed it, and R2 slapped R1. The report indicated R1 sustained red/purple bruise on the left had that measured 0.9 x 1.0 centimeters and that bruise had appeared around noon. The investigative report dated 7/18/19, indicated staff were not supervising the resident at the time, "staff heard a commotion coming from the living room. When staff entered area [R1] was grabbing and hitting [R5]. R5 was striking back and hitting. A facility reported incident submitted to the State Agency on 7/23/19, indicated the incident happened on 7/23/19, at 7:00 a.m. when R1 walked past R5 with a piece of paper in his hand. R5 swatted at R1's hand and R1's hand hit the table. The incident was witnessed by a staff member. R1's facility Face Sheet dated 7/26/19, included diagnosis of dementia with behavioral disturbance, Alzheimer's disease, and anxiety disorder. R1's annual Minimum Data Set (MDS) dated 6/25/19, indicated R1 had severe cognitive impairment, had behaviors of wandering 4-6 days of the assessment period and had physical behaviors directed towards others 1 to 3 days during the assessment period. R1's care plan dated 6/26/19, indicated R1 sometimes became frustrated with being at the facility and didn't understand why he couldn't go home, sometimes that lead to verbal and physical aggression. The care plan also indicated R1 had wandering behaviors and directed staff to provide redirection to another area on the unit when other residents are becoming irritated with R1's interaction with them, and engage in activity. R2's facility face sheet dated 7/26/19, included diagnoses of Alzheimer's disease and dementia without behavioral disturbance. R2's quarterly	2 800	waking hours and when in groups of residents. Resident #1 expired on 8/19/19. The DON will continue to monitor daily to ensure sufficient staffing to meet resident needs. Acuity levels will be monitored monthly by the Administrator and Director of Nursing. DON will monitor special treatments and Activities of Daily Living scores along with acuity levels monthly to determine staffing levels are adequate. Results of monitoring will be reported to quarterly QAA meeting.	

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2 800	Continued From page 4 MDS dated 5/14/19, indicated R2 had moderate cognitive impairment. R2's care plan dated 4/21/16 included, "has a history of aggressive behaviors directed at other residents who are verbally abusive toward him." R3's facility Face Sheet dated 7/26/19, included diagnoses of Alzheimer's disease and dementia without behavioral disturbance. R3's quarterly MDS dated 7/16/19, indicated R3 had moderate cognitive impairment. R3's care plan dated 5/10/19, included "resident has dementia with periods of disorientation and be physically aggressive/abusive toward others. R4's facility Face sheet dated 7/26/19, included diagnoses of dementia due to Parkinson's, dementia with behavioral disturbance, restlessness and agitation, and major depressive disorder. R4's quarterly MDS dated 7/9/19, indicated R4 had moderate cognitive impairment. R4's care plan dated 7/23/19, indicated R4 had hallucinations and periods of agitation. R5's facility Face Sheet dated 7/26/19, included diagnosis of dementia with behavioral disturbance, Alzheimer's disease, anxiety disorder, and major depressive disorder. R5's MDS dated 7/2/19, indicated R5 had moderate cognitive impairment. R5's care plan dated 3/26/19, included "Resident becomes irritated with others at times when they are too close in his personal space." During a continuous observation that began on 7/26/19, at 8:12 a.m. trained medication assistant (TMA)-A was the only staff member on the unit. R1 was sleeping in bed. R3 was in the kitchen drinking coffee, R4 sat in a Broda wheelchair at the dining room table. R2 was initially in his room,	2 800		

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2 800	Continued From page 5 and then walked to the table in living room area and sat down. R3 joined the other's at the table, and R5 wheeled himself down the hallway. For 4 minutes TMA-A walked to activity closet to gather supplies for activity, residents were not supervised during that time, R3 wheeled himself away from the table into the kitchen, TMA-A then provided redirection to R3 to go back to table for activity. -At 8:26 a.m. to 8:47 a.m. TMA-A engaged the three residents in an activity; residents were actively engaged in the activity. At 8:48 a.m. an unidentified staff member walked into the unit to check to see how things were going and then exited the unit. -At 8:54 a.m. TMA-A went to the kitchen area, left the 3 residents alone at the table and was out of view for 4 minutes. At 8:58 a.m. registered nurse (RN)-B walked into the unit to see how things were going and then exited the unit. At 9:02 a.m. NA-C came into the unit, asked if TMA-A need anything, TMA-A responded no, NA-C left the unit. -At 9:00 a.m. the activity ended. -At 9:10 a.m. R1 was walking up the hallway towards the living room area, at 9:24 a.m. TMA-A asked R1 to come down to living room area. -At 9:30 a.m. R1 was wandering up and down the hallway, R3 is in the bathroom, TMA-A assisted R2, R1 continued to wander and pushed/moved chairs in the dining. R1 wandered down the hallways and started to push on the exit door. TMA-A continued to assist R3. -At 9:39 a.m. R2 returned to the unit from restorative, R1 was observed wandering around the unit. R1 was attempting to get into the bathroom, TMA-A noticed and successfully redirected R1.	2 800		

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

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2 800	Continued From page 6 -At 9:47 a.m. R1 continued to wander up and down the hallways, walked close to other residents, TMA-A was at the medication cart not in direct view of residents in the living room area. -At 9:54 a.m. R2 sat next to TMA-A in living room area. R1 took a large painting off the wall, R2 became visibly annoyed, started to move to stand up and stated "oh God!! I hate him!". TMA-A successfully de-escalated and returned to conversation about animals with TMA-A. -At 9:56 a.m. TMA-A was 1:1 with R1, to move him away from R2, TMA-A then sat in a chair next to R2. R1 walked over to TMA-A and attempted to move the chair TMA-A was sitting in. R2 again became visibly upset, turned his head to R1, in an elevated voice stated, "HEY, LEAVE HER ALONE!" TMA-A, successfully de-escalated R2 again. R1 then walked in very close proximity to R2, TMA-A distracted R2 while R1 walked in front of him. -At 10:05 a.m. R3 returned to the unit from restorative therapy. R1 continued to wander the unit. -At 10:23 a.m. NA-C had taken over for TMA-A for a break. R1 continued to wander and was in the kitchen/dining room area and in very close proximity to R3, NA-C removed R3 from the area and took him to the adjacent room to watch the tractor bailing hay. -At 10:26 a.m. NA-C took R3 to the bathroom, R1 attempted to go into the bathroom and was redirected. -At 10:27 a.m. all five residents were back in the unit and in different locations, R1 continued to wander intermittently stopped attempted to move furniture. NA-C could not visualize all of the residents at the same time based on the location of the residents. During an continuous observation and interview	2 800		

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	00285	A. BUILDING: _____ B. WING _____	C 07/26/2019

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2 800	Continued From page 7 on 7/26/19, at 1:03 p.m. trained medication assistant (TMA-A) was at the medication cart with R4 along the side of her, R1 was grabbing onto the arm of R4's wheelchair attempting to move it. At 1:04 p.m. TMA-A called for assistance once she got R1 to let go of R4's wheelchair. TMA-A stated she had been at the medication cart getting medications ready to pass, when TMA-A observed R1 pushing R4's wheelchair down the hallway from dining room/kitchen area. TM-A stated she was not able to supervise the residents during that time. TMA-A continued by stating when she saw R1 pushing R4, she stopped and pushed R4 next to her. While TMA-A was attempting to redirect R1 and relocate R4, R3 was continuously stating "[R1] has bullets and kills people". TMA-A stated when she turned around to attempt de-escalate R3, who was in near proximity of the medication cart, R1 walked by R4 and started hitting him over the head with a stuffed turtle. TMA-A then went over and moved R4 and attempted to redirect R1 again however, he persisted to hold onto R4's wheelchair arm attempting to move it. At 1:07 p.m. LPN-A arrived in the unit and took TMA-A's report of the incident. R4 stated when R1 hit him on top of the head it hurt, but did not hurt anymore. R1 left the area and walked down the hallway. At 1:12 p.m. R1 again grabbed onto the arm of R4's wheelchair and attempted to move it while LPN-A and TMA-A stood on the other side of R4. R1 was redirected by TMA-A and then registered nurse (RN)-B who arrived on the unit, redirected and lead R1 away from R4. During an interview on 7/25/19 at 3:49 p.m. local sheriff indicated concern on the number of resident-to-resident altercations at the facility and they seemed constant. Sheriff indicated he had responded to a number of incidents and has to follow-up with family members, it had gotten to	2 800		

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2 800	Continued From page 8 the point where some families have told him not to call unless the injury was significant and/or unusual occurrence. Sheriff stated they have one guy that roams the hallways 24 hours a day, "why is he wandering the halls at 4:00 in the morning?" Sheriff indicated he had no problem with the staff and it could be that there isn't enough staff available. During an interview on 7/26/19, at 10:41 a.m. trained medicaiton assistant (TMA)-A stated there was not enough staff in the unit to make sure all the residents were safe. TMA-A stated R1 needed constant supervision when he's up, he continuously wanders, moves furniture around, and gets into other residents personal spaces, R2 and R3 get very irritated with him. R1 had aggressive behaviors toward other residents, but was also at high risk for being abused because of his behaviors. TMA-A indicated she feels like there are more incidents of resident to resident altercations since staffing was reduced. TMA-A stated she couldn't provide continuous supervision if she had to take someone to the bathroom or redirect a resident, there wasn't time to call someone for help. TMA-A stated she could not prevent and/or intervene if she couldn't continuously watch them. TMA-A also stated she could not possibly provide group activities and individualized activities when R1 was wondering around and had to continuously redirect to keep him safe and other residents safe from him. TMA-A indicated recently administration had cut nursing hours in the unit because census had changed from seven residents to five residents. TMA-A stated that there was only one staff member scheduled during the day shift, and a float person until 10:00 a.m. that would work between the units. TMA-A then stated from 10:00 a.m. until 2:00 p.m. there was only one staff	2 800		

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2 800	Continued From page 9	2 800		

member in the unit. On the evening shift, there is one NA scheduled then a float, and the nurse comes in and passes the medications. TMA-A stated we used to have someone from 4:00 p.m. to 8:00 p.m. Night shift has one staff member and that had not changed. TMA-A indicated that since she was a trained medication assistant (TMA) she was responsible for passing medications, conducting activities, and housekeeping tasks as well as routine toileting and personal cares.

During an interview on 7/26/19, at 11:00 a.m. licensed practical nurse (LPN)-A stated staffing levels had changed lately in the unit, and now only one NA was scheduled back there for days and evenings with a float person that would go between the units. LPN-A indicated the reason for this was because the census had changed, however felt the acuity of the residents had not. LPN-A stated one person is not enough in the unit to keep residents safe because of the behaviors. LPN-A stated residents are at risk for injury and harm because staff could directly supervise and/or redirect to prevent an incident they have to attend to someone's toileting needs, do checks, pass medications, ect.

During an interview on 7/26/19, at 12:31 p.m. NA-C stated there had been staffing changes related to the census. NA-C stated "you can't possibly supervise residents with only one person, if somebody [resident] is having a bad day, you can't do it by yourself. Supposed to call to get help but sometimes you don't have enough time to make the phone call." NA-C indicated it was very hard and very frustrating, cannot be everywhere at the same time, residents were not safe and more at risk for injury. NA-C stated R1 wonders all over and agitates other residents, "I don't know what is happening if I'm not right there

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2 800	Continued From page 10	2 800		

when he gets up." NA-C stated if there was more staff the unit would be safer because we could provide activities and keep them more occupied. NA-C stated she feels like since staffing changed in the unit, felt like there were more altercations.

During an interview on 7/26/19, at 12:45 p.m. interim director of nursing (DON), confirmed staffing had been changed on the unit because the census had gone down to five residents at the beginning of July. DON indicated the staffing levels were based on acuity level of the residents, acuity was based on the Minimum Data Set, and was not sure if the acuity level took into consideration the number of behaviors and level of supervision required. DON indicated staff that work in the unit have voiced concern about the level of staffing. DON stated, potentially residents safety is at risk because of the lack of staffing. DON indicated when the interdisciplinary team reviewed the resident to resident incident reports it was determined that the increased staff levels would not have prevented all of the incidents from occurring.

During an interview on 7/26/19, at 1:54 p.m. registered nurse (RN)-A stated she often times worked the unit in the evening. RN-A stated there was not adequate staffing levels to provide appropriate levels of supervision. RN-A indicated when she assisting a resident is one area of the unit, she couldn't see what was going on in another area, and didn't have time to call for assistance all the time. "I can't keep track of everybody, it's not safe".

During an interview on 7/26/19, at 3:51 p.m. RN-B indicated that staffing was reduced in the unit, if staff feel unsafe in the unit they could call the other unit for assistance. RN-B indicated it

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2 800	Continued From page 11 was difficult to provide the level of care the residents in the unit require and be cost effective at the same time. RN-B indicated it would be difficult for one person to provide all the necessary dementia related interventions. During an interview on 7/26/19, at 4:23 p.m. administrator confirmed staffing hours were changed based on the acuity of the unit and used the MDS and CMS time study report. Administrator stated the most recent change to scheduling happened this week where staffing in the unit was reduced to one staff in the unit during the day with a float between the units, and on the evening shift staff member and a four hour shift from 4:00 p.m. to 8:00 p.m. during high care times. Administrator indicated that staffing pattern equaled out to be an average of 7.77 hours of nursing hours per resident day, and indicated according to the acuity level of 3.05, staffing should be sufficient. Administrator stated that the facility had a meeting planned for 8/6/19, to review and evaluate the change that was made to the staffing patterns. Facility Assessment last 6/30/19, included the following: Acuity 1.5: Gunderson Tweeten Care Center utilized their electronic health record reports that pull acuity information from each resident's MDS to consider RUG levels as well as how much assistance our residents are requiring with activities of daily living. We also evaluate what and how many special treatments and conditions are occurring within our resident population. The assessment indicated the number/average range of residents that had behavioral symptoms and cognitive impairment as 4-5. -1.7: Interdisciplinary Team also considers other facts such as resident's preferences for getting	2 800		

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2 800	Continued From page 12 up and going to bed, preferences around bathing schedules, personal lift histories to include meaningful activities that resident enjoys, preferences for nap schedules, and food likes/dislikes and utilizes this information to enhance a more person centered approach to caring for each individual resident. -Staffing Plan 3.2 included staffing plan for Woodlands household: RN/LPN/TMA: one for day shift and one for overnight shift on Woodlands Memory Care Household (12 beds). Direct care staff for Woodlands: one shared NA 4 hour float with unit 2 for day shift and for evenings one 4 hour NA on evening shift and occasionally as needed night shift. Restorative assistant 6 days a week for 8 hours; RA shared between units. One activity aide evening for 4 hours SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.	2 800		

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2 800	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		