

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2024
NAME OF PROVIDER OR SUPPLIER  Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  125 5th Avenue Southeast Spring Grove, MN 55974	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38685</p> <p>Based on observation, interview and document review, the facility failed to report an allegation of staff to resident physical abuse to the administration and State Agency (SA) immediately, but not later than two hours after the allegation is made, for 1 of 1 resident (R1) reviewed who reported an allegation of physical abuse in the facility.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) assessment dated [DATE], indicated R1 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, auditory hallucinations, and psychotic disorder. R1 had no cognitive impairment and required partial to moderate assist with dressing, mobility, and transfers.</p> <p>R1's care plan focus dated 9/11/24, identified R1 as a vulnerable adult due to cognitive and physical limitations. It included an intervention dated 12/28/22, assist to safety in the event of a harmful situation, encourage to report any maltreatment.</p> <p>Nursing Home Incident Report (NHIR) submitted to the SA by the facility identified the date and time of submission as 12:28 p.m. on 11/21/24 and the submitter as the facility's social worker. Social worker and former DON met with R1 on 11/15/24 to discuss concern she raised regarding care she received two or three weeks ago. Two staff members were helping her get ready for bed. R1 stated, They wanted me to go to bed the way I don't usually do. DON went on to explain that typically, R1 would stand to get undressed and into her pajamas for bed. On the night in question, the gals wanted R1 to remain in her wheelchair. R1 was unsure of what they were doing, and so she tried to roll her wheelchair backwards. R1 then reported they grabbed my arms and tried to make me do it their way. I started hollering and two other people came in and told those two to leave. R1 does not recall the names of the staff members involved and shared she has not seen them again and is not sure if she could identify them if she saw them again. R1 stated no incident has happened since and that she feels safe.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 11/21/24 at 9:54 a.m., R1 was seated in her wheelchair in the dining room up to one of the tables. R1 stated about a month ago there were two black girls who came into her room around 8:45 p.m. to help her get ready for bed. R1 stated they were not listening to her, and they both grabbed her behind the arms to try and force her into bed. R1 stated she started hollering for help because they were not listening to her and were hurting her. R1 stated two white girls came in and told the other two girls to leave and they got her ready for bed. R1 stated she told the two white girls about what the other two staff did to her. R1 stated. it was disrespectful and abusive to do that to me because they were not listening to me, they hurt me, and I had bruises on my arms from it. R1 stated she had not seen those two black girls ever since and that she now feels safe here.</p> <p>During an interview on 11/21/24 at 10:11 a.m., social worker (SW)-A stated she was aware of the staff to resident physical abuse allegation with R1 on 11/15/24. SW-A stated she was informed due to a quality-of-life survey that was done and knew the allegation had been reported to the state by the quality-of-life surveyor. SW-A stated the former director of nursing (DON) headed the investigation and thought she would have reported it to the administrator. SW-A stated the former DON would not let us report it to the state agency. This allegation should have been reported to the state immediately but no later than 2 hours.</p> <p>During an interview on 11/21/24 at 11:52 a.m. the administrator stated the physical abuse alleged by R1 from a month ago was not reported to him until today. The administrator stated any allegations of physical abuse should be reported immediately to the state agency but no later than 2 hours.</p> <p>Facility policy titled, Plan for Abuse Prevention and Reporting, approved 7/2024, identified It is the policy of [NAME] 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 representatives are encouraged and supported in reporting suspected acts of abuse .[NAME] Care Center will ensure all that all alleged violations involving abuse .are reported immediately but no later then 2 hours after the allegation is made .Employees must always report any allegation of abuse or suspicion of abuse or suspicion of a crime immediately to the administrator. Note failure to report can make an employee just as responsible for the abuse in accordance with state law.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685</b></p> <p>Based on observation, interview and document review, the facility failed to thoroughly investigate an allegation of staff to resident physical abuse for 1 of 1 resident (R1) reviewed who reported an allegation of physical abuse in the facility.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) assessment dated [DATE], indicated R1 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, auditory hallucinations, and psychotic disorder. R1 had no cognitive impairment and required partial to moderate assist with dressing, mobility, and transfers.</p> <p>R1's care plan focus dated 9/11/24, identified R1 as a vulnerable adult due to cognitive and physical limitations. It included an intervention dated 12/28/22, assist to safety in the event of a harmful situation, encourage to report any maltreatment.</p> <p>Nursing Home Incident Report (NHIR) submitted to the SA by the facility identified the date and time of submission as 12:28 p.m. on 11/21/24 and the submitter as the facility's social worker. Social worker and former DON met with R1 on 11/15/24 to discuss concern she raised regarding care she received two or three weeks ago. Two staff members were helping her get ready for bed. R1 stated, They wanted me to go to bed the way I don't usually do. DON went on to explain that typically, R1 would stand to get undressed and into her pajamas for bed. On the night in question, the gals wanted R1 to remain in her wheelchair. R1 was unsure of what they were doing, and so she tried to roll her wheelchair backwards. R1 then reported they grabbed my arms and tried to make me do it their way. I started hollering and two other people came in and told those two to leave. R1 does not recall the names of the staff members involved and shared she has not seen them again and is not sure if she could identify them if she saw them again. R1 stated no incident has happened since and that she feels safe.</p> <p>Facility investigation dated 11/15/24 identified R1 was interviewed and two additional staff members that typically work the evening shift were interviewed. The facility investigation lacked other resident interviews, additional staff interviews fitting the description of the alleged perpetrators, and did not identify protection interventions were developed and implemented.</p> <p>During an observation and interview on 11/21/24 at 9:54 a.m., R1 was seated in her wheelchair in the dining room up to one of the tables. R1 stated about a month ago there were two black girls who came into her room around 8:45 p.m. to help her get ready for bed. R1 stated they were not listening to her, and they both grabbed her behind the arms to try and force her into bed. R1 stated she started hollering for help because they were not listening to her and were hurting her. R1 stated two white girls came in and told the other two girls to leave and they got her ready for bed. R1 stated she told the two white girls about what the other two staff did to her. R1 stated. it was disrespectful and abusive to do that to me because they were not listening to me, they hurt me, and I had bruises on my arms from it. R1 stated she had not seen those two black girls ever since and that she now feels safe here.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/21/24 at 10:11 a.m., social worker (SW)-A stated she was aware of the staff to resident physical abuse allegation with R1 on 11/15/24. SW-A indicated she was aware the two alleged perpetrator (AP)'s were described by R1 as two black females and that R1 described the two staff the entered the room due to R1 hollering out were two female white staff. SW-A indicated she did not interview other like residents or try and interview staff that fit the description of the AP's or the staff that R1 reported the allegation to and stated she should have. SW-A indicated the investigation should have been more thorough to keep all residents safe.</p> <p>During an interview on 11/21/24 at 11:52 a.m. the administrator indicated R1's physical abuse allegation was not thoroughly investigated and stated any allegations of physical abuse should be thoroughly investigated to keep all residents safe.</p> <p>Facility policy titled, Abuse Potential/Vulnerable Adult/QAPI review, effective 11/2024, identified It is the policy of [NAME] 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 representatives are encouraged and supported in reporting suspected acts of abuse .</p> <p>g. SUPERVISION OF STAFF 1. Staff will be supervised to identify inappropriate behaviors while caring for or in attendance with residents. a. Supervisory staff of each shift are alert to identify inappropriate staff behaviors while caring for or in attendance with residents, such as using derogatory language, rough handling, ignoring residents while giving care, etc., and events that may constitute abuse .The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of abuse: When an incident or suspected incident of abuse is reported, including resident to resident altercations when applicable, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include at a minimum: i. Review of the documentation and evidence; ii. Review of the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; iii. Observe the alleged victim, including their interactions with staff and other residents; iv. Interview the person reporting the incident; v. Interview any witnesses to the incident; vi. Interview the resident (as medically appropriate) or the resident's representative, vii. Interview the resident's attending physician as needed to determine the resident's condition; viii. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; ix. Interview the resident's roommate, family members, and visitors; x. Interview other residents to whom the accused employee provides care or services; xi. Review of all events leading up to the alleged incident; and xii. Document the investigation completely and thoroughly .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685</b></p> <p>Based on observation, interview and document review the facility failed to ensure Enhanced Barrier Precautions (EBP)- (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented or followed for management of a pressure ulcer to reduce the risk of infection to others for 1 of 1 resident (R2).</p> <p>Findings included:</p> <p>R2's care plan dated 1/3/23 identified a problem of Enhanced Barrier Precautions (EBP) due to wounds. Interventions identified EBP required the use of gown &amp; gloves during high contact resident care activities, including dressing, bathing, or showering, performing transfers, changing linens, providing hygiene, changing a resident's brief, or assisting them with toileting, direct care of an indwelling medical device, such as a central line, urinary catheter, feeding tube or tracheostomy, and when performing wound care on any skin opening that required a dressing.</p> <p>R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2's cognition was severely impaired and had diagnoses of vascular dementia and pressure ulcer of sacral region stage 3. Further identified R2 admitted with a stage 3 pressure ulcer that was current.</p> <p>R2's Physician Order report dated 11/1/24, identified a stage 3 pressure ulcer of sacral region treatment to: apply zinc oxide to peri-wound tissue, soak gauze in Dakin's solution 0.125% and pack into wound, cover with Vaseline-infused gauze and change twice a day.</p> <p>During an observation and interview on 11/20/24 at 2:44 p.m., R1 was lying in bed on her back and stated, I still have that blister on my bottom. R2's door or room had no signage for EBP, there was no cart with personal protective equipment (PPE) outside the door or anywhere in R1's room.</p> <p>During an observation on 11/21/24 at 8:57 a.m., R1 was seated in a bath chair covered with a bath blanket and was being pushed down the hall to her room by nursing assistant (NA)-A and NA-B. Neither NA-A or NA-B had gowns or gloves on. Once in R2's room, R2 was transferred via a full body mechanical lift to her bed. While R2 was repositioned on her side, she was noted to have a wound in her sacral area. NA-A stated R2 has had a pressure ulcer on her bottom for a long time. NA-A and NA-B were asked about the use of EBP with R2 due to her wound and they both indicated an unawareness of using gowns and gloves with high contact activities for residents with wounds. Both verified there was no signage on the door and no gowns available in the room.</p> <p>During an interview on 11/21/24 at 9:06 a.m., licensed practical nurse (LPN)-A stated none of the residents in the building use EBP. LPN-A verified R2 had a current pressure ulcer and stated there was no signage on R2's door and no PPE carts outside R2's room. LPN-A stated all the signs and carts disappeared quite awhile ago.</p> <p>During an interview on 11/21/24 at 9:39 a.m., registered nurse (RN)-A stated our old infection preventionist knew about the EBP regulation, we do have the signage and the policy she just never implemented it, so staff have not been doing it.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/21/24 at 9:11 a.m., interim director of nursing (IDON) indicated they had not implemented EBP for any of the residents as long as she had worked here and was not aware of the regulation to do so.</p> <p>Facility policy enhance barrier precautions dated 11/23, identified .Enhanced Barrier Precautions can be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: o Wounds or indwelling medical devices, regardless of [NAME] colonization status o Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. When implementing Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gown and gloves). For Enhanced Barrier Precautions, signage should also clearly indicate the high contact resident care activities that require the use of gown and gloves. Make PPE, including gowns and gloves, available immediately outside of the resident room, ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room), position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room, incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education, and provide education to residents and visitors.</p>		