STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tweeten Lutheran Health Care Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on interview and document review the facility failed to ensure a comprehensive care plan was developed to reflect 1 of 1 residents (R1) who had a diagnosis of acute respiratory failure with hypoxia. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of acute respiratory failure with hypoxia. R1's care plan was reviewed, from 10/8/24 to 11/13/24 did not identify a respiratory plan of care with goals and individualized interventions to care and manage R1's respiratory condition(s). R1's hospital discharge summary dated 10/16/24, identified R1 was hospitalized from 10/13/24 at 5:25 p.m. to 10/16/24,and returned to the facility at 2:45 p.m. R1 was hospitalized for severe hypotension (when blood pressure drops dangerously low), acute respiratory failure with hypoxia (when your lungs suddenly fail to adequately oxygenate the blood leading to a dangerously low level of oxygen in the blood) due to a choking/aspiration event and was discharged with new diet orders for nectar thickened liquids and soft and bite sized diet. During an interview on 11/27/24 at 12:54 p.m. LPN-A indicated R1 did have a diagnoses of acute respiratory failure with hypoxia upon admit and verified R1's care plan did not identify any interventions to assess and monitor for that. During an interview on 11/27/24 at 9:58 a.m., interim director of nursing (IDON) indicated R1 admitted on [DATE] with primary diagnosis of acute respiratory failure with hypoxia and verified this diagnosis was not on her care plan to provide interventions for respiratory assessment and monitoring. During a phone interview on 11/27/24 at 10:37 a.m. licensed practical nurse (LPN)-B indicated R1 was admitted with acute respiratory failure with hypoxia and verified the care plan did not identify interventions to assess and monitor for that routinely. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident with a diagnosis of acute respiratory failure with hypoxia, it should be care planned with person centered interventions to include a full respiratory assessment twice a day and as needed and monitor for changes. Facility policy, Care Planning-Comprehensive Person-Centered Care dated 5/2024, identified a purpose statement: a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident . Interventions are actions, treatments, procedures, or activities designed to meet an objective .The comprehensive person centered care plan will: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising their rights, including the right to refuse treatment;d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including the resident's desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions. p. Be culturally competent q. Reflect trauma-informed interventions. 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident's physician (or primary health care provider) is integral to this process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident . 13. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on interview and document review the facility failed to ensure a comprehensive nutritional assessment was completed and further failed to identify, comprehensively assess and monitor for signs/symptoms of dehydration for 1 of 3 residents (R1) reviewed for change in condition. The facility's failures resulted in harm when R1 required a 3 day hospitalization for profound hypernatremia and hypovolemia. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of congestive heart failure, hypernatremia (a condition where there is too much sodium in the blood that can be caused by diarrhea and not drinking enough fluids) and hyperosmolality (a condition where the blood has a high concentration of salt, glucose and other substances which draws water out of the body's organs). R1 was always continent of bowel and bladder with no special diet. R1 received diuretics. R1's order summary dated 10/8/24, identified R1 had an order to receive torsemide 20 milligrams (mg) twice a day for heart failure. Additional orders to receive docusate sodium (emollient laxative that draws water and fat into your stool, making it softer and easier for stool to pass) give 100 mg twice a day for constipation. R1's Nutritional Therapy assessment dated [DATE] identified R1 was obese with no recent weight change, received a regular diet, used an adaptive divided plate with Dycem, mugs with lids and straws and built-up utensils. R1's food and fluid were adequate to meet estimated needs. Nutritional needs estimation did not identify how many calories, protein, or the amount of fluids R1 would need daily. R1's nutritional assessment did not identify R1 was on diuretics. R1's Bowel and Bladder Observation dated 10/11/24, identified R1 typically had a fluid intake of 501 to 1000 milliliters (ml)/daily. R1's discharge-return anticipated MDS assessment dated [DATE], identified R1 was frequently incontinent of bowel, received a mechanically altered diet and diuretics. Review of R1's record did not include a comprehensive assessment that identified R1's risk for dehydration, nor did the care plan address goals and interventions to prevent or mitigate R1's risk for dehydration related to (but not limited to) level of assistance, diuretic usage, change in diet to thickened liquids, and requiring assistance with eating. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R1's care plan identified a problem dated 10/15/24, nutritional status potential for significant wight change and malnutrition. Intervention dated 11/11/24 to provide a pureed diet with nectar thickened liquids, provide feeding assistance when in an upright position in the wheelchair, not in the bed or recliner and complete oral cares after meals due to observed residue in mouth. An additional problem dated 10/30/24, R1 was limited in the ability to toilet self-related to immobility, weakness, and deconditioning, was frequently incontinent of bowel and bladder with a long-term goal to have a Bowel Movement (BM) every 3 days. Interventions included to monitor and record BM every shift and administer docusate sodium, Citrucel (bulk-forming laxative), and Miralax (osmotic laxative) per provider orders and to monitor the effectiveness of the medication. An additional intervention was to encourage fluids and reminder to drink fluids in between meals. R1's Vital report for fluid intake identified total fluid intakes each day for October and November 2024 however, in review of R1's record between 10/8/24 through 10/28/24, revealed the record did not include assessments/evaluations to ensure appropriate fluid balance and/or evident R1 was monitored for signs/symptoms of dehydration. Documented intakes included: 10/8/24: 200 ml 10/9/24: 960 ml 10/10/24: 840 ml 10/11/24: 990 ml 10/12/24: 650 ml 10/13/24: 420 ml R1's hospital discharge summary identified R1 was hospitalized from 10/13/24 at 5:25 p.m. to 10/16/24,and returned to the facility at 2:45 p.m. R1 was hospitalized for severe hypotension (when blood pressure drops dangerously low), acute respiratory failure with hypoxia (when your lungs suddenly fail to adequately oxygenate the blood leading to a dangerously low level of oxygen in the blood) due to a choking/aspiration event and was discharged with new diet orders for nectar thickened liquids and soft and bite sized diet. 10/16/24: 120 ml 10/17/24: 240 ml 10/18/24: 460 ml 10/19/24: 540 ml 10/20/24: 672 ml 10/21/24: 440 ml 10/22/24: 640 ml (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	10/23/23: 0 ml R1's hospital discharge summary identified R1 was hospitalized from 10/23/24 at 10:00 a.m. to 10/29/24 and returned to the facility at 1:00 p.m. R1 was hospitalized for profound hypernatremia and stupor secondary to poor oral intake and hypovolemia (a condition where the body loses too much fluid, such as blood or water which can lead to organ malfunction or failure), R1's torsemide was discontinued due to hypovolemia and may be restarted at a later date if needed. R1 will need to be offered water by staff every 4 to 6 hours, R1 may not ask for water so it needs to be offered. R1's Nutrition Reassessment dated [DATE] identified R1 received mechanical soft diet with thickened liquids. R1's current intake at meals was 50 to 74%. Food and fluid intake adequate to meet R1's needs was not identified and the assessment did not include an evaluation of R1's daily fluid consumption. R1's bowel and bladder record reviewed between 11/2/24 through 11/13/24 identified R1 had 17 large loose stools. R1's Vital report for fluid intake identified total fluid intakes each day for October and November 2024 however, in review of R1's record between 10/29/24 through 11/13/24, revealed the record did not include assessments/evaluations to ensure appropriate fluid volume balance and/or evident R1 was monitored for signs/symptoms of dehydration. Additionally, the record did not include documentation R1 was offered fluids every 4-6 hours per the hospital discharge summary dated 10/29/24. Documented intakes included: 10/29/24: 0 ml 10/30/24: 1,150 ml 10/31/24: 300 ml 11/1/24: 240 ml 11/2/24: 950 ml 11/3/24: 0 ml 11/4/24: 0 ml 11/5/24: 320 ml 11/6/24: 520 ml 11/7/24: 605 ml 11/8/24: 0 ml 11/9/24: 350 ml (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/10/24: 320 ml 11/11/24: 0 ml 11/12/24: 580 ml 11/13/24: 560 ml R1's Speech therapy (ST) Evaluation and Plan of treatment dated 11/11/24 identified R1 had a diagnosis of dysphagia (difficulty swallowing) required assist with eating and recommendations were to receive nectar thickened liquids with pureed consistencies. During a phone interview on 11/26/24 at 2:02 p.m., family member (FM)-A identified she was R1's guardian. FM-A indicated R1 had previously lived in a group home and had gotten COVID and had four hospitalization s since 9/25/24. FM-A stated the first and second time R1 had problems with her breathing, the third time she had high sodium levels and stated she didn't think R1 was getting enough to drink. FM-A stated after one of R1's hospitalization s she had to be on thickened liquids and didn't think the staff were offering the fluids like they should have been and R1 needed help with drinking fluids. During an interview on 11/26/24 at 4:26 p.m., nursing assistant (NA)-A identified R1 had a pureed diet and thickened liquids and needed assist with eating. NA-A stated she was not aware that fluids needed to be encouraged with R1 until the day she passed away on 11/13/24. NA-A stated the kitchen staff would pick up R1's lunch trays and document the fluids given. NA-A further stated R1 typically did not drink her fluids well. During an interview on 11/27/24 at 9:30 a.m., NA-B indicated R1 was on pureed foods and thickened liquids and stated R1 typically didn't eat much preferred desserts but would drink. NA-B stated initially R1 did not like thickened liquids but once we explained why she had to have thickened she would drink, she liked the thickened juice. During an interview on 11/27/24 at 1:51 p.m. licensed practical nurse (LPN)-B indicated low fluid intake along with loose stools can lead to dehydration and an electrolyte imbalance. LPN-B stated R1 was not drinking enough and was having several loose stools which can lead to dehydration. LPN-B stated she was unsure they had a system in place to monitor fluid intake unless a resident was on a fluid restriction. LPN-B indicated R1 was not being monitored for dehydration. During an interview on 11/27/24 at 12:54 p.m., LPN-A stated R1's care plan did not identify R1 was at risk for dehydration and did not identify the amount of fluids R1 would need daily to prevent dehydration. LPN-A indicated from 11/3/24 to 11/10/24, R1 received less than 600 ml of fluids daily and and 15 large loose stools would place R1 at risk for dehydration. During an interview on 11/27/24 at 1:44 p.m., dietary aide (DA)-A stated the nursing staff are responsible to document flood and fluid intake for their residents. On unit 2 the kitchen staff are responsible to document the food and fluid intake in the resident medical record. The residents who ate in their rooms, dietary would pick up the resident trays and document how much they ate based on what was left on their tray. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/27/24 at 1:15 p.m., dietary manager (DM)-A stated R1's admission nutritional assessment was not comprehensive and did not include R1 was administered diuretic medications, also did not identify the amount of calories and fluids R1 would need daily. DM-A stated she would start getting worried if a resident was not drinking 400 ml per meal. DM-A explained from 11/3/24 to 11/13/24, R1's fluid intake was less than 600 ml daily along with over 15 loose stools during that time, she would worry about dehydration. DM-A was unsure if R1's intakes were being monitored or who would be responsible for that. During a phone interview on 12/2/24 at 12:10 p.m., registered dietician (RD)-A stated a nutritional assessment was completed on all residents upon admit, with significant changes and annually. RD-A stated she did not comprehensively assess R1 for the amount of fluid intake she would need daily and did not develop a care plan for R1's risk for dehydration. RD-A stated typically the average resident would need 1500 ml per day to stay hydrated and verified that R1 was receiving less than 600 ml daily for 10 days prior to R1's death along with over 15 large loose stools. RD verified R1 was admitted with torsemide and taking this medication would put R1 at risk for dehydration and then was hospitalized from 10/23/24 to 10/29/24 for severe hypernatremia and was receiving thickened liquids due to difficulty swallowing, these factors put her at higher risk for dehydration. RD-A stated R1's body was losing fluids faster than she could take in and stated R1 should have been monitored for dehydration. During an interview on 11/27/24 at 2:03 p.m., interim director of nursing (IDON) indicated the facility did not currently have a system in place to monitor residents for fluid intake unless a resident was on a fluid restriction. IDON indicated R1's fluid intake was less than 600 ml daily for about 10 days along with over 15 large loose stools which had a high potential to lead to dehydration, the provider should have been notified right away. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident who had loose stools, bowel medications should be held, if loose stools continue for two days the provider should be notified to address this. PA-A further stated in conjunction with R1's lack of fluids and chronic loose stools could lead to dehydration which can cause hypernatremia, which is a condition where the level of sodium in the blood is too high. PA-A stated R1 would be at high risk for dehydration with low fluid intake, loose stools and recent history of hypernatremia, facility should be closely monitoring residents like this a reporting it to the provider. Facility policy Dehydration Nutrition Interventions dated 9/2024, included Individuals at risk for dehydration will be identified and provided with sufficient fluid intake to maintain proper hydration and health. Implementation: Each individual will receive sufficient amounts of fluid based on individual need and personal preference to prevent dehydration and maintain health. 1. Risk factors for and/or clinical signs of dehydration will be identified through routine nursing assessments. 2. Adequate fluids should be offered based on a comprehensive nutrition assessment of factors affecting fluid needs and fluid intakes. 3. Fluids should be provided based on each individual's beverage preferences and physician's orders for fluid consistency. 4. If fluids intake is not adequate to meet needs, an IV or enteral feeding tube may be recommended. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Facility policy Encouraging and Restricting Fluids dated 7/2024 included: The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. The policy directed staff on the protocol to encourage fluids and documentation requirements. The documentation requirements directed staff to record any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin Further directing staff to notify the supervisor if the resident refuses. Facility policy Comprehensive Medical Nutrition Therapy assessment dated ,d+[DATE] included The RDN will complete a comprehensive medical nutrition therapy assessment for each individual that is referred or identified. The purpose of nutrition assessment is to obtain, verify, and interpret data needed to identify nutrition-related problems, their causes, and significance.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on interview and record review the facility failed to monitor and evaluate the necessity of a bowel medication for adequate monitoring for 1 of 1 resident (R1) who received scheduled bowel medications and had loose stools throughout her stay. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1's cognition was intact and had diagnoses of hypernatremia (a condition where there is too much sodium in the blood that can be caused by diarrhea and not drinking enough fluids) and hyperosmolality (a condition where the blood has a high concentration of salt, glucose and other substances which draws water out of the body's organs). R1 was always continent of bowel and bladder. R1's Bowel and Bladder Observation dated 10/11/24, identified R1 was always continent of bowel, had a bowel movement (BM) every 1 to 3 days and typically had a fluid intake to 501 to 1000 milliliters (ml)/daily. R1's discharge-return anticipated MDS assessment dated [DATE], identified R1 was frequently incontinent of bowel. R1's care plan dated 10/30/24 identified a problem, R1 was limited in the ability to toilet self-related to immobility, weakness, and deconditioning, was frequently incontinent of bowel and bladder with a long-term goal to have a BM every 3 days. Interventions included to monitor and record BM every shift and administer docusate sodium, Citrucel (bulk-forming laxative), and Miralax (Osmotic Laxative) per provider orders and to monitor the effectiveness of the medication. R1's Order Summary dated 10/8/24, identified docusate sodium (emollient laxative that draws water and fat into your stool, making it softer and easier for stool to pass) give 100 milligrams (mg) twice a day for constipation. R1's Vital report for bowel movements identified the following: October 2024: 10/9/24 at 2:39 p.m., large loose stool 10/16/24 at 10:17 p.m., large incontinent loose stool x 2 10/18/24 at 8:28 a.m., large loose foamy stool with foul odor 10/19/24 at 1:30 p.m., large incontinent loose stool, at 3:09 p.m., medium incontinent loose stool 10/20/24 at 1:50 p.m., large liquid incontinent loose stool x 2 10/21/24 at 11:07 p.m., large loose stool (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/30/24 at 10:19 a.m., large loose stool 10/31/24 at 12:22 p.m., 1 large loose stool and 1 medium loose stool November 2024: 11/2/24 at 1:38 p.m., large loose stool x 2. 11/3/24 at 1:23 p.m., large loose incontinent stool, at 1:41 p.m., and large loose liquid incontinent stool x 2. 11/4/24 at 1:34 p.m., large loose incontinent stool 11/6/24 at 4:36 a.m., small continent liquid stool and at 9:37 p.m., large loose stool. 11/7/24 at 9:38 p.m., medium liquid stool 11/8/24at 1:36 p.m., large loose continent stool x 3. 11/9/24 at 7:43 a.m., large loose incontinent stool, at 11:43 a.m., small incontinent loose stool and at 9:26 p.m., large loose stool. 11/10/24 at 5:25 a.m., large loose incontinent stool, at 1:15 p.m., large loose incontinent stool, at 9:26 p.m., large loose incontinent stool and 10:57 p.m., large loose incontinent stool. 11/11/24 at 4:04 p.m., large loose incontinent stool 11/12/24 at 5:27 a.m., large loose incontinent stool 11/13/24 at 5:07 a.m., large loose stool R1's medication administration record (MAR) dated October 2024, identified that docusate sodium was given twice a day with the exception of the following dates and times: -10/14/24 am and pm due to hospitalization . -10/15/24 am and pm due to hospitalization . -10/16/24 am due to hospitalization . -10/21/24 am due to condition. -10/23/24 to 10/29/24 due to hospitalization R1's MAR dated November 2024, identified that docusate sodium was given twice a day with the exception of the following dates and times: -11/11/24 am due to loose stools. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/13/24 am due to loose stools. R1's docusate sodium was given all other days from 10/8/24 to 11/13/24 even though the medical record identified R1 was having current loose stools. R1's progress note dated 10/19/24 at 2:33 p.m., .identified that R1's docusate sodium was held due to loose stools. R1's progress note dated 10/20/24 at 12:18 p.m., .identified that R1 had many loose stools . R1's progress note dated 11/6/24 at 2:46 p.m., identified a request for med tech to hold bowel medications for this evening as R1 had been having loose stools. According to R1's MAR, bowel medications were not held on 11/6/24 and R1 had a large loose stool. R1's progress note dated 11/11/24 at 2:07 a.m., . identified R1 had loose stools . R1's progress note dated 11/12/24 at 1:20 p.m., .identified R1 continued to have loose stools and stomach upset, will have med tech hold any bowel meds for now .had a red raw bottom from loose stools, Z-Guard (medicated cream or paste that works by forming a barrier on the skin to protect it from irritants/moisture) applied to this area . According to R1's MAR, bowel medications were not held on 11/12/24 and R1 had a large loose stool. R1's progress note dated 11/12/24 at 11:43 p.m., identified R1 had loose stools .rectal area raw. Z-Guard applied. R1's progress note dated 11/13/24 at 6:13 a.m., identified R1 had diarrhea .had one more diarrhea after being given Loperamide at 10:30 p.m., .had redness on buttocks, staff reminded to put on cream after cleansing. During an interview on 11/26/24 at 4:25 p.m., nursing assistant (NA)-A stated she had worked frequently with R1 the last week leading up to 11/13/24. NA-A stated R1 had loose stools daily sometimes several and that each loose stool was immediately reported to the nurse. NA-A stated R1 would complain of stomach pain and then have a loose stool. NA-A stated she asked the nurse if R1 was getting medications that could be causing diarrhea. During an interview on 11/27/24 at 9:30 a.m., NA-B stated she regularly performed cares for R1 and stated R1 had frequent large loose stools. NA-B stated she would report every time R1 had a loose stool to the nurse in charge. NA-B further stated, anytime you would lay R1 down and roll her over it was projectile pooping. During an interview on 11/27/24 at 12:54 p.m., licensed practical nurse (LPN)-A indicated R1 was given docusate sodium twice a day most days even though R1 had several loose stools. LPN-A stated if a resident were to have a loose stool bowel medications should be held, if there were three or more large loose stools a provider would need to be notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tweeten Lutheran Health Care Center	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.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/27/24 at 1:51 p.m. LPN-B stated when a resident who received bowel medications routinely, we would check the documentation to ensure the resident was not having loose stools. Nurses would also check in with the aides prior to giving the bowel medication. The provider should be notified of anything out of the normal. LPN-A stated R1 was having frequent loose stools since admission and docusate sodium was given most days in light of her having loose stools. LPN-A further stated loose stools can lead to dehydration and an electrolyte imbalance. During an interview on 11/27/24 at 2:03 p.m., interim director of nursing (IDON) verified R1 had loose stools on and off since admit and was given docusate sodium twice a day most of R1's stay when it should have been held, the provider should have been notified right away. IDON indicated the docusate sodium was an unnecessary medication for R1 and should have been given only as needed. During a phone interview on 12/2/24 at 2:18 p.m., physician assistant (PA)-A stated any resident who had loose stools, bowel medications should be held, if loose stools continue for two days the provider should be notified to address this. PA-A further stated chronic loose stools can lead to dehydration (when the body loses more fluids than it takes in) which can cause hypernatremia, which is a condition where the level of sodium in the blood is too high. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Bowel Management dated 5/2024, identified Factors that may change the bowel routine. 1. Diarrhea is caused by intolerance of foods, taking certain medications (ie antibiotics), over medication with laxatives, certain foods (spicy or greasy foods, or caffeinated beverages) the presence of a virus, food poisoning, etc. Attempt to determine the cause of diarrhea and treat accordingly .Good habits to prevent bowel problems. 1. Dietary habits: a. Adequate fluid intake: 1500-2500 ml of non-caffeinated, nonalcoholic beverages, soups, and other liquids is required to replace urinary and fecal losses for older adults. Residents with a fever require more .4. Good pharmacological habits: a. This requires the nurse to assess the resident for their individual needs and develop a plan of care. Pharmacological treatment should be used only after other measures have not worked. Because excessive use of laxatives can cause damage to the colon and increase the problem of constipation, the least harsh laxative should be used. 5. Pharmacological agents include: .b. Stool Softeners: (DSS) These soften the stool by holding water and fat in the stool. Again, it is very important these residents receive adequate hydration .Implementation .3. Following admission assessment, a bowel assessment will be completed quarterly, annually and with significant change of condition. With this a 3-day bowel/bladder monitoring record with be completed annually and with significant change in condition. 1. if a resident becomes increasingly incontinent of bowel, a bowel assessment will be completed and if a pattern of incontinence is identified a toileting plan will be initiated for the resident to decrease incontinent episodes. [NAME] Staff will .2. Case Managers develop and maintain the resident's plan of care including a bowel program if the resident is at risk or has an actual problem with diarrhea or constipation. Include preventive management for residents on constipating medications. For a detailed reference refer to RNF Practice Guidelines for the Management of Constipation in Adultso.3. Nursing staff report to the Charge Nurse regarding any resident abdominal or rectal discomfort, or complaints of diarrhea or constipation. 4. Nursing staff document bowel movements in the BM book accurately for amount (S, M, L) and consistency (liquid, soft, formed, hard) and method (voluntary, involuntary). 5. Bowel Movement Monitoring: (unless the resident has a different plan of care) . c. Diarrhea Control: 1. Ensure a high fluid intake to keep resident well hydrated. Clear liquid diet 24-48 hours when resident also has nausea/vomiting, as tolerated. 2. Begin BRAT diet (Bananas, rice cereal, applesauce, and toast). These are high in fiber, are easy on the stomach, and a bit constipating. To help absorb more fluid in the colon and minimize watery diarrhea, add Metamucil. This will also help minimize cramps (caused by fluid-filled colon). 3. Stop milk, cheese, and other milk products except for live culture yogurt. Live culture yogurt will replace lactobacillus which is needed to digest mild products. Restart milk products, along with the yogurt once the diarrhea has resolved. 4. Give Imodium after each loose stool (may be repeated four times within 24 hours per directions on package). If resident isn't having reasonable improvement in diarrhea in the next 1-2 days, or if diarrhea is getting worse, contact Physician/Physician Assistant.