DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1G0D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00285

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245429**

2. STATE VENDOR OR MEDICAID NO. (L2) **068252700**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWEETEN LUTHERAN HEALTH CARE CENTER**
(L4) **125 5TH AVENUE SOUTHEAST**
(L5) **SPRING GROVE, MN** (L6) **55974**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/14/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 12/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/02/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245429

December 29, 2016

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

Dear Ms. Borreson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 12, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 29, 2016

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

RE: Project Number S5429027

Dear Ms. Borreson:

On November 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 26, 2016. This survey found the most serious deficiencies 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) whereby corrections were required.

On December 14, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 19, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2016, effective December 12, 2016 and therefore remedies outlined in our letter to you dated November 10, 2016, will not be imposed.

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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245429 Y1	A. Building B. Wing Y2	12/14/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0332	Correction	ID Prefix F0431	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.25(m)(1)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	12/05/2016	LSC	12/05/2016	LSC	12/05/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/05/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	12/29/2016	10160	12/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/26/2016	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245429	A. Building 01 - MAIN BUILDING 01 B. Wing	12/19/2016

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 12/12/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 12/29/2016	SIGNATURE OF SURVEYOR 37008	DATE 12/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1G0D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00285

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245429**

2. STATE VENDOR OR MEDICAID NO. (L2) **068252700**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWEETEN LUTHERAN HEALTH CARE CENTER**
(L4) **125 5TH AVENUE SOUTHEAST**
(L5) **SPRING GROVE, MN** (L6) **55974**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/26/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 11/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/07/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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23. LTC AGREEMENT BEGINNING DATE (L41)

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25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 10, 2016

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

RE: Project Number

Dear Ms. Borreson:

On October 26, 2016, a 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved

and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day 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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 January 26, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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 _____	10/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		12/5/16

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

Electronically Signed | 11/18/2016

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 _____	10/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) was accurately coded for 4 of 4 residents (R18, R38, R2, R16) reviewed for dental services. Findings include: R18's annual MDS (comprehensive assessment) dated 4/5/16, had identified for oral/dental status no oral concerns were present. R18's teeth were observed on 10/24/2016, at 4:59 p.m. and surveyor noted missing and broken lower front teeth. R18's oral assessment dated 4/6/16, indicated R18 had obvious or likely cavity or broken natural teeth. R18 had his own teeth and denied having any pain or problems with them at this time. He states he is missing some teeth but that causes no problems. On 10/26/2016, at 8:22 a.m. the director of nursing (DON) stated the dental assessment indicated R18 had obvious or likely cavity or broken natural teeth. The DON stated The annual MDS had been inaccurately coded for R18 and should have been coded to reflect R18 had obvious or likely cavity or broken natural teeth.	F 278	F278 Gundersen Tweeten Care Center will continue to ensure that the assessment accurately reflects the resident's status, the assessment is conducted or coordinated by a registered nurse with the appropriate participation of health professionals, the assessment is signed and certified that the assessment is completed by a registered nurse and each individual who completes a portion of the assessment has signed and certified the accuracy of that portion of the assessment. On 11/16/16 R18, R38, R2 and R16's observations were reviewed and MDS' were modified with accurate coding to reflect the resident's status by DON. All other resident assessments, MDS and care plans will be reviewed by MDS Coordinator to ensure coding is accurate for all residents. This will be monitored by DON weekly for 3 months. Completion date: 12/5/16	

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F 278	Continued From page 2 R38's annual MDS dated 3/8/16, had identified for oral/dental status no oral concerns were present. R38's teeth were observed on 10/24/2016, at 4:45 p.m. and surveyor noted broken and carious lower front teeth. R38's dental assessment dated 4/1/16 indicated no dental concerns. On 10/26/2016, at 9:57 a.m. the director of nursing (DON) stated R38's front teeth were broken and carious. The DON stated the oral assessment dated 4/1/16 should have indicated obvious or likely cavity or broken natural teeth. The DON stated she would expect the care plan to include the current condition of resident's teeth and stated R38's teeth have been in this condition since admission to the facility. The DON stated the annual MDS dated 3/6/16 was coded inaccurately and should have indicated R38 had obvious or likely cavity or broken natural teeth. R2's annual Data Set (MDS) dated 10/8/16, had identified for oral/dental status no oral concerns were present. R2's teeth were observed on 10/24/2016, at 4:26 p.m. and surveyor noted R2 had upper dentures and did not have any lower teeth. R2's dental assessment dated 10-17-16, indicated R2 had no natural teeth or tooth fragments. On 10/26/2016, at 10:08 a.m. registered nurse (RN)-B stated R2's annual MDS was coded inaccurately. RN-B stated the MDS should have	F 278		

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F 278	Continued From page 3 indicated R2 had no natural teeth or tooth fragments. RN-B stated she was new to the building and was still learning. On 10/26/2016, at 10:31:48 AM the director of nursing (DON) stated R2's annual MDS should have indicated R2 had no natural teeth or tooth fragments. The DON verified the annual MDS for R2 was coded inaccurately. R16's annual Data Set (MDS) dated 1/26/16, had identified for oral/dental status no oral concerns were present. R16's teeth were observed on 10/24/2016, at 6:04 p.m. and surveyor noted R16 had missing teeth. R16's dental assessment completed 1/27/16, indicated R16 had obvious or likely cavity or broken natural teeth. On 10/26/2016, at 12:28 p.m. the director of nursing (DON) stated R16's annual MDS was coded inaccurately to reflect condition of her teeth. The DON stated the annual MDS should have indicated R16 had obvious or likely cavity or broken natural teeth. The facility policy Resident Assessment, dated 3/15/16, indicated Purpose: To identify the resident's care needs. To develop a comprehensive plan of care for the resident. To identify the resident's strengths. To assist the resident to attain the highest practical level of mental and physical function and well-being.	F 278		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		12/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 332	Continued From page 4 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and facility practice for 4 of 9 residents (R38, R25, R14, R6) reviewed for medication administration. This resulted in a medication error rate of 15 percent. Findings include: R38 was administered scheduled medication on 10/25/16 at 8:48 a.m. by registered nurse(RN)-A. RN-A was observed to administer Miralax (bowel medication) 17 grams mixed in four ounces of fluid. R38's physician orders report dated 9/25/16 through 10/25/16 read: Miralax powder 17 grams/dose once a day with label instructions to mix with at least eight ounces of fluid. On 10/25/16 at 8:42 a.m. RN-A confirmed R38's Miralax was administered in four ounces of fluid. "We just give four ounces, that's all we got. That's the biggest cups we have, we don't have anything bigger. I've never seen med cups that big. I don't know if the kitchen would have enough glasses for us to use eight ounces." R25 was administered scheduled medication on	F 332	F332 Gundersen Tweeten Care Center will continue to ensure that it is free of medication error rates of five percent or greater. All physician orders were reviewed by DON on 11/17/16 to ensure order was complete with provider instructions. All nurses were re-educated and tested for competency for Medication Administration. This will be monitored by Quality Nurse with medication pass observations weekly x1 month then monthly thereafter. Completion date 12/5/16.	

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F 332	Continued From page 5 10/25/16 at 8:48 a.m. by RN-A. RN-A was observed to administer Miralax 8.5 grams mixed in three ounces of fluid. R25's physician orders report dated 9/25/16 through 10/25/16 read: Miralax powder 17 gram/dose twice a day with special instructions to mix in six to eight ounces of apple juice or water. On 10/25/16 at 8:38 a.m. RN-A stated she only gave R25 half a dose because it sometimes made R25 sick. RN-A added she gave the remaining half of the dose at 10 a.m. RN-A confirmed R25's Miralax was not administered as ordered and it would probably be a medication error. On 10/25/16 at 1:08 p.m. the facility's physician assistant (PA)-A stated she was unaware R25's Miralax dose was broken into two separate doses. Adding she expected the nurse to get an order changed prior to altering how a medication was administered. R14's 10/25/16 noon dose of Lortab (controlled pain medication) was omitted from his noon medication administration. R14's physician orders report dated 9/25/16 through 10/25/16 read: Lortab 5/325 mg one tab three times a day. On 10/25/16 at 2:40 p.m. RN-A stated she forgot to give R14 his noon dose of Lortab, adding the error would have been caught at shift change. Event Report for R14 dated 10/25/16 2:48 p.m. read, "Missed giving the noon med with his other meds and will given [sic] now and his 5 PM [p.m.]	F 332		

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F 332	Continued From page 6 Lortab until 7 PM to make up the difference, so he does not have any pain." R6 was administered scheduled medication on 10/26/16 at 7:15 a.m. by licensed practical nurse (LPN)-A. LPN-A was observed to administer propranolol a medication to treat high blood pressure. R6's physician orders report dated 9/26/16 through 10/26/16 read, propranolol 10 mg one and a half tablets three times daily. Pharmacy label read, propranolol 10 mg give one and a half tablets by mouth three times a day * Hold if systolic blood pressure less than 100 or heart rate less than 60. On 10/26/16 at 7:22 a.m. LPN-A confirmed she had not obtained R6's blood pressure or heart rate prior to the administration of R6's propranolol. On 10/25/16 at 1:22 p.m. the director of nursing (DON) stated she was unaware the medication carts lacked cups that held eight ounces of fluid and medications should be administered per label instructions. On 10/26/16 at 1:41 p.m. the DON added the blood pressure and pulse for R6 should be obtained prior to administration of propranolol. Facility policy, 11A2: Medication Administration-General Guidelines dated February 2015, reads: "4. Five rights- right resident, right drug, right dose, right route, and right time are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration.	F 332		

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F 332	Continued From page 7 B.2. Medications are administered in accordance with written orders of the prescriber. 4. When medications are administered by mobile cart taken to the resident's location, medications are administered at the time they are prepared. Medications are not pre-poured either in advance of the med pass or for more than one resident at a time."	F 332		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		12/5/16

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F 431	Continued From page 8 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure failed to ensure medications were stored in their original pharmacy container before administering to residents for 1 of 2 medication carts in the facility, emergency medications were securely stored, and controlled medications were separately locked in a permanently affixed compartment for storage and available for authorized access only. This had the potential to effect all 30 residents on the whispering pines unit. Findings include: Emergency Medication Kits: On 10/25/16 at 2:24 p.m. the medication storage area inside the charting room located on the Whispering Pines unit was observed with registered nurse (RN)-A. RN-A confirmed the charting room was an unsecured room in which all facility staff have access. RN-A unlocked a cabinet that contained the controlled emergency medication kit. The kit itself was closed with a zip tie (tag). RN-A opened a second cabinet that did not lock. Inside the second cabinet contained the emergency medication kit, also closed with a zip tie.	F 431	F431 Gundersen Tweeten Care Center will continue to ensure all drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable and store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The Emergency Medication Kit has been relocated to a locked permanently affixed cupboard and the Controlled Emergency Medication Kit had an additional lock applied to the permanently affixed cupboard. RN-A was re-educated on facility policy to not set-up medications prior to med pass and the importance of notifying provider prior to alternating how a medication was administered. LPN-A was re-educated on facility policy to not leave meds unattended on the cart and the need to do required treatments prior to passing medications. All other licensed nursing staff were re-educated on facility policies regarding proper medication storage and facility policies on medication administration on 11/29/16. This will be	

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F 431	Continued From page 9 On 10/26/16 the following staff were observed to enter the charting room: 7:12 a.m. nursing assistant-C 7:52 a.m. maintenance manager and activity aide-A 8:55 a.m. administrative secretary- A On 10/26/16 at 8:10 a.m. licensed practical nurse (LPN)-A was observed to remove the emergency medication kit from the locked refrigerator in the charting room and place the emergency medication kit on top of her medication cart parked in the Whispering Pines unit next to room 112. LPN-A removed a vial of Novolog insulin, leaving the opened emergency medication kit on the top of her medication cart. LPN-A was observed to go into room 112, closing the door, leaving the opening emergency medication kit opened and unsecured on top of the medication cart. While LPN-A was in room 112 with the door closed R34 was observed by a surveyor to reach onto the medication cart and remove a tissue. LPN-A stated the refrigerated emergency medication kit was normally locked in the refrigerator and it was the first time she had used it. The refrigerated emergency medication kit contained the following insulin vials: Lantus, Novolog, Levemir, Novolin-N, Novolin-R, and Novolin 70/30. The refrigerated emergency medication kit also contained three vials of lorazepam (anti-anxiety medication). The controlled medication emergency mediation kit contained the following: diazepam (medication used to treat anxiety and muscle spasms), hydrocodone/acetaminophen (pain medication), morphine sulfate (pain medication), oxycodone	F 431	monitored by Quality Nurse weekly x1 month then monthly thereafter. Completion date 12/5/16.	

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F 431	Continued From page 10 (pain medication), and tramadol (pain medication.) The emergency medication kit contained a total of 40 medications. On 10/25/16 at 2:54 p.m. the director of nursing (DON) stated the emergency kit did not need to be locked and it had been like that for two years. On 10/26/16 at 1:35 p.m. the DON verified that all staff in the facility had access to the charting room on the whispering pines unit. Adding, the zip tie tag had been considered a lock from the pharmacy. The DON verified the charting room door did not lock, that anyone would be able to open a zip tie tag, and that all facility staff had access to the emergency medication kit. The DON stated that medication should not be left unattended/unsecured. Whispering Pines medication cart: On 10/25/16 at 8:54 a.m. during medication administration observation the top drawer of the whispering pines medication card was found to have three medication cups with pre-set up pills. RN-A stated it was normal for her to pre-set up medications for the residents she had a hard time catching. Adding, that as far as she knew it was a policy to pre-set up medications and she had been doing it for years. RN-A identified the medications in cup one as R19's acetaminophen (pain medication), Aricept (Alzheimer's medication), aspirin (blood thinning medication), buspirone (anxiety medication), divalproex (anti-seizure medication), furosemide (diuretic), isorbide mononitrate (medication used to treat chest pain), metoprolol (high blood pressure medication), potassium, and Zoloft (antidepressant medication). Cup two as R53's	F 431		

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F 431	Continued From page 11	F 431		

acetaminophen, aspirin, calcium carbonate, and hydrochlorothiazide (high blood pressure medication.) Cup three as R24's acetaminophen, bupropion (anti-depressant medication), and vitamin D3.

On 10/25/16 at 3:55 p.m. RN-A had the top drawer of the whispering pines medication cart opened. Again observed in the top drawer was three medication cups stacked on top of each other. Inside of the medication cups were pills. RN-A stated the pills were "The narcs [narcotics] for later." RN-A identified the medication cups as cup one for R28's scheduled Lortab (controlled pain medication) 5/325 mg 1 tab, Cup two as R2's scheduled oxycodone (controlled pain medication) 5 mg 1 tab, and cup three for R15's scheduled Lortab 5/325 mg 1 tab.

On 10/25/16 at 1:22 p.m. the DON verified that pre-setting up medication is not a facility policy.

On 10/26/16 at 12:54 p.m. the facility pharmacist was called with no answer and no return phone call in regards to pre-setting up of medications.

Facility policy, Storage of Medications dated February 2015 reads, "Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access."

Facility policy, Controlled Substance Storage dated February 2015 reads, "Schedule [II-V] medications and other medications subject to abuse or diversion are stored in a permanently affixed, double locked, compartment separate

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F 431	Continued From page 12 from all other medications."	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident bathroom sinks, flooring, walls, shower room, door frames and windows in common areas were kept in a state of good repair, safe, clean and in a sanitary manner for 16 of 41 residents (R17, R42, R21, R27, R25, R33, R41, R7, R16, R13, R2, R14, R41, R54, R7, R35) Findings include: A tour of the facility was conducted on 10/1/16, began at 8:01 a.m. with the director of facility operations (DFO) and the following concerns were identified: R17's bathroom sink had green colored staining. R42's bathroom sink had green colored staining and the bathroom floor was worn. R21's bathroom sink had green colored staining. R27's room has torn base board molding by the entrance door.	F 465	F465 Gundersen Tweeten Care Center will continue to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. On 11/14/16 the administrator and director of facility operations completed an environmental audit of the facility. From this a checklist was developed for the maintenance staff to use to ensure all areas were identified for needs of repair in regards to stained sinks, base boards, molding on door frames, floors, bubbling of plaster, walls that needed painting, door frames needing painting, loose floor tiles, cracked vinyl on Broda chair, closet doors that do not latch, loose protective paneling on doors, caulking around windows and toilets. Maintenance began working on this list of items on 11/15/16 with full completion date of 12/5/16. Environmental walk-throughs will continue to be done on a quarterly basis to ensure proper upkeep of the facility.	12/5/16

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 _____	10/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 13 R25's bathroom sink had green staining. R33's floor is worn through the pattern and finish is gone; the door molding is loose; the walls around the three windows in the room have damaged plaster and bubbling paint. The wall behind the bed has gouges in it with missing paint. R41's door frame is chipped and the door jamb molding is loose. R16's bathroom sink had green and rust colored staining. R13's door frame had loose molding and loose floor tile under the sink. R2 had missing paint on the wall behind a table. R14's Broda chair headrest had cracked vinyl, causing it to be a non-cleanable surface. R41's door frame had chipped paint and loose molding. R3 had plaster that was disintegrating with peeling paint on the wall around the window. The wall behind the back of the bed was scraped with missing paint. The closet door did not latch. R54 had plaster walls with areas that had disintegrated and had peeling paint. A plastic panel on the lower half of the interior bathroom door was falling off. R7 had a piece of molding on the door frame was loose. The wall around the window had disintegrating plaster and peeling paint. The door	F 465		

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 _____	10/26/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 14 frame had chipped paint. The linoleum, in the room, had multiple scuff marks and appeared dirty. R35 had disintegrating plaster walls with bubbling painted. The closet accordion doors did not latch so the doors could not be fully closed giving full visual privacy when needed, the linoleum around the toilet did not seat up to the toilet. The door frame had chipped paint. The following was observed in the "Solarium" in the Woodlands Unit had the following: · The base board molding by the exit door next to the television in the dayroom of the secured unit was not adhering to the wall. · Floor tile in front of the same exit door was discolored and had buildup of brownish debris. · The metal door surface is loose on the exit door. · The large window in the Solarium had black debris along the base of the glass. The DFO confirmed the vapor barrier was broken causing a rust build-up. There is also a gap between the glass and the window sill. When pointed out to the DFO, he indicated it needed to be caulked to prevent insects from entering facility through this gap. The DFO verified the above findings during the tour of the facility on the findings above when each area and room was toured.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey ated 10/26/16, Tweeten Lutheran Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Tweeten Lutheran Health Care Center is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1967, addition was constructed to the South Wing that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 41 at the time of the survey.	K 000		

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

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K 000	Continued From page 2	K 000		
K 018 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are	K 018	K018 Gundersen Tweeten Care Center will continue to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinkled smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors.	12/5/16