Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2025

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

RE: CCN: 245429
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 30, 2025, we notified you a remedy was imposed. On February 27, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 25, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 1, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of January 30, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 1, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 25, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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January 30, 2025

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

RE: CCN: 245429
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 9, 2025, a survey was completed at your facility by the Minnesota Department(s) 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 1, 2025.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 1, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 1, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 1, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Tweeten Lutheran Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 1, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 9, 2025, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental

Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited

deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. BUILDING _____ B. WING _____	C 01/09/2025

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
E 000	Initial Comments On 1/6/25-1/9/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance.	E 000		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the	E 018		2/25/25

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

Electronically Signed | 02/07/2025

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

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E 018	Continued From page 1 location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of	E 018		

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E 018	Continued From page 2 potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track the location of on-duty staff and residents in the facility during an emergency. This had the potential to affect all residents at the facility and staff providing services at the facility. Findings include: The facility's "Emergency Preparedness" three ring binder dated 6/4/24, lacked a policy and procedure to track staff and residents during an emergency. On 1/9/24 at 9:37 a.m., the administrator-in-training, administrator trainer and maintenance supervisor confirmed the facility had not developed policies and procedures related to tracking residents and staff during an emergency.	E 018	E018 Gundersen Tweeten Care Center will ensure that the facility has a comprehensive system in place to track residents and staff during emergencies, improving safety and compliance with federal regulations. 1. Corrective Actions for Identified Deficiencies: The facility immediately developed and implemented a policy and procedure for tracking the location of on-duty staff and sheltered residents during emergencies. A Resident and Staff Emergency Tracking Log was created to document the location of all individuals in the facility and to ensure accountability in the event of an evacuation. Facility staff were instructed to complete emergency tracking documentation during all future drills and actual emergencies. Appendix E Tracking staff, residents, and others during evacuation. 2. Identifying Other Residents at Risk & Conducting an Audit: A facility-wide audit was conducted to ensure that all resident and staff emergency tracking protocols were being followed and to identify any additional gaps in preparedness. The Emergency Preparedness Committee reviewed the facility□s emergency plan and made necessary revisions to address	

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E 018	Continued From page 3	E 018	tracking deficiencies. 3. Staff Education on Emergency Tracking Procedures: Mandatory in-service training was provided to all staff on February 7th, 2025, covering: Proper use of the Resident and Staff Emergency Tracking Log Procedures for documenting resident and staff movement during an emergency. Roles and responsibilities of staff in tracking during an evacuation. Communication methods to ensure all individuals are accounted for. Training was added to the new employee orientation program to ensure all new hires are familiar with emergency tracking procedures. 4. Maintaining Compliance Through Audits & Monitoring: Monthly review will be conducted during safety meetings, reflective in minutes. 5. Responsible Party & Ongoing Compliance Reporting: The Director of Maintenance and Administrator will be responsible for ongoing compliance with tracking procedures. Findings from audits, drills, and compliance monitoring will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for further review and corrective action as needed. The Emergency Preparedness Plan will be reviewed annually and updated as necessary to ensure continued compliance.	
F 000	INITIAL COMMENTS On 1/6/25-1/9/25, a standard recertification	F 000		

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F 000	Continued From page 4 survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54297240C (MN00105878). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		2/25/25

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F 645	Continued From page 5	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing

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F 645	Continued From page 6 facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) was completed or clarified for 1 of 1 resident (R) 25 reviewed for PASARR who has a mental disorder who previously receivied services. Findings include: R25's Significant change Minimum Data Set (MDS) assessment dated 9/17/24 indicated R25 had intact cognition. R25 can hear adequately and communicate needs verbally. R25 was admitted on 8/5/24, with diagnoses of schizoaffective Disorder, Bipolar Disorder, Narcissistic Personality Disorder, Anxiety. R25's current medication regimen includes psychotropic medication of Depakote and Zyprexa. During an observation and interview on 1/6/25 at 3:22 p.m., R25 was in his room and was difficult	F 645	F645 Gundersen Tweeten Care Center will ensure full compliance with PASARR screening requirements for all current and future residents. Enhanced care planning for residents with mental illness and intellectual disabilities. Improved communication between facility staff, residents, and external agencies to ensure appropriate mental health services. 1. Addressing the Issue for the Cited Resident (R25): A Level II PASARR screening was immediately initiated for R25 upon identification of the deficiency. The facility coordinated with the local PASARR authority to ensure R25 received the appropriate assessment. R25□s care plan was reviewed and updated based on the PASARR Level II recommendations. The facility scheduled follow-up psychiatric appointments for R25 and established a structured appointment-tracking system to prevent missed sessions. The Director of Nursing (DON) and Social Services Worker	

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F 645	Continued From page 7 to understand at times as R25 mumbled his words. R25 indicated he wanted to go home or somewhere different, stating so he can get back into a routine with visits to his previous psychiatrist. During an interview on 1/07/25 at 11:52 a.m., social services worker (SSW) indicated R25 wanted to go back to his group home and the county case worker is looking for placement as he cannot go to his previous one since it is on the second floor. SSW indicated R25 spends a lot of his time sleeping and noted a change in R25 behaviors such as refusing to talk or come out of room. SSW further explained R25 should have a PASARR Level II assessment due to his diagnosis and mental health concerns. During an interview on 1/7/25 at 1:08 p.m., nursing assistant (NA)-1 indicated R25 tends to stay in bed most of the time and refuses to go to activities. During an interview on 1/07/25 at 2:21 p.m. director of nursing (DON) said R25 has a case worker and case manager and they are in touch regarding appointments and changes in care. During an interview on 1/08/25 at 9:15 a.m., SSW verified they have no paperwork or documentation the facility initiated a request for a PASARR level II screening. And should have with his extended stay and mental health illnesses. During an interview on 1/8/25 at 9:36 a.m. power of attorney (POA) had returned a phone call and indicated the facility staff were to be working with R25 on all appointments and verified R25 previously saw a psychiatrist for mental health	F 645	(SSW) ensured communication with R25□s Power of Attorney (POA) regarding all scheduled mental health appointments. 2. Identifying Other Residents at Risk & Conducting an Audit: A facility-wide audit of all residents was conducted to determine if other residents required PASARR Level II screenings but had not received one. Any resident identified as needing a PASARR Level II assessment had the screening initiated immediately. The facility cross-checked PASARR documentation to ensure all Level I and Level II screenings were properly completed before admission. 3. Staff Education and Training ; The DON and Social Services Director provided targeted education to all nursing, admissions, and social services staff on PASARR regulations, including: The importance of PASARR Level I and Level II screenings. The proper procedures for ensuring compliance before and after admission. How to recognize when a resident requires a Level II assessment. Staff members were required to complete a post-training competency test to ensure understanding. 4. Maintaining Compliance (Ongoing Monitoring & Audits): Weekly audits will be conducted for four (4) weeks to ensure compliance with PASARR screening requirements. The admissions team will complete a PASARR Compliance Checklist for every new admission to verify that the necessary screenings are completed before a resident enters the facility. Social services staff will review	

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F 645	Continued From page 8 concerns. POA said the staff were supposed to set up all mental health appointments and include both the facility and POA on emails with the times so they could all join virtual with R25 to encourage a stable routine and positive outcome. The POA said the facility reached out and R25 had missed the last two sessions. During a phone interview on 1/8/25, county worker confirmed R25 was not on current case load although prior to nursing home admission, R25 was seen and followed regularly by R25's psychiatrist . During an email communication on 1/8/205 at 10:10 a.m. local county worker wrote a level II assessment was not completed because the facility had not requested one. During an interview on 1/08/25 at 9:51 a.m., DON was not aware of R25 PASARR status. DON stated appointments were supposed to be set up with the county and an email would be sent to confirm R25 appointment dates. The DON, R25 and POA would attend appointments. The DON verified they had not attended any appointments with R25 due to them being canceled. The DON was unsure why the appointment was canceled and not aware R25 was not being seen by his psychiatrist every other month for R25's behaviors and medication regimen. A facility policy identified as Preadmission Screening and Annual Resident Review (PASARR) dated 1/24, indicated individuals diagnosed with major mental illness and the PASARR process consists of a level 1 screen by the state and federal requirements as well as the review and implementation of the level II	F 645	residents with mental health and intellectual disability diagnoses monthly to confirm their PASARR status remains up to date. 5. Responsible Party for Ongoing Compliance: The Social Services Director and DON will oversee PASARR compliance. Audit results and corrective actions will be reviewed in the Quality Assurance and Performance Improvement (QAPI) Committee meetings monthly. Any identified deficiencies will be immediately addressed, and additional education will be provided as needed.	

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F 645	Continued From page 9 recommendations upon admission. A facility policy identified as Behavioral Assessment, Intervention, and Monitoring dated 9/24, indicated that the facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practical psychical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The policy also reads all residents will receive a level I PASARR prior to admission and if the level one indicates that the individual may meet the requirement for a mental health disorder, intellectual disability, or related condition they will be referred to the state PASARR representative for the Level II screening.	F 645		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		2/25/25

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F 812	Continued From page 10 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a clean and sanitized environment to prevent the potential of cross contamination or food borne illness. This practice has the potential to effect all residents, staff and visitor who may receive food from the kitchen. Finding includes: During an initial tour and observation of the kitchen on 1/6/25 at 1:32 p.m., the dietary manager (DM) explained the process of storage for the kitchen. There were several large pans, mixing bowls, and containers used in the steam kitchen area found to be unclean and had dry crusted food on them. The DM acknowledged the items were dirty and pulled them from the storage area. There were several dirty utensils found in storage drawers. During a follow up kitchen observation on 1/08/25 at 10:48 a.m. cook (C)-1 confirmed the storage area for kitchen utensils and having identified several large pans having had dried food on them and one large baking pan with a small amount of paper. C-1 confirmed the pan was dirty and needed to be taken back to the dishwasher area. There was also several small dirty pans with either crusted food or some other type of debris found during this visit including ones going to be used for the next meal. C-1 explained if staff found dirty kitchen items they would send them back through the washer. C-1 verified staff were educated on this area and the normal process is to rewash them either by hand or run them	F 812	F812 Gundersen Tweeten Care Center will ensure a clean and sanitized environment to prevent the potential of cross contamination or food borne illness. 1. Corrective Actions for Identified Deficiencies: All large pans, mixing bowls, utensils were examined and were pulled from storage areas if not completely clean. Immediate education was provided to kitchen staff and the expectation is to send the dirty kitchen items through the dishwasher again or clean them in the proper sink before placing them into use or storage. 2. Corrective Actions for Identified Deficiencies: A full kitchen audit was completed to ensure all kitchen items were properly clean within storage areas. The Cleaning Dishes/Dish Machine policy was reviewed and no corrections were needed to the policy. 3. Staff Education and Training: The Dietary Manager did a mandatory in-service with all dietary staff on the expectation of following the policy and procedure for washing dishes, inspecting for cleanliness and dryness, putting dishes away and for following the steps for proper implementation of the dishwasher prior to all meals and after using kitchen item before proper storage. Staff members were required to complete a post-training competency test to ensure understanding. 4. Maintaining Compliance: Dietary Manager will conduct daily audits of	

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F 812	Continued From page 11 through the dishwasher prior to using them for future food preparation or storage. C-1 stated all staff who work in the kitchen are trained on how to properly handle the cleaning of kitchen items, food storage, and use of the dishwasher. During an interview on 1/08/25 at 1:58 p.m. DM explained the sanitary policy and kitchen cleanliness. DM verified there were no problems with the dishwasher, and it is serviced as needed. The DM confirmed the unclean items from the initial tour and were discussed with staff and items were pulled out to be cleaned. DM verified there is about 10 staff, with some newer who work in the kitchen at various times. The DM said their expectation is for staff to send dirty kitchen items through the dishwasher again or clean them in the proper sink before placing them into use or storage. The DM verified they all have been educated and trained. The DM did verify the purpose of the training and ongoing education for proper cleaning and sanitization of kitchen items is to prevent the spread of germs or cross contamination which could potentially lead to foodborne illness. Gunderson Tweeten Care Center Policy titled Cleaning Dishes/Dish machine (revised 2/22) included, all flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Staff will follow a list of procedures for washing dishes. Staff are required to inspect for cleanliness and dryness and put dishes away if clean. The staff are expected to follow the steps for proper implementation of the dishwasher prior to all meals and after using	F 812	kitchen items x2 weeks, then weekly audits 3 weeks and then monthly audits for 3 months to ensure compliance. 5. Responsible Party for Ongoing Compliance: The Dietary Manager will oversee compliance. Audit results and corrective actions will be reviewed in the Quality Assurance and Performance Improvement (QAPI) Committee meetings monthly. Any identified deficiencies will be immediately addressed, and additional education will be provided as needed.	

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F 812	Continued From page 12 kitchen items before proper storage	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		2/25/25

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F 880	Continued From page 13 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 6 of 6 (R2, R21, R16, R13, R3, R9) residents observed for handwashing/hand hygiene. In addition, the facility failed to have a system for surveillance to identify possible communicable disease or infections. This deficient practice had	F 880	F880 Gundersen Tweeten Care Center will ensures that the facility is compliant with infection control standards and maintains a safe environment for residents, staff, and visitors. 1. Corrective Actions for Identified Deficiencies: Immediate re-education was provided to all staff involved (NA-B, NA-C,	

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F 880	Continued From page 14 the potential to affect all 28 residents who resided in the facility, staff and visitors. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated 10/22/24, identified diagnosis Alzheimer's disease (brain disorder that causes problems with memory, thinking and behavior.) and needed assistance with eating. R21's quarterly MDS dated 10/29/24, identified diagnosis of Alzheimer's disease and needed assistance with eating. R26 quarterly MDS dated 12/10/24, identified diagnosis of Alzheimer's and needed clean up assistance with eating. During an observation and interview on 1/6/25 at 5:43 p.m., nursing assistant (NA)-B at the dining table between R2 and R21 during the meal. NA-B was feeding R2 her meal and then assisted R21 with her meal. NA-B did not perform hand hygiene prior to assisting R21. NA-B then placed gloves on without performing hand hygiene and wiped R21's face. NA-B then removed R26's clothing protector, hand hygiene was not performed prior to removing the R26's clothing protector. NA-B then returned to table to feed R2 her meal, NA-B did not perform hand hygiene prior to assisting R21 with meal. NA-B stated handwashing should be done in between each resident and before and after cares. R16's quarterly MDS dated 12/9/24, identified diagnosis of Parkinson's disease (is a movement disorder of the nervous system that worsens over time) and was independent with ambulation.	F 880	NA-D, and LPN-C) regarding proper hand hygiene practices, including the necessity of handwashing before and after resident contact, glove use, and care tasks. Staff were required to demonstrate proper hand hygiene competency before resuming resident care duties. Infection Control Coordinator (ICC) conducted an immediate in-service training on hand hygiene procedures following CDC and CMS guidelines. Facility infection control surveillance was reinstated immediately. Infection tracking logs were updated, and all current infections among residents and staff were reviewed to identify any potential outbreaks. 2. Identifying Other Residents at Risk & Conducting an Audit: A facility-wide audit of hand hygiene compliance was initiated to assess adherence among all staff. Infection Control Coordinator performed a retrospective review of infection control logs and identified gaps in surveillance since January 2025. All residents were assessed for signs of infections, and the findings were reviewed by the Director of Nursing (DON) and Medical Director. A root cause analysis was completed to determine gaps in staff adherence to hand hygiene and surveillance practices. 3. Staff Education on Infection Control and Hand Hygiene: Mandatory in-service training was held for all staff (nursing, housekeeping, dietary, therapy) on February 11th, 2025, focusing on: Proper hand hygiene techniques and the "Five Moments for Hand Hygiene". Correct gloves use and changing practices. Standard and transmission-based	

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F 880	Continued From page 15 R13's quarterly MDS dated 11/5/24, identified diagnosis of dementia (decline in mental ability) and needed assistance for transfers. During an observation and interview on 1/7/25 at 11:44 a.m., R16 was in the recliner in his room, and NA-C placed a gait belt on and ambulated R16 to the dining room, NA-C did not perform hand hygiene after transfer. At 11:48 a.m., NA-C then entered R13's room and applied gait belt to R13 and transferred R13 to the toilet. NA-C did not perform hand hygiene prior to entering room or prior to transferring R13. NA-C stated handwashing/hand hygiene should be done before and after touching a resident, when removing gloves, after touching bodily fluid, and before touching anything in the room. R3's quarterly MDS dated 11/26/24, identified a stage 3 pressure ulcer. During observation and interview on 1/7/25 at 3:27 p.m., licensed practical nurse (LPN)-C was sitting at the nursing station with gloved hands, LPN-C was observed touching her face with the gloved hands and at 3:24 p.m., proceeded to R3's room and removed gloves and applied gown and gloves. LPN-C did not perform hand hygiene prior to donning gown and gloves and then entered R3's room. LPN-C stated handwashing/hand hygiene should be done in between residents, and between glove changes. R9's quarterly MDS dated 11/12/24, identified diagnosis of Alzheimer's Disease was independent with propelling her wheelchair. During an observation and interview on 1/8/25 at	F 880	precautions. The importance of infection surveillance and reporting. Infection Control Coordinator was designated as the staff liaison for ongoing infection control education. Competency evaluations for hand hygiene were incorporated into new hire orientation and annual training. 4. Maintaining Compliance Through Audits & Monitoring: Weekly hand hygiene compliance audits will be conducted for four weeks, then monthly for three months, and findings will be reported to the Quality Assurance and Performance Improvement (QAPI) committee. Infection control surveillance logs will be reviewed weekly by the Infection Preventionist to ensure timely identification, reporting, and tracking of infections. The Infection Control Coordinator will conduct unannounced hand hygiene observations during various shifts to ensure compliance. Feedback from audits will be shared with staff during shift huddles and monthly staff meetings. 5. Responsible Party & Ongoing Compliance Reporting: Infection Control Coordinator (ICC) and Director of Nursing (DON) will be responsible for ongoing monitoring of infection control practices and ensuring adherence to facility policies. Findings from audits, surveillance reports, and compliance measures will be reported to the QAPI committee monthly for review and any necessary action. The Infection Control Program will undergo an annual review to ensure alignment with updated CDC, CMS, and state guidelines.	

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F 880	Continued From page 16 10:59 a.m., NA-D ambulated R16 from the activity room to R16's room holding on to the gait belt and assisted to the recliner. NA-D did not perform hand hygiene after leaving R16's room and returned to activity room and began pushing R9's wheelchair. NA-D did not perform hand hygiene prior to propelling R9's wheelchair. NA-D stated handwashing/hand hygiene should be done before and after touching a resident and before touching wheelchairs. During an interview on 1/9/25 at 9:21 a.m., director of nursing (DON) stated handwashing/hand hygiene should be done before and after touching a resident, after removing gloves and before and after care. DON stated her expectation would be for all staff to do handwashing/hand hygiene after these tasks. Review of facility infection control surveillance logs noted no surveillance of infections of residents or staff had been completed since July of 2024. During an interview on 1/8/25 at 1:20 p.m., DON stated no infection surveillance program is being done and stated, "This is something that has fallen by the wayside and is not being done." DON stated she is not tracking staff infection or resident infections or looking for any correlations. During an interview on 1/9/24 at 12:49 p.m., medical director (MD) stated the facility not performing surveillance of infections since July 2024 is major concern and oversight by the facility. MD stated infection surveillance is an important factor in resident care. MD stated her expectations would be for the facility to regularly report, track and make sure appropriate infection	F 880		

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F 880	Continued From page 17 prevention measures are in place and ensure staff are taking infection control measures. The facility's Infection Prevention and Control Plan Overview dated 11/2024, identified the facility will have an infection control surveillance system to include use of standardized definitions of infection, use of surveillance tools that can uncover an outbreak, and feedback results to the primary caregivers so they can assess the residents for signs of infection.	F 880		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects	F 887		2/25/25

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F 887	Continued From page 18 associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain documentation staff were offered, and or provided education regarding the benefits and potential risks associated with COVID-19 vaccination for 3 of 3 staff (LPN-A, LPN-B, HSK-A) reviewed for COVID-19 vaccinations.	F 887	F887 Gundersen Tweeten Care Center will ensure the facility will maintain documentation that staff were offered, and or provided education regarding the benefits and potential risks associated with COVID-19 vaccination and continuously monitored and revised as	

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	245429	A. BUILDING _____ B. WING _____	C 01/09/2025

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F 887	Continued From page 19 Findings include: Review of Centers for Disease Control and Prevention (CDC) Clinical Guidance for COVID-19 Vaccination, updated 10/31/24, directed the following guidance: People 5-64 years: should receive 1 dose of an age-appropriate 2024-2025 COVID-19 vaccine; People 65 years and older: should receive 2 doses of any 2024-2025 COVID-19 vaccine, spaced 6 months apart. During an interview on 1/9/24 at 11:38 a.m., human resources director (HR)-F stated the facility did not have any documentation of COVID-19 vaccine being offered or education provided for licensed practical nurse (LPN)-A; LPN-B or housekeeper (HSK)-A. During an interview on 1/9/25 at 1:20 p.m., director of nursing (DON) stated she is unaware if employees were offered the COVID-19 vaccine. During an interview on 1/9/25 at 12:49 p.m., medical director (MD) stated her expectation would be for the facility to ensure staff are provided education on risk versus benefits and be offered the COVID-19 vaccine when available. The facility policy on COVID-19 vaccine dated 11/2024, identified when COVID-19 vaccine is available each staff member will be offered and provided education regarding the benefits, risks, and potential side effects of the COVID-19 vaccine. The policy also identified the facility maintains documentation that staff were offered and provided education regarding benefits and potential risks of COVID-19 vaccination.	F 887	necessary to ensure compliance with COVID-19 immunization requirements and to maintain the health and safety of residents and staff. 1. Address the Issue for the Cited Deficiency: Conducted an immediate review of staff vaccination records and identified those who were missing documentation of being offered the COVID-19 vaccine or receiving education. Provided staff (LPN-A, LPN-B, HSK-A) with documented education on the benefits, risks, and potential side effects of the COVID-19 vaccine. Offered information on where to receive their COVID-19 vaccine to all staff who had not yet received it. Reinforced the policy that all staff must receive education on COVID-19 vaccination and have documented proof of being offered the vaccine. 2. Identify Other Residents and Staff at Risk & Audit: Conducted a full audit of all resident and staff records to verify documentation of COVID-19 vaccine education and offer. Any missing documentation was immediately addressed by re-educating staff and residents and ensuring proper records were updated. Identified any unvaccinated individuals and offered facilities to where they can receive their vaccination. 3. Education Provided on the Process: Conducted mandatory training for all staff, including HR, nursing, and administration, on the facility□s COVID-19 immunization policy and documentation requirements. Provided updated training materials to all staff, including education on COVID-19	

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F 887	Continued From page 20	F 887	vaccine benefits, risks, and required documentation. Developed and distributed informational materials to residents and staff to encourage vaccination and clarify any concerns. 4. Maintenance of Compliance: Implemented weekly audits of staff and resident immunization records for four weeks to ensure ongoing compliance with documentation requirements. Reinforced the facility□s COVID-19 vaccination policy, ensuring all new hires receive education and are offered the vaccine upon employment. Established a tracking system for staff and resident vaccination records, ensuring timely updates and follow-up for booster doses. 5. Responsible Party & Reporting to QAPI: The Director of Nursing (DON) and Infection Preventionist are responsible for ongoing compliance with COVID-19 immunization requirements. The Human Resources Director is responsible for ensuring all staff records are up to date with documentation of education and vaccine offer. The facility will report audit findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly to ensure continued adherence to regulations.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/07/2025. At the time of this survey, TWEETEN LUTHERAN HEALTH CARE CENTER found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/07/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. TWEETEN LUTHERAN HEALTH CARE CENTER is a one-story building with partial basements. The building was constructed at three different times. The original building was built in 1965 and was determined to be of Type II (222) construction. In 1967 an addition was constructed	K 000		

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K 000	Continued From page 2 to the South Wing and was determined to be of Type II (222) construction. In 1972 an addition was constructed, the Activities / Chapel, and was determined to be of Type II (222) construction. Because the original building and the additions are of the same type of construction allowed for existing buildings, the facility was surveyed has one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors 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 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide approved discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6.	K 271	K271 Gundersen Tweeten Care Center will ensure that approved exit discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code,	2/25/25

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K 271	Continued From page 3 This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that exterior to Exit Door (#2), threshold to slab as-well-as slab-to-slab height transition greater than ½ inch, presenting a trip and fall hazard. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 271	section 19.2, 7.1.6.with respect to changes in elevation and shall be maintained free of obstructions. The slab elevation transition outside exit door number 2 was corrected on 2/6/2025 by installing tapered outdoor rated mat strips to match elevation differences which will allow wheel chairs to negotiate the exit path. The Environmental Services Director will do monthly audits of all exit discharge walking surfaces monthly ongoing. POC will be reviewed at next safety committee and at the next QAPI committee meeting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		2/25/25

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K 353	Continued From page 4 Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2, 5.2.2.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by observation, in the Data Server Room, that a data cable bundle appeared to be exhibiting a load on the sprinkler system piping. An interview with the Administrator verified this deficient finding at the time of discovery.	K 353	K353 Gundersen Tweeten Care Center will continue to ensure that maintenance and testing automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, standard for the inspection, testing and maintaining of water-based fire protection systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. On 1/30/25 data cords were supported above the sprinkler pipe by adjusting the hanger bracket, so the sprinkler pipe was not bearing any load. The Environmental Services Director will audit for cables on the sprinkler pipes monthly. POC will be reviewed at next safety committee and next QAPI committee.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable	K 355	K355 Gundersen Tweeten Care Center will ensure that all portable fire extinguishers are properly inspected and maintain documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 2010 (edition), Standard for	2/25/25

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K 355	Continued From page 5 Fire Extinguishers, section 7.2.4.1, 7.2.4.5, 7.3.2.1, These deficient findings could have a isolated impact on the residents within the facility. Findings include: 1. On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by observation and a review of available documentation, that no vendor documentation was available to review associated to the most recent annual inspection of fire extinguishers. 2. On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by observation, in the Beauty Shop, that the fire extinguisher hang-tag indicated that the device had been missed / not been found as part of the most recent annual inspection. An interview with the Administrator verified these deficient findings at the time of discovery.	K 355	Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.5, 7.3.2.1. Beauty shop fire extinguisher was inspected, and tag was updated to show monthly inspection. The Environmental Services Director will audit all fire extinguishers monthly. POC will be reviewed at next safety committee and next QAPI committee meetings.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.	K 374		2/25/25

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K 374	Continued From page 6 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that the following smoke barrier door assemblies exhibited an air-gap(s) greater than 1/8 inch, which would allow the passage of smoke: Memory Care, Door Assy by RM129, Door Assy by RM 10. 2. On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that fire / smoke barrier door assembly by RM 209 did not properly self-close and seal the opening upon testing. An interview with the Administrator verified these deficient findings at the time of discovery.	K 374	K374 Gundersen Tweeten Care Center ensure to test, maintain and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4. On 1/31/25, Door contractor serviced doors by installing fire rated material to doors to eliminate gap between doors for doors: memory care doors, doors by room 129, doors by room 10, doors by room 209. Contractor also adjusted the closure for doors by room 209. The Environmental Services Director will inspect the smoke barrier doors monthly. POC will be reviewed at next safety committee and next QAPI committee	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		2/25/25

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K 712	Continued From page 7 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by review of available documentation that fire drill form(s) were incomplete in data capture. 2. On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by review of available documentation that documentation presented for review did not confirm that fire alarm signal transmission, associated to 3rd shift drills, is being completed. An interview with the Administrator verified this deficient finding at the time of discovery.	K 712	K712 Gundersen Tweeten Care Center ensure that all fire drills are conducted and documented per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. On 2/4/25 the Administrator and maintenance staff to review the policy and procedure for testing alarm monitor signal transmission. All future silent third shift fire drills will have a test of the monitoring company signal transmission completed within 24 hours of the fire drill and results recorded on the fire drill documentation form. This will be monitored monthly by administrator. POC will be reviewed at next safety committee and next QAPI committee.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility	K 761		2/25/25

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K 761	Continued From page 8 maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 01/07/2025 between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation identified that (3) door inspections forms had been started, but not completed, as part of the most recently completed smoke / fire door inspection. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761	K761 Gundersen Tweeten Care Center will ensure to inspect and test non-rated doors, including corridor doors to patient rooms and smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. On 1/31/25 the identified 3 fire door inspections were inspected and documented on the appropriate maintenance schedule. This will be monitored monthly by administrator. POC will be reviewed at next safety committee and next QAPI committee.	