



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 2, 2026

Administrator
Tweeten Lutheran Health Care Center

125 5TH AVENUE SOUTHEAST
SPRING GROVE, MN 55974

RE: CCN:245429

Cycle Start Date: December 19, 2025

Dear Administrator:

On December 19, 2025, a survey was completed at your facility by the Minnesota Departments of Health 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) , as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 19, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 19, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 2, 2026

Administrator
Tweeten Lutheran Health Care Center
125 5TH AVENUE SOUTHEAST
SPRING GROVE, MN 55974

Re: State Nursing Home Licensing Orders
Event ID: 1DE9E5-H1

Dear Administrator:

The above facility survey was completed on December 19, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2026

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

RE: CCN: 245429

Cycle Start Date: December 19, 2025

Dear Administrator:

On January 2, 2026, we informed you that we may impose enforcement remedies.

On February 9, 2026, the Minnesota Department(s) of Health and Public Safety completed a revisit, and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

- F689, F686, F609, F607 - with F689 being recited at S/S G.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies 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 10, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 10, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 10, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$13,343, 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 10, 2026, 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 10, 2026. 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)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of

compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

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

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

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

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

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

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 June 19, 2026, 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:

tamika.brown@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 tamika.brown@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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center	STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
--------------------	--	---------------	---	----------------------

F0000	<p>INITIAL COMMENTS</p> <p>On 12/17/25, 12/18/25, 12/19/25 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed. H54291381C (2693028) and H54291720C (2694230) with a deficiency issued at F607, F609, F655, F657, F658, F686, F689, F727, and F732.</p> <p>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.</p>	F0000		01/16/2026
F0607 SS = D	<p>Develop/Implement Abuse/Neglect Policies</p> <p>CFR(s): 483.12(b)(1)-(5)(ii)(iii)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95,</p> <p>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.</p>	F0607	<p>Gundersen Tweeten Care Center will continue to ensure to immediately report injuries of unknown source. Policy #TWTTCO-3028 Plan for Abuse Prevention and Reporting and #TWTSS Identifying Neglect were reviewed for accuracy and revised as needed. All staff we re-educated on timely reporting of injuries of unknown origin. Education included starting the initial investigation, location of injury, notifying leadership, and submitting the allegation to the regulatory agency. Education module was developed and provided to all staff and staff attesting to their completion via signature. Audit on all events will be reviewed and anything that falls outside of 2-hour timeline will be reviewed for late submission. Results of the audits will be reported to the QA Committee monthly until compliance is achieved and then x3 months. DON is ultimately responsible for compliance.</p>	01/23/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0607 SS = D	<p>Continued from page 1</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to immediately investigate injuries of unknown source according to the facility's abuse prohibition policy for 2 of 2 residents (R7, R6) reviewed for injuries of unknown origin.</p> <p>Findings include</p> <p>R7's face sheet dated 12/19/25, identified diagnoses of Alzheimer's disease (a progressive neurological disorder characterized by worsening memory loss) and Parkinson's disease (a progressive brain disorder leading to movement issues).</p> <p>R7's quarterly Minimum Data Set (MDS) dated 11/25/25, identified R7 was dependent for transfer and had moderate cognitive impairment.</p> <p>R7's progress note dated 11/21/25, indicated a bruise of unknown origin was found on R7's right breast and that R7 denied abuse. In review of R7's record and facility incident reports there was no other information pertaining to how or when R7 would have received the bruise to her breast nor was it evident staff interviews were completed.</p> <p>R6's face sheet dated 12/19/25, identified diagnoses of heart failure (a condition in which heart doesn't pump blood as well as it should), diabetes mellitus (a condition that affects how the body uses sugar as fuel), and atrial fibrillation (irregular heartbeat causing rapid, inefficient pumping).</p> <p>R6's admission Minimum Data Set (MDS) dated 10/23/25, identified R6 was dependent with toileting hygiene/transfers and had intact cognition.</p>	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0607 SS = D	<p>Continued from page 2</p> <p>R6's progress note dated 12/18/25 at 6:45 a.m., identified a dark black and blue bruise about the size of a half dollar noted to the right side of the rectum. R6 claimed it was from having a bowel movement the other day. R6 denied abuse and or pain. In review of R6's record and facility incident reports there was no other information pertaining to the bruise to R6's rectum nor staff interviews completed.</p> <p>During an interview on 12/18/25 at 2:30 p.m., director of nursing (DON) stated a bruise found on a breast or anal region of a resident would be considered suspicious for abuse and should have had an investigation begin immediately, however, an investigation was not initiated after R7 nor R6's bruises were discovered.</p> <p>Review of the facility's Abuse Potential/Vulnerable Adult/Quality Assurance Performance Improvement Policy dated 7/25, identified the following:</p> <p>Investigation "Abuse" Policy Requirements identified that it is the policy of the facility that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknow source, exploitation, and misappropriation of property) are promptly and thoroughly investigated. All incidents will be investigated eve if not reportable and the results of the investigation will be documented.</p> <p>Procedure: The investigation is the process used to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to the administration.</p> <p>-Investigations of injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse. Injuries include, but are not limited to, bruising of the inner thigh, chest, face, and breast, bruises of unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma.</p>	F0607		
F0609 SS = D	<p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p>	F0609	Gundersen Tweeten Care Center will continue to ensure to immediately investigate injuries of unknown source. Policy #TWTCO-3028 Plan for Abuse Prevention and Reporting and #TWTSS Identifying Neglect were reviewed for accuracy and revised as needed. All staff we re-educated on timely reporting of injuries of unknown origin. Education included starting the initial investigation, location of injury, notifying	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0609 SS = D	<p>Continued from page 3</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to immediately report injuries of unknown origin to the administrator and failed to report to the State Agency (SA) within the required reporting guidelines for 2 of 2 residents (R7, R6) reviewed for an injury of unknown origin.</p> <p>Findings include:</p> <p>Based on interview and document review, the facility failed to immediately report injuries of unknown origin to the administrator and failed to report to the State Agency (SA) within the required reporting guidelines for 2 of 2 residents (R7, R6) reviewed for an injury of unknown origin.</p> <p>Findings include:</p> <p>R7's face sheet dated 12/19/25, identified diagnoses of Alzheimer's disease (a progressive neurological disorder characterized by worsening memory loss) and Parkinson's disease (a progressive brain disorder leading to movement issues).</p> <p>R7's quarterly Minimum Data Set (MDS) dated 11/25/25, identified R7 was dependent for transfer and had</p>	F0609	<p>Continued from page 3</p> <p>leadership, and submitting the allegation to the regulatory agency. Education module was developed and provided to all staff and staff attesting to their completion via signature. Audit on all events will be reviewed and anything that falls outside of 2-hour timeline will be reviewed for late submission. Results of the audits will be reported to the QA Committee monthly until compliance is achieved and then x3 months. DON is ultimately responsible for compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0609 SS = D	<p>Continued from page 4 moderate cognitive impairment.</p> <p>R7's progress note dated 11/21/25, identified a bruise was found on R7's right breast of unknown origin and that R7 denied abuse.</p> <p>During an interview on 12/18/25 at 2:54 p.m., licensed practical nurse (LPN)-A stated she had discovered R7's bruise on her right breast on 11/21/25 and was of an unknown origin, however, believed the bruise was from the sit to stand lift and because R7 denied being abused she did not report it to the administrator immediately, but had sent an email notification a few hours after it was discovered.</p> <p>During an interview on 12/18/25 at 2:30 p.m., director of nursing (DON) stated a bruise found on a breast of a resident would be considered suspicious for abuse and should have been reported to the SA within two hours. R7's bruise was not investigated nor reported to the SA.</p> <p>R6's face sheet dated 12/19/25, identified diagnoses of heart failure, diabetes mellitus, and atrial fibrillation.</p> <p>R6's admission Minimum Data Set (MDS) dated 10/23/25, identified R6 was dependent with toileting hygiene/transfers and had intact cognition.</p> <p>R6's progress note dated 12/18/25 at 6:45 a.m., identified a dark black and blue bruise about the size of a half dollar noted to the right side of the rectum. R6 claimed it was from having a bowel movement the other day. R6 denied abuse and or pain.</p> <p>During an interview on 12/18/25 at 2:54 p.m., licensed practical nurse (LPN)-A stated she identified a new bruise near R6's anal region at 6: 45 a.m., however, did not notify the director of nursing nor the administrator immediately of the findings. LPN-A stated a bruise located near the anal region would be considered suspicious, but believed since R6 believed the bruise came from having a bowel movement a few days earlier and said he had not been abused she waited to send an email at a later time to inform the administration of the bruise.</p> <p>Review of the facility's Abuse Potential/Vulnerable Adult/QAPI review policy dated 7/25, identified reporting and response "Abuse" policy requirements identified that is was the policy of the facility that allegations involving abuse no later than 2 hours after the allegation is made.</p>	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0609 F0655 SS = D	<p>Baseline Care Plan</p> <p>CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning</p> <p>§483.21(a) Baseline Care Plans</p> <p>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders.</p> <p>(B) Physician orders.</p> <p>(C) Dietary orders.</p> <p>(D) Therapy services.</p> <p>(E) Social services.</p> <p>(F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and</p>	F0609 F0655	<p>F655 Gundersen Tweeten Care Center will assure baseline care plans for falls are continuously evaluated and updated to reflect interventions that were identified because of fall investigations. Policy #TWTNSG Baseline Care Plan was reviewed for accuracy and revised as needed.</p> <p>R2 Baseline care plan reviewed and revised. Fall risk interventions implemented.</p> <p>Checklist developed and staff education provided for individual role responsibilities (Social Services, Nursing, Activities, Dietary) for new admissions to ensure baseline care plan is individualized and all components completed. Fall and Skin policies reviewed. Staff educated on care plan revision, completed.</p> <p>New admission base line care plan completed within 48 hours of admission (per policy) from 12/19/25 to current. Facility reviewed baseline care plans for residents at risk and/or had falls and ensured accuracy prior to the completion of comprehensive care plan with continual revisions as needed.</p> <p>All care plan revisions updated as resident needs change. Care plan changes updated on Point of Care, Matrix care needs sign off for CNA's and treatment sheets for charge nurses. This will implement "real time" changes to care plans are individualized and implemented.</p> <p>48-hour audit to be completed by MDS Coordinator on all new admissions to assure all baseline care plan components are accurate and in place. Audits continue weekly x 4 weeks or until compliance met and monthly x 3 months to be reviewed at Quality meetings.</p> <p>DON is ultimately responsible for compliance.</p> <p>Completion Date: 1/23/25</p>	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0655 SS = D	<p>Continued from page 6 dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to assure baseline line care plan for falls was continuously evaluated and updated to reflect interventions that were identified as a result of fall investigations for 1 of 2 resident (R2) reviewed for falls.</p> <p>Findings include:</p> <p>R2's face sheet dated 12/19/25, identified diagnoses of neurocognitive disorder with Lewy bodies (a progressive brain disorder causing decline in memory) and polyneuropathy (numbness, tingling or burning feeling in hands and feet).</p> <p>R2's Admission Minimum Data Set (MDS) dated 12/9/25, identified R2 was independent in bed mobility, needed supervision/touching assistance for transfers, had severe cognitive impairment, had fall in the last month prior to admission, had two falls since admission with no injury.</p> <p>R2's baseline care plan dated 12/4/25, identified R2 had been newly admitted to the facility and requires assistance from staff. Goal to be free from injury. Corresponding interventions as followed: call light or pendant should be within reach at all times, keep area clean and free from clutter; keep frequently used personal items close by and within reach; resident will be orientated to call light on admission to facility and may be issued a pendant for use in the facility if appropriate. R2's baseline care plan did not identify R2's level of risk for falling.</p> <p>R2's progress note dated 12/7/25 at 5:00 p.m., identified R2 fell in the dining area, due to not realizing he was weak and stood up from wheelchair with brakes not on. R2 was placed on one to one this shift for fall prevention.</p> <p>R2's Fall Investigation Event dated 12/7/25 at 5:19 p.m., identified R2 had a witnessed fall in the dining room after attempted self-transfer from wheelchair.</p>	F0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0655 SS = D	<p>Continued from page 7</p> <p>Interventions to increase staff assistance as appropriate; R2 needs one to one supervision; assist to toilet, during all transfers, during ambulation/wheelchair. R2's baseline care plan had not been updated to reflect the fall prevention interventions that were added to the fall investigation event.</p> <p>R2's Fall Investigation Event dated 12/8/25 at 8:30 a.m., identified R2 had a witnessed fall in the dining room after attempting to stand up. Interventions to instruct resident to change positions slowly, increase staff assistance as appropriate in the early morning, to and from toilet, during all transfers, during ambulation.; increase in assistance and surveillance. R2's baseline care plan had not been updated to reflect the fall prevention interventions that had been added to the fall investigation event.</p> <p>During an interview on 12/19/25 at 12:15 p.m., director of nursing (DON) stated R2 was identified as a high fall risk on admission and at time of admission a baseline care plan was created in the electronic health record (EHR), however, did not identify R2's risk for falls nor appropriate fall prevention interventions to mitigate the risk for future falls.</p> <p>Review of the facility's Baseline Care Plan Policy dated 2/25, identified the baseline care plan is to be developed and implemented within 48 hours of admission to promote continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission.</p> <p>Implementation:</p> <ul style="list-style-type: none"> -Upon admission the facility will begin the process of developing a baseline care plan will be completed within 48 hours of admission/readmission. -Information for the baseline care plan will be based upon admission/readmission orders, information from the transferring provider and discussion with the resident and resident representative. -The care plan will include at the minimum the following information: initial goals, physician orders, dietary orders, therapy services, social services, instructions needed to provide effective and person centered care that meets professional standards of quality of care, address resident health and safety concerns to prevent decline or injury such as elopement or fall risk. 	F0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0655 F0657 SS = D	<p>Care Plan Timing and Revision</p> <p>CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on Observation, interview, and document review the facility failed to revise the care plan for 2 of 3 residents (R8, R4) who were reviewed for falls and pressure ulcers.</p> <p>Findings include:</p> <p>R8's face sheet dated 12/19/25, identified diagnoses of malignant neoplasm (cancer) of the lung and brain.</p> <p>R8's admission Minimum Data Set (MDS) dated 9/29/25, identified R8 needed maximum assist for transfers, had a fall 2-6 months prior to entry and had moderate cognitive impairment.</p>	F0655 F0657	F657 Gundersen Tweeten Care Center will ensure care plans are revised timely for identified falls and pressure ulcers. Policy #TWTNSG Baseline Care Plan was reviewed for accuracy and revised as needed. Resident events will be reviewed daily as they occur and when finalized, the care plan will be revised for prevention of reoccurrence. R8 & R4 care plans were reviewed and revised for individualized fall and skin interventions. All residents have been identified, and care plans were reviewed and updated. Staff education for the Interdisciplinary Team occurred on how to edit the care plan to include individualized interventions and what risks/events to be updated. The care plans revisions will be reviewed/updated according to the comprehensive assessments weekly x4 weeks or until compliance is achieved. Audit frequency will be reduced as compliance is sustained. The results of the audits will be reported to the QA Committee monthly x3 months. DON is ultimately responsible for compliance.	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0657 SS = D	<p>Continued from page 9</p> <p>R8's fall focus care plan dated 10/13/25, identified R8 was at risk for falling related to impaired mobility/balance and forgets she needs help for transfers and will attempt to transfer self even with frequent reminders she needs assistance. Goal to remain free from injury. Interventions were as followed:</p> <ul style="list-style-type: none"> -assure resident is wearing eyeglasses and that they are clean and in good repair. - assure the floor is free of glare, liquids, foreign objects, provider proper, well-maintained footwear. Encourage use of environmental devices such as hand grips, hand rails, etc. -give resident verbal reminders not to ambulate/transfer without assistance. -keep bed at proper height -monitor overall condition for underlying infection that could contribute to altered mental status, weakness, and overall increased risk for falling. -provide resident an environment free of clutter. Keep call light in reach at all times. Keep personal items and frequently used items within reach. Encourage resident to assume a standing position slowly. Leave night light on in room. -15 min safety check every evening from 6-9 p.m. due to high-risk for falls and ability to remember she cannot get up alone. Initiated 10/22/25. -place resident in a fall prevention program providing hourly rounding to ensure resident is safe. Initiated 12/18/25. <p>R8's fall investigation event dated 10/6/25 at 11:17 p.m., identified R8 had an unwitnessed fall in the bathroom. R8 stated she need to go to the bathroom and self-transferred, became weak and fell to the floor. Interventions of toilet at regular intervals, increase assistance and surveillance, increase in staff assistance as appropriate in the early morning, to and from toilet, during all transfers, during ambulation. Remind resident to use call lights and 30-minute checks. R8's care plan did not identify an intervention for R8 to have increase assistance in early morning, to and from toilet, during transfers, and during ambulation, remind R8 to use the call light nor 30-minute checks to offer bathroom to mitigate the risk of falls.</p>	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0657 SS = D	<p>Continued from page 10</p> <p>R8's fall investigation event dated 10/20/25 at 8:43 p.m., identified R8 was found on the floor by bed and had attempted to get into bed without assistance. Intervention of sign placed in room to remind to call for help and 15-minute checks at bedtime. R8's care plan did not identify an intervention of sign placed in room to remind R8 to call for help and the intervention that directed 15-minute checks at bedtime was not added until 10/22/25.</p> <p>R8's fall investigation event dated 10/25/25 at 8:27 a.m., identified R8 had an unwitnessed fall in her room. R8 stated she wanted to be toileted and could not locate her call light due to being on her right side when call light was on her left side. Root cause of fall was identified as toileting status/need. Interventions to provide staff assistance in the early a.m. and after meals; increase staff assistance as appropriate in the early morning to and from toilet, during all transfers and during ambulation; increase assistance and surveillance; remind resident to stay in bed and ask for assistance when in need of transfer. R8's care plan did not identify an intervention to increase staff assistance nor to remind resident to stay in bed and ask for assistance when in need of transfer.</p> <p>R8's fall investigation event dated 11/5/25 at 6:45 p.m., identified R8 was found on the floor in her room by the bathroom door. Cause of fall was identified as confusion/lack of remembering to call for help. Root cause of fall was not marked off. Interventions left blank. Interdisciplinary team (IDT) review to have resident placed on 30-minute checks with offer of bathroom use or transfer to bed at appropriate times. R8's care plan did not identify a revision to include an intervention for R8 to be placed on 30-minute checks to offer bathroom use nor to transfer to be at a specified appropriate time.</p> <p>R8's fall investigation event dated 11/10/25 at 6:45 p.m., identified had an unwitnessed fall in her room near her bathroom. R8 was in her wheelchair and was attempting to get into bed with wheelchair brakes unlocked. Cause of fall that R8 attempted self-transfer to bed from wheelchair and wheelchair brakes not on and wearing regular socks without non-skid grippy material. Root cause of the fall was identified as physical function and footwear. Interventions of increase assistance and surveillance and reduce risk of injury (i.e., low bed, floor mat, nonslip socks, lower or remove side rails). R8's care plan did not identify an</p>	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0657 SS = D	<p>Continued from page 11 intervention for R8 of specific increase in assistance/surveillance nor to address the causal factors of no appropriate footwear or wheelchair brakes being unlocked during the transfer.</p> <p>R8's fall investigation report dated 11/29/25 at 2:45 a.m., identified R8 was found on the fall mat beside her bed on her left side. R8 stated she was attempting to get up to the bathroom. R8's fall prevention interventions on report of hourly rounding and signs visible from bed. R8's care plan did not identify a fall mat next to her bed, hourly rounding, nor address or specify what signs are to be visible from R8's bed.</p> <p>R8's progress note dated 12/17/25 at 3:05 p.m., identified R8 was found sitting on the floor in her room. R8 stated she was attempting to plug in her cell phone and leaned forward to pick up her charger on the floor and slid out of the wheelchair. R8's care plan did not identify any revisions to address fall prevention interventions regarding sliding out of wheelchair due to leaning out of wheelchair.</p> <p>During an interview on 12/18/25 at 2:54 p.m., licensed practical nurse (LPN)-A stated she does not update a resident's care plan for any immediate fall prevention intervention she puts in place and said the director of nursing or nurse managers are responsible to ensure the care plans are updated timely.</p> <p>During an interview on 12/19/25 at 9:53 a.m., registered nurse -education (RN-EDU) stated she is unaware of who is responsible for revising a resident's care plan if changes need to be made after the IDT meets to discuss interventions to prevent falls.</p> <p>R4's face sheet dated 12/19/25, identified diagnoses of dementia (a severe decline in mental abilities) and Parkinson's Disease (a progressive brain disorder leading to movement issues like tremors, stiffness, and slowness).</p> <p>R4's Annual Minimum Data Set (MDS) dated 12/9/25, identified R4 needed maximum assistance for bed mobility/transfers, at risk for pressure ulcers with, had one stage one pressure ulcer and had moderately impaired cognition.</p> <p>R4's pressure ulcer focus care plan dated 12/8/23, identified R4 was at risk for pressure injury related to poor nutrition, immobility, chairfast and had skin breakdown on heels and coccyx. Goal of R4's skin to remain intact. Interventions as followed:</p>	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0657 SS = D	<p>Continued from page 12</p> <p>-Air mattress to bed and cushion in Broda wheelchair to reduce pressure when lying or sitting.</p> <p>-Inspect skin with cares. Report and signs of skin breakdown (sore, tender, red, or broken areas) to charge nurse. Notify physician of problems. Lotion skin with cares.</p> <p>-Keep clean and dry as possible.</p> <p>-Weekly total body skin assessments to be performed and documented by charge nurse.</p> <p>-Apply skin prep to both heels twice daily and allow to dry and bilateral heel protectors on when in bed. Initiated on 12/2/25.</p> <p>-Right buttocks stage one: cleanse with soap and water, gently pat dry, apply barrier ointment to skin and reposition every 2 hours while in bed and Broda chair to offload area. Initiated 12/2/25.</p> <p>R4's skin integrity event dated 11/24/25, identified that R4 had non-blanchable redness with open areas on left heel and right buttocks. Left heel measured 2.5 x 1.0 and right buttocks measured 1.5 x 1.5, however, the event did not specify whether the measurements were in inches or centimeter. Intervention of boots to be ordered by hospice and always worn. With investigative review determined heels to be offloaded with pillows and boots. R4's care plan did not identify intervention to offload heels with pillows or boots.</p> <p>During an interview on 12/19/25 at 12:19 p.m., director of nursing (DON) stated a resident's care plan should be revised in a timely manner when a new intervention to prevent falls or prevent/manage a pressure ulcer, however, has not been trained to revise a care plan and does not ensure the revisions are made after being discussed at IDT.</p> <p>Review of the facility's Care Planning-Comprehensive Person-Centered Care Policy dated 02/25, identified the IDT must review and update the care plan for the following: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from the hospital stay; at least quarterly, in conjunction with required MDS assessment.</p>	F0657		
F0658 SS = D	<p>Services Provided Meet Professional Standards</p> <p>CFR(s): 483.21(b)(3)(i)</p>	F0658	<p>F658</p> <p>R1 Occupational Therapy order for cognitive evaluation was placed on 12/5, re-submitted therapy and completed</p>	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0658 SS = D	<p>Continued from page 13 §483.21(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed to ensure a physician's order for occupational therapy and cognitive testing were implemented per standards of practice and for 1 of 1 resident (R1) reviewed for accidents.</p> <p>Findings include:</p> <p>R1's face sheet dated 12/18/25, identified diagnosis of mild cognitive impairment, chronic kidney disease, and history of neoplasm (cancer) of the breast.</p> <p>R1's admission Minimum Data Set (MDS) dated 12/8/25, identified R1 had daily wandering behaviors, was independent for transfers and ambulation without the use of any mobility devices, had moderate cognitive impairment, and used a wander/elopement alarm daily.</p> <p>R1's progress note dated 12/5/25, identified R1 was seen by the physician assistant (PA) and obtained orders for occupational therapy (OT) to evaluate and treat and to have therapy do cognitive testing and provider PA with the score.</p> <p>During an interview on 12/18/25 at 9:42 a.m., physical therapy assistant (PTA) stated R1's orders from 12/5/25 to have occupational therapy evaluate, treat, and perform cognitive testing had not been received from nursing as of 12/18/25.</p> <p>During an interview on 12/18/25 at 9:51 a.m., registered nurse case manager (RN-CM) stated R1's order from the physician assistant dated 12/5/25 was transcribed and the order was placed in the therapy box, however, was not followed up on.</p> <p>During an interview on 12/19/25 at 12:15 p.m., director of nursing (DON) stated R1's occupational therapy orders had not been communicated to the therapy director after it was received, should have been communicated as soon as the order was received, and nursing should have followed up to ensure the order was received.</p> <p>During an interview on 12/19/25 at 1:57 p.m., physician</p>	F0658	<p>Continued from page 13 on 12/18.</p> <p>Contracted Therapy Service for Resident Care policy was reviewed and revised.</p> <p>All current residents written orders reviewed for contracted services to ensure orders were acknowledged and processed. All residents identified and care plans were reviewed and updated.</p> <p>RN Case Manager will log all contracted service orders upon receiving order. Orders will then be electronically submitted by RN Case Manager to therapy leaders. Weekly x 3-month audits to be completed to assure orders were acknowledged and processed. Then monthly x 3 months or compliance is achieved and reported to Quality Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0658 SS = D	Continued from page 14 assistant (PA) stated her expectation was for any order she wrote to be processed promptly, with the appropriate individuals notified to ensure the order is completed as directed. Requested a policy for following physician orders and was not received.	F0658		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed monitor, comprehensively assess, and develop and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 1 of 1 resident (R4) reviewed for pressure ulcers. Findings include: R4's face sheet dated 12/19/25, identified diagnoses of dementia (a severe decline in mental abilities) and Parkinson's Disease (a progressive brain disorder leading to movement issues like tremors, stiffness, and slowness). R4's skin risk assessment with Braden (a healthcare tool for pressure ulcer risk) dated 9/8/25, identified R4 was not at risk for pressure ulcers. R4's Annual Minimum Data Set (MDS) dated 12/9/25, identified R4 received hospice services, needed maximum assistance for bed mobility/transfers, at risk for	F0686	F686 Gundersen Tweeten Care Center will continue to monitor, comprehensively assess, and develop and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration. Policy # TWTNSG Pressure Ulcer/Skin Breakdown – Clinical Protocol and Prevention of Pressure Ulcers/Injuries were reviewed for accuracy and revised as needed. R4 care plan was reviewed and revised for individualized skin interventions. All like residents' care plans were review/revised according to individualized skin interventions. When risks or events are finalized, the care plan will be revised for prevention of reoccurrence with individualized interventions. The RN Case manager was educated on wound care and responsibility to complete weekly pressure ulcer assessment, staging and measurements. The Charge nurses were educated on pressure ulcer prevention and wound care and the importance to report to the case manager any findings between assessments and the case manager will evaluate timely. All licensed nursing staff will receive education and competency on Wound Staging which is scheduled with Gentell on February 7, 2026. Auditing will be done on Comprehensive Skin Assessments, skin/wound assessments and measurements to ensure individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration weekly x4 weeks to ensure correct measuring, evaluation and staging of wounds is complete or until compliance is achieved. Audit frequency will be reduced as compliance is sustained. The results of the audits will be reported to the QA Committee monthly x3 months. DON is ultimately responsible for compliance.	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = D	<p>Continued from page 15 pressure ulcers, had one stage one pressure ulcer and had moderately impaired cognition.</p> <p>R4's pressure ulcer focus care plan dated 12/8/23, identified R4 was at risk for pressure injury related to poor nutrition, immobility, chairfast and had skin breakdown on heels and coccyx. Goal of R4's skin to remain intact. Corresponding interventions dated 12/8/23 included:</p> <ul style="list-style-type: none"> -Air mattress to bed and cushion in Broda wheelchair to reduce pressure when lying or sitting. -Inspect skin with cares. Report and signs of skin breakdown (sore, tender, red, or broken areas) to charge nurse. Notify physician of problems. Lotion skin with cares. -Keep clean and dry as possible. -Weekly total body skin assessments to be performed and documented by charge nurse. -apply skin prep to both heels twice daily and allow to dry and bilateral heel protectors on when in bed. Initiated on 12/2/25. <p>R4's skin alteration form dated 11/24/25, identified that R4 had non-blanchable redness on left heel and right buttocks. Left heel measured 2.5 x 1.0 and right buttocks measured 1.5 x 1.5; the report did not identify the unit of measurement nor any other wound characteristics. Intervention of boots to be ordered by hospice and always worn. Summary of investigation identified heels were being offloaded with pillow and boots to be ordered by hospice. R4's record did not identify documentation of offloading of pillow prior to identification of left heel redness on 11/24/25.</p> <p>Hospice situation, background, assessment, response (SBAR) note dated 11/24/25, identified left heel had non-blanchable bruising measuring 2.5 centimeters (cm) x 1.0 cm; large blister on right heel measuring 5.0 cm x 6.0 cm. R4's hospice note did not identify any other wound characteristics, however ordered skin barrier spray to both heels twice daily and heel boots on at all times.</p> <p>R4's Wound Management Detailed Report dated 11/24/25, identified R4's left heel had a purple bruise that measured 2.5 cm x 1.0 cm. R4's wound management report did not identify any other wound characteristics such as pain, surrounding skin, and drainage. The wound</p>	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = D	<p>Continued from page 16 management detailed report did not include the intervention of heel boots that was identified in the skin alteration form and review of R4's care plan indicated the care plan was not revised to include the intervention until 12/2/25 (8 days after the wound was identified).</p> <p>R4's progress note dated 12/1/25, identified a hospice note due to a worsening right heel blister, with less fluid filled, purple in areas, less painful to R4.</p> <p>R4's Wound Management Detailed Report dated 12/4/25, identified left heel wound measured 8.0 cm x 2.0 cm and purple in color. Although the wound had increased from 2.5 cm x 1.0 cm the evaluation identified the wound was stable. R4's wound management report lacked a comprehensive wound assessment that included color, drainage, tissue type, odor, and pain and did not address pressure relieving interventions nor treatments being utilized.</p> <p>R4's progress note dated 12/10/25, indicated a new wound was found on R4's right heel that measured 7.5 x 3.5 (did not identify unit of measurement) and left heel was 4.0 x 2.0 (did not identify unit of measurement). Will order air mattress due to pressure wounds on heels. R4's record did identify a corresponding comprehensive wound assessment of either heel wound.</p> <p>During an interview on 12/19/25 at 11:21 a.m., registered nurse case manager (RN-CM) stated staff nurses are performing the comprehensive wound assessments for all wounds on a resident's scheduled bath day, however, the assessment are not reviewed to ensure the wounds are not worsening, the appropriate treatments/pressure relieving measures are being utilized.</p> <p>During an observation and interview on 12/19/25 at 1:05 p.m. R4 had green heel boots on both feet. RN-CM stated R4's right heel had an unstageable pressure ulcer that measured 3.5 cm x 7.0 cm, dry, covered in eschar (a thick, dark, leathery layer of dead tissue that forms over wounds), dark color, not "blistering in appearance"; R4's left heel was an unstageable pressure ulcer that measured 2.0 cm x 1.6 cm, dry, brown "discolored", "not really boggy but feels mushy" over the wound, surrounding skin pink, no edema around it, skin intact with no pain. RN-CM could not articulate any further details of the description of right or left heel appearance. RN-CM R4's wounds were being treated with skin prep (a spray that creates a breathable protective film on the skin to shield it from friction) twice</p>	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = D	<p>Continued from page 17 daily to both heels, heel protectors and an air mattress.</p> <p>R4's Wound Management Detailed Report dated 12/19/25 at 1:30 p.m. identified R4 had a pressure ulcer on left heel that was first identified on 11/24/25 as a bruise. Report identified area appears to be pressure ulcer not a bruise. Wound description of measurements of 1.6 cm c 2.0 cm with no depth, no exudate, no odor, stage identified as unstageable-slough and/or eschar, 50 % of necrotic tissue, surrounding skin pink/normal, skin is more "brown than black" and heel feels slightly mushy but not really boggy.</p> <p>During an interview on 12/19/25 at 12:15 p.m., director of nursing (DON) stated R4's left heel that was identified on 11/24/25 did not have a comprehensive assessment, proper wound identification, nor weekly comprehensive assessment by a registered nurse to determine wound improvement/progression.</p> <p>During an interview on 12/19/25 at 1:48 p.m., physician assistant (PA) stated any resident that is determined to be a high risk for developing a pressure ulcer should have interventions in place to prevent the development of a pressure ulcer and any resident admitted to the nursing home without a pressure ulcer should not develop a pressure ulcer and if the resident is admitted with or develops a pressure ulcer that the pressure ulcer is managed to heal with interventions put in place by the facility.</p> <p>Review of the facility's Prevention of Pressure Ulcers/Injuries policy dated 2/25, indicated the following:</p> <p>Skin Inspection:</p> <ul style="list-style-type: none"> -A head to toe skin inspection on all residents is completed weekly by a licensed nurse in alignment with bathing to identify any signs of developing pressure injuries, inspect pressure points, wash the skin after each episode of incontinence, moisture dry skin daily, and reposition resident as indicated on care plan. -A resident with a wound present a comprehensive wound assessment will be completed by a registered nurse weekly <p>Prevention:</p> <ul style="list-style-type: none"> -Moisture: keep skin clean, dry, and free of exposure to urine and fecal matter. 	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = D	Continued from page 18 -Nutrition: use a screening tool to determine if resident is at risk for under nutrition. Skin inspection: -a head to toe skin inspection on all residents will be completed on admission, daily with cares, and weekly by licensed nurse in alignment with bathing. Residents with a wounds: -For those residents that have a wound present, a comprehensive wound assessment will be completed by a registered nurse weekly.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to immediately respond to elopement when 1 of 1 resident (R1) activated an exit alarm and walked outside off the facility property without appropriate clothing for temperature of 1 degree/windchill of -7 degrees. In addition, the facility failed to comprehensively investigate/analyze falls for root cause, implement appropriate interventions and revise the care plan to prevent and/or reduce the risk for future falls for 1 of 3 residents (R8) reviewed for accidents. Findings include: R1's face sheet dated 12/18/25, identified diagnosis of mild cognitive impairment, chronic kidney disease (condition where kidneys have been damaged), and history of neoplasm (cancer) of the breast. R1's progress note dated 12/2/25, identified R1 had been admitted and had a history of wandering out of her	F0689	F689 Gundersen Tweeten Care Center will ensure the safety and well-being for all residents and will immediately respond to an elopement situation. Policy #TWTNSG Wandering and Elopement was reviewed for accuracy and revised as needed. Policy #TWTNSG- Fall Prevention was reviewed for accuracy and revised as needed. R1 was located and found outside and brought back into facility where she was found to be free of injury. Social Services was contacted and advised to place resident in locked unit until further investigation was completed. Based on investigation result, resident assessment and family wishes she remained on the locked unit. R8's falls were comprehensively reviewed and analyzed for root cause and individualized interventions were identified and care plan was reviewed and revised as needed for prevention and/or to reduce the risk for future falls. All potential exit doors were identified. All door alarms are checked daily and Wanderguard wrist bands are checked shiftily to ensure the system is accurately working. All residents were comprehensively assessed for risk of elopement and falls and then care plans were reviewed and revised according to individualized risks. Staff education on elopement and investigation of fall events, root cause, and intervention revision on care plan occurred. When risks or events occur, the investigation will occur timely, and the care plan will be revised for prevention of reoccurrence. Staff education occurred on how to add to the care plan and what risks/events need care plan updates. Risks/events and care plan revisions will be reviewed weekly x4 consecutive weeks until compliance is achieved. Audit frequency will be reduced as compliance is sustained. Results will be reported to the QA Committee monthly until compliance is achieved for three months. DON is ultimately responsible for compliance.	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 19 home and nursing aware that if R1 needed to be admitted to the secured memory care unit this can be done.</p> <p>R1's elopement evaluation dated 12/2/25, identified R1 was ambulatory, had a risk factor of being cognitively impaired, poor decision-making skills, displayed behaviors that may indicate an attempt to leave may be forthcoming. R1 was identified as an elopement risk, and an exit alarm was placed.</p> <p>R1's progress note dated 12/2/25, identified wander/elopement alarm applied to left ankle for safety.</p> <p>R1's Admission Minimum Data Set (MDS) dated 12/8/25, identified R1 had daily wandering behaviors, was independent for transfers and ambulation without the use of any mobility devices, had moderate cognitive impairment, and used a wander/elopement alarm daily.</p> <p>R1's vulnerable adult focus care plan dated 12/4/25, identified R1 was vulnerable due to admission, cognitive, and physical limitations, and required assistance to safety in the event of a harmful situation. Goal of resident assisted to safety in the event of a harmful situation. Interventions as followed: assist Resident to safety in the event of a harmful situation; Exit alarm bracelet applied to body due to safety concerns to alert staff of any attempt to exit building without assistance. Check twice daily for placement and functioning device. Change exit alarm bracelet every 80 to 90 days.</p> <p>R1's progress note dated 12/13/25 at 3:56 p.m., identified R1 left the facility out of the front door, alarm sounded, but stated "patio door". R1 was up the block from the facility, when aide was searching for resident, R1 saw the aide, called her by name, and then walked back to the facility with staff. R1 was wearing sweatshirt and pants and no injuries observed. R1 was moved to secured unit upon return to the facility.</p> <p>According to Houston County (KMNEITZE3-weather station) the temperature on 12/13/25 at 3:00 p.m. had an actual temperature of 1 degree with a wind chill of -7 degrees.</p> <p>During a facility tour on 12/17/25 at 2:36 p.m., the front facility exit needed to pass through two doors to come out to a parking lot: the parking lot with a small decline towards the street with a curb at the end of the parking lot. The street running in front of the</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 20 building to the left sloped downwards towards a field; the street running to the right of the parking lot had a steeper slope with a curve at the end that went uphill to another block; near the curve in the road there was a grocery store parking lot to the right and beyond the parking lot was a highly traveled highway; the sidewalk/street going up to the next block had a steep incline with a curb on the right side; the house in which R1 had been found was ¾ way down the block and on the left side of the street which had concrete steps in the front of the house with 3 steps.</p> <p>R1's behavioral symptom focus care plan dated 12/16/25, identified R1 experienced wandering behavior, seeks out exit doors, was at risk for elopement. The corresponding intervention directed staff to assess resident for placement in a specifically designed therapeutic unit.</p> <p>During an interview on 12/17/25 at 11:37 a.m., nursing assistant (NA)-A stated she had been in the secured unit on 12/13/25. Around 3:00 p.m. she opened the unit door to go into the general population area; she heard the exit alarms sounding and saw licensed practical nurse (LPN)-A running in the hallway. LPN-A informed NA-A that the patio door exit alarm was sounding and that she believed R1 had went out that door. NA-A looked in the patio area for R1 but did not see her. NA-A then returned into the facility and observed LPN-A coming down the hallway and informed her R1 was on the street in the front of the building about a block away. NA-A went outside to get R1 but by the time NA-A went outside to that location, R1 was not there. NA-A then walked down the street to the left of the building where she saw a person walking on the street, however, when she got closer, she identified it was not R1. NA-A then went the opposite way and continued around the corner up the hill and still had not located R1. NA-A then began walking down the street and about 15 minutes after she began looking for R1, she observed R1 (in only a long sleeve shirt and pants) walking down some steps in front of a house. When R1 saw NA-A she called out NA-A's name and walked towards NA-A through the snow. NA-A stated R1's face was red, her hands were "very cold", she then ambulated back to the facility with NA-A with no issue.</p> <p>During an interview on 12/17/25 at 12:19 p.m., licensed practical nurse (LPN)-A stated around 3:00 p.m. on 12/13/25, she heard an exit alarm sound, and immediately went to the alarm panel which identified it was the patio door by the dining room. LPN-A immediately ran to the patio door and did not observe</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 21</p> <p>R1 outside the area or notice any footprints in the snow. Nursing assistant (NA)-A arrived shortly after and went outside to look in the patio area first. LPN-A then went to the front door where she was able to see R1 standing about a block away near a tree on the road. LPN-A stated she did not attempt to go outside to bring R1 back into the facility because "it was really cold out and I did not have a coat." Instead, she walked away from the window and door where she could visualize R1 to get another staff member to assist R1 back into the facility, however, when LPN-A returned to the window R1 was not there. LPN-A stated after she had located a staff member to go outside, she went back to the same window however R1 was no longer standing where she was. Nursing assistant (NA)-A walked around outside to locate R1, found her coming down a stairway at a house on the next block up the hill and brought R1 back into the facility. LPN-A stated she assessed R1 for any injuries and did not observe any and she was just "cold." LPN-A stated R1 was then placed in the secured unit after discussion with management for safety.</p> <p>During an interview on 12/17/25 at 12:36 p.m., trained medication aide (TMA)-A stated she had not received any education regarding prevention of elopement or what to do if a resident elopes, however, TMA-A stated if she observed a resident outside after an elopement, she would immediately go outside to attempt to get the resident back inside.</p> <p>During an interview on 12/17/25 at 12:50 p.m., director of nursing (DON) stated R1 had an exit alarm bracelet placed on admission because she was an elopement risk. R1 was independent in the facility and had a history of setting off the exit alarms due by getting close to the doors. DON further stated LPN-A should have exited the building immediately after locating R1 on the street and brought her back into the facility.</p> <p>During an interview on 12/17/25 at 1:11 p.m., licensed social worker (LSW) stated after a resident elopement and the resident is located outside of the facility, staff would need to attempt to get the resident immediately and not take eyes off the resident. By taking "eyes off" of R1 this could have put R1 at risk for getting injured.</p> <p>During an interview on 12/17/25 at 2:55 p.m., NA-B stated R1 had a history of wandering throughout the facility and would go near the exit doors at times, but had not seen R1 attempt to exit the facility and if a resident had been observed outside after an elopement she would immediately go outside and attempt to get the resident back into the facility. Staff should not take</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 22 eyes off of the person, because in the short time that they are not seen they could have the potential to get farther away and could get hurt.</p> <p>During an interview on 12/17/25 at 4:45 p.m., administrator stated that after an exit alarm goes off and a resident had been observed outside of the facility the staff member that observes the resident should have gone outside immediately to attempt to get the resident back to safety. LPN-A should not have been concerned about not having a coat on, because R1 also did not have a coat on, and it was so cold that day R1 went outside.</p> <p>Review of the facility's Wandering and Elopement Policy dated 2/25, identified the facility will work to ensure the safety of the residents under their care. The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>Implementation:</p> <p>-If a resident is identified as a risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Strategies may include receiving a Wandergard (name brand for an exit alarm) bracelet; placing a resident in a room farther from exits and need for frequent monitoring; photos of the resident should be updated annually.</p> <p>Missing Resident: If a resident is missing initiate the elopement/missing resident emergency procedure.</p> <p>-staff will check with the charge nurse and check the leave of absence book to see if the resident signed out of the building.</p> <p>-If the resident is not authorized to leave the, initiate a search of the building and premises. This includes to check with all on-duty staff and identify when they were last seen, where they were last seen, and what were they wearing. Designate staff to check resident room and bathrooms, therapy areas, common areas, patio/courtyard, clinic area, kitchen, and immediate surrounding areas outside.</p> <p>R8's face sheet dated 12/19/25, identified diagnoses of malignant neoplasm (cancer) of the lung and brain.</p> <p>R8's Admission Minimum Data Set (MDS) dated 9/29/25,</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 23 identified R8 needed maximum assist for transfers and bed mobility, had a fall 2-6 months prior to entry and had moderate cognitive impairment.</p> <p>R8's fall risk assessment dated 9/29/25, identified R8 was at risk for falling due to impaired balance and needing assistance.</p> <p>R8's fall focus care plan dated 10/13/25, identified R8 was at risk for falling related to impaired mobility and balance. Interventions dated 10/13/25 were as followed:</p> <ul style="list-style-type: none"> -assure resident is wearing eyeglasses and that they are clean and in good repair. - assure the floor is free of glare, liquids, foreign objects, provider proper, well-maintained footwear, encourage use of environmental devices such as hand grips, hand rails, etc. -give resident verbal reminders not to ambulate/transfer without assistance. -keep bed at proper height -monitor overall condition for underlying infection that could contribute to altered mental status, weakness, and overall increased risk for falling. -provide resident an environment free of clutter. Keep call light in reach at all times. Keep personal items and frequently used items within reach. Encourage resident to assume a standing position slowly. Leave night light on in room. <p>R8's fall investigation event dated 10/6/25 at 11:17 p.m., identified R8 had an unwitnessed fall in the bathroom. R8 stated she needed to go to the bathroom, self-transferred, became weak and fell to the floor. Root cause of the fall identified as confused/forgetful. Associated interventions directed staff to toilet at regular intervals, increase assistance and surveillance, increase in staff assistance as appropriate in the early morning, to and from toilet, during all transfers, during ambulation. Interdisciplinary team (IDT) review determined potential factors that contributed to the fall were increased weakness, new environment, forgetfulness. Intervention to be taken to prevent further falls were to remind resident to use call lights and 30-minute checks. Although the fall investigation event indicated potential causal factors of toileting needs, there was</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 24 no comprehensive assessment to determine R1's toileting needs, no comprehensive assessment that identified how 30-minute checks were determined, and no indication R8's care was revised.</p> <p>R8's fall investigation event dated 10/20/25 at 8:43 p.m., identified R8 was found on the floor by bed and had attempted to get into bed without assistance. Root cause identified as mood/behavior. IDT review identified R8 not aware of limitations and an intervention of sign placed in room to remind to call for help and 15-minute checks at bedtime. There was no other information pertaining to why R8 was attempting to get out of bed and did not identify if the care plan had been followed prior to R8's fall. Although the fall investigation event indicated potential causal factors of R8 wanting to go to bed, this was not addressed in the care plan interventions. R8's care plan was revised on 10/22/25 to include 15-minute checks from 6:00 p.m. to 9:00 p.m., however, did not include sign placed in room to remind R8 to call for help.</p> <p>During an observation on 12/19/25 at 10:30 a.m., R8 was in her room, a sign was located near R8's head of her bed that read "call for help". R8 stated she the sign helped her remember to ask for help, but at times she still forgets to ask for help.</p> <p>During an interview on 12/19/25 at 10:15 a.m., licensed practical nurse (LPN)-A stated staff document the 15-minute checks for R8 on paper and then it scanned into the electronic health record. LPN-A confirmed the care plan was not revised to include the sign prompting R1 to call for help but stated the sign was placed shortly after R8 fell on 10/20/25; she could not articulate an exact date of when the sign was posted.</p> <p>R8's fall investigation event dated 10/25/25 at 8:27 a.m., identified R8 had an unwitnessed fall in her room. R8 stated she wanted to be toileted and could not locate her call light due to being on her right side when call light was on her left side. Root cause of fall was identified as toileting status/need. Interventions to provide staff assistance in the early a.m. and after meals; increase staff assistance as appropriate in the early morning to and from toilet, during all transfers and during ambulation; increase assistance and surveillance; remind resident to stay in bed and ask for assistance when in need of transfer. The fall investigation did not address if the care plan</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 25</p> <p>was followed prior to the fall. Although the fall investigation event indicated potential causal factors of call light placement and toileting needs, there was no comprehensive assessment to determine R1's toileting needs and no indication R8's care was revised.</p> <p>R8's fall investigation event dated 11/5/25 at 6:45 p.m., identified R8 was found on the floor in her room by the bathroom door. Cause of fall was identified as confusion/lack of remembering to call for help. Root cause of fall was not marked off. Interventions left blank. IDT review identified potential factors that could have contributed to the fall were cancer and chronic pain. Interventions added to place R8 on 30-minute checks with offer of bathroom use or transfer to bed at appropriate times. Although the fall investigation event indicated potential causal factors of toileting needs, there was no comprehensive assessment to determine R1's toileting needs and no indication R8's care was revised.</p> <p>R8's fall investigation event dated 11/10/25 at 6:45 p.m., identified R8 had an unwitnessed fall in her room near her bathroom. R8 was in her wheelchair and was attempting to get into bed with wheelchair brakes unlocked. Cause of fall were identified that R8 attempted self-transfer to bed from wheelchair, wheelchair brakes not locked, wearing regular socks without non-skid grippy material. Root cause of the fall was identified as physical function and footwear. Interventions of increase assistance and surveillance and reduce risk of injury (i.e., low bed, floor mat, nonslip socks, lower or remove side rails). Although the fall investigation event indicated potential causal factors toileting needs, wheelchair brakes not being locked and inappropriate footwear there was no indication R8's care plan was revised to include associated interventions. ----review your statement for accuracy</p> <p>R8's fall investigation report dated 11/29/25 at 2:45 a.m., identified R8 was found on the fall mat beside her bed on her left side. R8 stated she was attempting to get up to the bathroom. R8's fall prevention interventions on report of hourly rounding and signs visible from bed. There was no indication of a comprehensive analysis to identify causal factors and R8's care plan was not revised until 12/18/25 which was 19 days after the fall occurred.</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	<p>Continued from page 26</p> <p>R8's fall investigation report dated 12/17/25 at 3:05 p.m., identified R8 was found sitting on the floor in her room. R8 stated she was attempting to plug in her cell phone and leaned forward to pick up her charger on the floor and slid out of the wheelchair. There was no indication of a comprehensive analysis to identify causal factors and no indication R8's care plan was revised.</p> <p>During an interview on 12/19/25 at 12:15 p.m., director of nursing (DON) stated R8's falls had been looked at to attempt to do a "deep dive" of her falls, however, facility had only been looking at "bits and pieces" of the reasons R8 had been having repeat falls and not the "whole picture" to determine appropriate interventions were in place.</p> <p>Review of the facility's Falls and Fall Risk, Managing Policy dated 2/25, identified the facility will identify interventions related to resident's specific risks and causes to try and prevent the resident from falling and minimize the complications from falling.</p> <p>Resident centered approaches to managing falls and fall risk:</p> <ul style="list-style-type: none"> -the staff with the input of the attending physician will implement a resident centered fall prevention plan to reduce the specific risks factors of falls for each resident at risk or with history of falls. -if a systemic evaluation of a residents fall risk identifies several possible interventions, the staff may choose to prioritize interventions. -if falling reoccurs despite initial interventions, staff will implement additional of different interventions or indicate why the current approach remains relevant. <p>Monitoring Subsequent falls and fall risk:</p> <ul style="list-style-type: none"> -the staff will monitor and document Each resident's response to interventions intended to reduce falling or the risk of falling. -If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has resolved. 	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0689 SS = D	Continued from page 27 -If the resident continues to fall, staff will reevaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. -The staff and or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk of falling or injury due to falls.	F0689		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by:	F0727	Gundersen Tweeten Care Center will ensure a registered nurse (RN) is on duty a minimum of eight consecutive hours a day in a 24-hour period. Policy # TWTHR-565 Nurse Staffing Hours and Scheduling Guidelines was reviewed for accuracy and revised as needed. Education was provided to the staff scheduler and Director of Nursing on the requirement of having a minimum of one RN working eight hours over every 24-hour period. RNs will be differentiated on the staff schedule to ensure this requirement is met. The Director of Nursing will review the schedule to ensure RN scheduling is accurate per the requirement. Concerns with staffing adequacy will be communicated to the Administrator for review and resolution. Results will be reported to the Quality Committee monthly until compliance is achieved for three months. DON is ultimately responsible for compliance.	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0727 SS = F	Continued from page 28 Based on interview and document review the facility failed to ensure a registered nurse (RN) was on duty a minimum of eight consecutive hours a day in a 24-hour period for one day between 11/1/25 through 12/18/25. This had the potential to affect all thirty-six residents residing in the facility. Findings include: Review of facility posted nurse staffing information and daily nurse staff posting from 11/1/25 through 12/18/25, identified the following: -On 12/13/25, the facility posted nurse staffing information indicated one RN was working the day shift, however, the daily schedule did not have evidence of a RN working eight consecutive hours in that 24-hour period. During an interview on 12/18/25 at 12:14 p.m., director of nursing (DON) stated the 12/13/25 facility posted nurse staffing had identified that RN was on the day shift for 8 hours, however, the nurse schedule identified that only licensed practical nurses were on the schedule during that 24 hour period and that the facility did not have RN coverage for the date of 12/13/25. Review of the facility's Nurse Staffing Hours policy dated 11/25, identified that that facility will post the total number of hours and actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift, however, the policy did not identify the facility to have a RN coverage for eight consecutive hours in a 24-hour period.	F0727		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care	F0732	F732 Gundersen Tweeten Care Center will accuracy of the nurse staff posting data. Policy #TWTHR-565 was reviewed for accuracy and revised as needed. The Daily Staffing Sheet was reviewed and revised to accurately reflect licensed versus non-licensed staff. The Director of Nursing and scheduler will ensure the daily staffing sheet is completed correctly and follow up with any inaccuracies. Charge nurse on duty for each shift will be responsible for updating the form for any changes in hours as they occur. Each charge nurse will initial document at end of shift signifying form is completed and correct. Education will be provided to nurses to ensure correct documenting and updating of daily staffing sheet. Daily audit of staffing sheets to	01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0732 SS = C	<p>Continued from page 29 per shift:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>§483.35(i)(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents, staff, and visitors.</p> <p>§483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure accuracy of the nurse staff posting on 12/13/25. This had the potential to affect all 36 residents that reside in the facility and/or resident representatives.</p> <p>Findings include:</p> <p>Review of the nurse staff posting on 12/13/25 identified a census of 36 residents with staffing listed as followed:</p> <p>-night shift-1 licensed practical nurse (LPN) for 8 hours.</p>	F0732	Continued from page 29 be completed by DON to assure completion. Results to be reported to Quality committee for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0732 SS = C	<p>Continued from page 30</p> <p>-day shift-1 RN for 8 hours.</p> <p>-evening shift-1 LPN for 8 hours.</p> <p>Review of the nursing schedule on 12/13/25, identified an LPN had been scheduled for all shifts during the 24-hour period.</p> <p>During an interview on 12/18/25 at 12:14 p.m., director of nursing (DON) stated 12/13/25 nurse staff posting had a RN listed on the posting from 5:30 a.m. to 2:00 p.m., however was incorrect because a LPN worked the 5:30 to 2:00 p.m. shift that day. DON stated she believed the nurse that had been scheduled for the day shift on 12/13/25 was an RN, however, when she verified license, she identified the day shift nurse was an LPN, which in turn made the posting inaccurate.</p> <p>Review of Nurse Staffing Hours Policy dated 11/25, identified the facility post the following every shift: facility name; current date; total number and actual hours worked by the following categories of licensed an unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses, certified nursing aides;</p> <p>current resident census.</p>	F0732		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 12/17/25, 12/18/25, 12/19/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	20000		01/16/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20000	<p>Continued from page 1 The following complaints were reviewed. H54291381C (2693028) and H54291720C (2694230) with a licensing order issued at:830, 900, 570.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/in_fobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p>	20000		
20570	<p>Comprehensive Plan of Care; Revision</p> <p>CFR(s): MN Rule 4658.0405 Subp. 4</p> <p>Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal</p>	20570	Corrected	01/23/2026

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20570	<p>Continued from page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on Observation, interview, and document review the facility failed to revise the care plan for 2 of 3 residents (R8, R4) who were reviewed for falls and pressure ulcers.</p> <p>Findings include</p> <p>R8's face sheet dated 12/19/25, identified diagnoses of malignant neoplasm (cancer) of the lung and brain.</p> <p>R8's admission Minimum Data Set (MDS) dated 9/29/25, identified R8 needed maximum assist for transfers, had a fall 2-6 months prior to entry and had moderate cognitive impairment.</p> <p>R8's fall focus care plan dated 10/13/25, identified R8 was at risk for falling related to impaired mobility/balance and forgets she needs help for transfers and will attempt to transfer self even with frequent reminders she needs assistance. Goal to remain free from injury. Interventions were as followed:</p> <ul style="list-style-type: none"> -assure resident is wearing eyeglasses and that they are clean and in good repair. - assure the floor is free of glare, liquids, foreign objects, provider proper, well-maintained footwear. Encourage use of environmental devices such as hand grips, hand rails, etc. -give resident verbal reminders not to ambulate/transfer without assistance. -keep bed at proper height -monitor overall condition for underlying infection that could contribute to altered mental status, weakness, and overall increased risk for falling. -provide resident an environment free of clutter. Keep call light in reach at all times. Keep personal items and frequently used items within reach. Encourage resident to assume a standing position slowly. Leave night light on in room. -15 min safety check every evening from 6-9 p.m. due to high-risk for falls and ability to remember she cannot 	20570		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20570	<p>Continued from page 3 get up alone. Initiated 10/22/25.</p> <p>-place resident in a fall prevention program providing hourly rounding to ensure resident is safe. Initiated 12/18/25.</p> <p>R8's fall investigation event dated 10/6/25 at 11:17 p.m., identified R8 had an unwitnessed fall in the bathroom. R8 stated she need to go to the bathroom and self-transferred, became weak and fell to the floor. Interventions of toilet at regular intervals, increase assistance and surveillance, increase in staff assistance as appropriate in the early morning, to and from toilet, during all transfers, during ambulation. Remind resident to use call lights and 30-minute checks. R8's care plan did not identify an intervention for R8 to have increase assistance in early morning, to and from toilet, during transfers, and during ambulation, remind R8 to use the call light nor 30-minute checks to offer bathroom to mitigate the risk of falls.</p> <p>R8's fall investigation event dated 10/20/25 at 8:43 p.m., identified R8 was found on the floor by bed and had attempted to get into bed without assistance. Intervention of sign placed in room to remind to call for help and 15-minute checks at bedtime. R8's care plan did not identify an intervention of sign placed in room to remind R8 to call for help and the intervention that directed 15-minute checks at bedtime was not added until 10/22/25.</p> <p>R8's fall investigation event dated 10/25/25 at 8:27 a.m., identified R8 had an unwitnessed fall in her room. R8 stated she wanted to be toileted and could not locate her call light due to being on her right side when call light was on her left side. Root cause of fall was identified as toileting status/need. Interventions to provide staff assistance in the early a.m. and after meals; increase staff assistance as appropriate in the early morning to and from toilet, during all transfers and during ambulation; increase assistance and surveillance; remind resident to stay in bed and ask for assistance when in need of transfer. R8's care plan did not identify an intervention to increase staff assistance nor to remind resident to stay in bed and ask for assistance when in need of transfer.</p> <p>R8's fall investigation event dated 11/5/25 at 6:45 p.m., identified R8 was found on the floor in her room by the bathroom door. Cause of fall was identified as confusion/lack of remembering to call for help. Root cause of fall was not marked off. Interventions left</p>	20570		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20570	<p>Continued from page 4 blank. Interdisciplinary team (IDT) review to have resident placed on 30-minute checks with offer of bathroom use or transfer to bed at appropriate times. R8's care plan did not identify a revision to include an intervention for R8 to be placed on 30-minute checks to offer bathroom use nor to transfer to be at a specified appropriate time.</p> <p>R8's fall investigation event dated 11/10/25 at 6:45 p.m., identified had an unwitnessed fall in her room near her bathroom. R8 was in her wheelchair and was attempting to get into bed with wheelchair brakes unlocked. Cause of fall that R8 attempted self-transfer to bed from wheelchair and wheelchair brakes not on and wearing regular socks without non-skid grippy material. Root cause of the fall was identified as physical function and footwear. Interventions of increase assistance and surveillance and reduce risk of injury (i.e., low bed, floor mat, nonslip socks, lower or remove side rails). R8's care plan did not identify an intervention for R8 of specific increase in assistance/surveillance nor to address the causal factors of no appropriate footwear or wheelchair brakes being unlocked during the transfer.</p> <p>R8's fall investigation report dated 11/29/25 at 2:45 a.m., identified R8 was found on the fall mat beside her bed on her left side. R8 stated she was attempting to get up to the bathroom. R8's fall prevention interventions on report of hourly rounding and signs visible from bed. R8's care plan did not identify a fall mat next to her bed, hourly rounding, nor address or specify what signs are to be visible from R8's bed.</p> <p>R8's progress note dated 12/17/25 at 3:05 p.m., identified R8 was found sitting on the floor in her room. R8 stated she was attempting to plug in her cell phone and leaned forward to pick up her charger on the floor and slid out of the wheelchair. R8's care plan did not identify any revisions to address fall prevention interventions regarding sliding out of wheelchair due to leaning out of wheelchair.</p> <p>During an interview on 12/18/25 at 2:54 p.m., licensed practical nurse (LPN)-A stated she does not update a resident's care plan for any immediate fall prevention intervention she puts in place and said the director of nursing or nurse managers are responsible to ensure the care plans are updated timely.</p> <p>During an interview on 12/19/25 at 9:53 a.m., registered nurse -education (RN-EDU) stated she is unaware of who is responsible for revising a resident's</p>	20570		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20570	<p>Continued from page 5 care plan if changes need to be made after the IDT meets to discuss interventions to prevent falls.</p> <p>R4's face sheet dated 12/19/25, identified diagnoses of dementia (a severe decline in mental abilities) and Parkinson's Disease (a progressive brain disorder leading to movement issues like tremors, stiffness, and slowness).</p> <p>R4's Annual Minimum Data Set (MDS) dated 12/9/25, identified R4 needed maximum assistance for bed mobility/transfers, at risk for pressure ulcers with, had one stage one pressure ulcer and had moderately impaired cognition.</p> <p>R4's pressure ulcer focus care plan dated 12/8/23, identified R4 was at risk for pressure injury related to poor nutrition, immobility, chairfast and had skin breakdown on heels and coccyx. Goal of R4's skin to remain intact. Interventions as followed:</p> <ul style="list-style-type: none"> -Air mattress to bed and cushion in Broda wheelchair to reduce pressure when lying or sitting. -Inspect skin with cares. Report and signs of skin breakdown (sore, tender, red, or broken areas) to charge nurse. Notify physician of problems. Lotion skin with cares. -Keep clean and dry as possible. -Weekly total body skin assessments to be performed and documented by charge nurse. -Apply skin prep to both heels twice daily and allow to dry and bilateral heel protectors on when in bed. Initiated on 12/2/25. -Right buttocks stage one: cleanse with soap and water, gently pat dry, apply barrier ointment to skin and reposition every 2 hours while in bed and Broda chair to offload area. Initiated 12/2/25. <p>R4's skin integrity event dated 11/24/25, identified that R4 had non-blanchable redness with open areas on left heel and right buttocks. Left heel measured 2.5 x 1.0 and right buttocks measured 1.5 x 1.5, however, the event did not specify whether the measurements were in inches or centimeter. Intervention of boots to be ordered by hospice and always worn. With investigative review determined heels to be offloaded with pillows and boots. R4's care plan did not identify intervention to offload heels with pillows or boots.</p>	20570		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20570	<p>Continued from page 6</p> <p>During an interview on 12/19/25 at 12:19 p.m., director of nursing (DON) stated a resident's care plan should be revised in a timely manner when a new intervention to prevent falls or prevent/manage a pressure ulcer, however, has not been trained to revise a care plan and does not ensure the revisions are made after being discussed at IDT.</p> <p>Review of the facility's Care Planning-Comprehensive Person-Centered Care Policy dated 02/25, identified the IDT must review and update the care plan for the following: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from the hospital stay; at least quarterly, in conjunction with required MDS assessment.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	20570		
20830	<p>Adequate and Proper Nursing Care; General</p> <p>CFR(s): MN Rule 4658.0520 Subp. 1</p> <p>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to immediately respond to elopement when 1 of 1 resident (R1) activated an exit alarm and walked outside off the facility property without appropriate clothing for temperature of 1 degree/windchill of -7 degrees. In addition, the facility failed to comprehensively investigate/analyze falls for root cause, implement appropriate interventions and revise</p>	20830	Corrected	01/23/2026

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 7 the care plan to prevent and/or reduce the risk for future falls for 1 of 3 residents (R8) reviewed for accidents.</p> <p>Findings include:</p> <p>R1's face sheet dated 12/18/25, identified diagnosis of mild cognitive impairment, chronic kidney disease (condition where kidneys have been damaged), and history of neoplasm (cancer) of the breast.</p> <p>R1's progress note dated 12/2/25, identified R1 had been admitted and had a history of wandering out of her home and nursing aware that if R1 needed to be admitted to the secured memory care unit this can be done.</p> <p>R1's elopement evaluation dated 12/2/25, identified R1 was ambulatory, had a risk factor of being cognitively impaired, poor decision-making skills, displayed behaviors that may indicate an attempt to leave may be forthcoming. R1 was identified as an elopement risk, and an exit alarm was placed.</p> <p>R1's progress note dated 12/2/25, identified wander/elopement alarm applied to left ankle for safety.</p> <p>R1's Admission Minimum Data Set (MDS) dated 12/8/25, identified R1 had daily wandering behaviors, was independent for transfers and ambulation without the use of any mobility devices, had moderate cognitive impairment, and used a wander/elopement alarm daily.</p> <p>R1's vulnerable adult focus care plan dated 12/4/25, identified R1 was vulnerable due to admission, cognitive, and physical limitations, and required assistance to safety in the event of a harmful situation. Goal of resident assisted to safety in the event of a harmful situation. Interventions as followed: assist Resident to safety in the event of a harmful situation; Exit alarm bracelet applied to body due to safety concerns to alert staff of any attempt to exit building without assistance. Check twice daily for placement and functioning device. Change exit alarm bracelet every 80 to 90 days.</p> <p>R1's progress note dated 12/13/25 at 3:56 p.m., identified R1 left the facility out of the front door, alarm sounded, but stated "patio door". R1 was up the block from the facility, when aide was searching for resident, R1 saw the aide, called her by name, and then walked back to the facility with staff. R1 was wearing sweatshirt and pants and no injuries observed. R1 was moved to secured unit upon return to the facility.</p>	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 8</p> <p>According to Houston County (KMNEITZE3-weather station) the temperature on 12/13/25 at 3:00 p.m. had an actual temperature of 1 degree with a wind chill of -7 degrees.</p> <p>During a facility tour on 12/17/25 at 2:36 p.m., the front facility exit needed to pass through two doors to come out to a parking lot: the parking lot with a small decline towards the street with a curb at the end of the parking lot. The street running in front of the building to the left sloped downwards towards a field; the street running to the right of the parking lot had a steeper slope with a curve at the end that went uphill to another block; near the curve in the road there was a grocery store parking lot to the right and beyond the parking lot was a highly traveled highway; the sidewalk/street going up to the next block had a steep incline with a curb on the right side; the house in which R1 had been found was ¾ way down the block and on the left side of the street which had concrete steps in the front of the house with 3 steps.</p> <p>R1's behavioral symptom focus care plan dated 12/16/25, identified R1 experienced wandering behavior, seeks out exit doors, was at risk for elopement. The corresponding intervention directed staff to assess resident for placement in a specifically designed therapeutic unit.</p> <p>During an interview on 12/17/25 at 11:37 a.m., nursing assistant (NA)-A stated she had been in the secured unit on 12/13/25. Around 3:00 p.m. she opened the unit door to go into the general population area; she heard the exit alarms sounding and saw licensed practical nurse (LPN)-A running in the hallway. LPN-A informed NA-A that the patio door exit alarm was sounding and that she believed R1 had went out that door. NA-A looked in the patio area for R1 but did not see her. NA-A then returned into the facility and observed LPN-A coming down the hallway and informed her R1 was on the street in the front of the building about a block away. NA-A went outside to get R1 but by the time NA-A went outside to that location, R1 was not there. NA-A then walked down the street to the left of the building where she saw a person walking on the street, however, when she got closer, she identified it was not R1. NA-A then went the opposite way and continued around the corner up the hill and still had not located R1. NA-A then began walking down the street and about 15 minutes after she began looking for R1, she observed R1 (in</p>	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 9 only a long sleeve shirt and pants) walking down some steps in front of a house. When R1 saw NA-A she called out NA-A's name and walked towards NA-A through the snow. NA-A stated R1's face was red, her hands were "very cold", she then ambulated back to the facility with NA-A with no issue.</p> <p>During an interview on 12/17/25 at 12:19 p.m., licensed practical nurse (LPN)-A stated around 3:00 p.m. on 12/13/25, she heard an exit alarm sound, and immediately went to the alarm panel which identified it was the patio door by the dining room. LPN-A immediately ran to the patio door and did not observe R1 outside the area or notice any footprints in the snow. Nursing assistant (NA)-A arrived shortly after and went outside to look in the patio area first. LPN-A then went to the front door where she was able to see R1 standing about a block away near a tree on the road. LPN-A stated she did not attempt to go outside to bring R1 back into the facility because "it was really cold out and I did not have a coat." Instead, she walked away from the window and door where she could visualize R1 to get another staff member to assist R1 back into the facility, however, when LPN-A returned to the window R1 was not there. LPN-A stated after she had located a staff member to go outside, she went back to the same window however R1 was no longer standing where she was. Nursing assistant (NA)-A walked around outside to locate R1, found her coming down a stairway at a house on the next block up the hill and brought R1 back into the facility. LPN-A stated she assessed R1 for any injuries and did not observe any and she was just "cold." LPN-A stated R1 was then placed in the secured unit after discussion with management for safety.</p> <p>During an interview on 12/17/25 at 12:36 p.m., trained medication aide (TMA)-A stated she had not received any education regarding prevention of elopement or what to do if a resident elopes, however, TMA-A stated if she observed a resident outside after an elopement, she would immediately go outside to attempt to get the resident back inside.</p> <p>During an interview on 12/17/25 at 12:50 p.m., director of nursing (DON) stated R1 had an exit alarm bracelet placed on admission because she was an elopement risk. R1 was independent in the facility and had a history of setting off the exit alarms due by getting close to the doors. DON further stated LPN-A should have exited the building immediately after locating R1 on the street and brought her back into the facility.</p> <p>During an interview on 12/17/25 at 1:11 p.m., licensed social worker (LSW) stated after a resident elopement</p>	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 10 and the resident is located outside of the facility, staff would need to attempt to get the resident immediately and not take eyes off the resident. By taking "eyes off" of R1 this could have put R1 at risk for getting injured.</p> <p>During an interview on 12/17/25 at 2:55 p.m., NA-B stated R1 had a history of wandering throughout the facility and would go near the exit doors at times, but had not seen R1 attempt to exit the facility and if a resident had been observed outside after an elopement she would immediately go outside and attempt to get the resident back into the facility. Staff should not take eyes off of the person, because in the short time that they are not seen they could have the potential to get farther away and could get hurt.</p> <p>During an interview on 12/17/25 at 4:45 p.m., administrator stated that after an exit alarm goes off and a resident had been observed outside of the facility the staff member that observes the resident should have gone outside immediately to attempt to get the resident back to safety. LPN-A should not have been concerned about not having a coat on, because R1 also did not have a coat on, and it was so cold that day R1 went outside.</p> <p>Review of the facility's Wandering and Elopement Policy dated 2/25, identified the facility will work to ensure the safety of the residents under their care. The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>Implementation:</p> <ul style="list-style-type: none"> -If a resident is identified as a risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Strategies may include receiving a Wandergard (name brand for an exit alarm) bracelet; placing a resident in a room farther from exits and need for frequent monitoring; photos of the resident should be updated annually. Missing Resident: If a resident is missing initiate the elopement/missing resident emergency procedure. -staff will check with the charge nurse and check the leave of absence book to see if the resident signed out of the building. -If the resident is not authorized to leave the, 	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 11 initiate a search of the building and premises. This includes to check with all on-duty staff and identify when they were last seen, where they were last seen, and what were they wearing. Designate staff to check resident room and bathrooms, therapy areas, common areas, patio/courtyard, clinic area, kitchen, and immediate surrounding areas outside.</p> <p>R8's face sheet dated 12/19/25, identified diagnoses of malignant neoplasm (cancer) of the lung and brain.</p> <p>R8's Admission Minimum Data Set (MDS) dated 9/29/25, identified R8 needed maximum assist for transfers and bed mobility, had a fall 2-6 months prior to entry and had moderate cognitive impairment.</p> <p>R8's fall risk assessment dated 9/29/25, identified R8 was at risk for falling due to impaired balance and needing assistance.</p> <p>R8's fall focus care plan dated 10/13/25, identified R8 was at risk for falling related to impaired mobility and balance. Interventions dated 10/13/25 were as followed:</p> <ul style="list-style-type: none"> -assure resident is wearing eyeglasses and that they are clean and in good repair. - assure the floor is free of glare, liquids, foreign objects, provider proper, well-maintained footwear, encourage use of environmental devices such as hand grips, hand rails, etc. -give resident verbal reminders not to ambulate/transfer without assistance. -keep bed at proper height -monitor overall condition for underlying infection that could contribute to altered mental status, weakness, and overall increased risk for falling. -provide resident an environment free of clutter. Keep call light in reach at all times. Keep personal items and frequently used items within reach. Encourage resident to assume a standing position slowly. Leave night light on in room. <p>R8's fall investigation event dated 10/6/25 at 11:17 p.m., identified R8 had an unwitnessed fall in the bathroom. R8 stated she needed to go to the bathroom, self-transferred, became weak and fell to the</p>	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 12 floor. Root cause of the fall identified as confused/forgetful. Associated interventions directed staff to toilet at regular intervals, increase assistance and surveillance, increase in staff assistance as appropriate in the early morning, to and from toilet, during all transfers, during ambulation. Interdisciplinary team (IDT) review determined potential factors that contributed to the fall were increased weakness, new environment, forgetfulness. Intervention to be taken to prevent further falls were to remind resident to use call lights and 30-minute checks. Although the fall investigation event indicated potential causal factors of toileting needs, there was no comprehensive assessment to determine R1's toileting needs, no comprehensive assessment that identified how 30-minute checks were determined, and no indication R8's care was revised.</p> <p>R8's fall investigation event dated 10/20/25 at 8:43 p.m., identified R8 was found on the floor by bed and had attempted to get into bed without assistance. Root cause identified as mood/behavior. IDT review identified R8 not aware of limitations and an intervention of sign placed in room to remind to call for help and 15-minute checks at bedtime. There was no other information pertaining to why R8 was attempting to get out of bed and did not identify if the care plan had been followed prior to R8's fall. Although the fall investigation event indicated potential causal factors of R8 wanting to go to bed, this was not addressed in the care plan interventions. R8's care plan was revised on 10/22/25 to include 15-minute checks from 6:00 p.m. to 9:00 p.m., however, did not include sign placed in room to remind R8 to call for help.</p> <p>During an observation on 12/19/25 at 10:30 a.m., R8 was in her room, a sign was located near R8's head of her bed that read "call for help". R8 stated she the sign helped her remember to ask for help, but at times she still forgets to ask for help.</p> <p>During an interview on 12/19/25 at 10:15 a.m., licensed practical nurse (LPN)-A stated staff document the 15-minute checks for R8 on paper and then it scanned into the electronic health record. LPN-A confirmed the care plan was not revised to include the sign prompting R1 to call for help but stated the sign was placed shortly after R8 fell on 10/20/25; she could not articulate an exact date of when the sign was posted.</p>	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 13</p> <p>R8's fall investigation event dated 10/25/25 at 8:27 a.m., identified R8 had an unwitnessed fall in her room. R8 stated she wanted to be toileted and could not locate her call light due to being on her right side when call light was on her left side. Root cause of fall was identified as toileting status/need. Interventions to provide staff assistance in the early a.m. and after meals; increase staff assistance as appropriate in the early morning to and from toilet, during all transfers and during ambulation; increase assistance and surveillance; remind resident to stay in bed and ask for assistance when in need of transfer. The fall investigation did not address if the care plan was followed prior to the fall. Although the fall investigation event indicated potential causal factors of call light placement and toileting needs, there was no comprehensive assessment to determine R1's toileting needs and no indication R8's care was revised.</p> <p>R8's fall investigation event dated 11/5/25 at 6:45 p.m., identified R8 was found on the floor in her room by the bathroom door. Cause of fall was identified as confusion/lack of remembering to call for help. Root cause of fall was not marked off. Interventions left blank. IDT review identified potential factors that could have contributed to the fall were cancer and chronic pain. Interventions added to place R8 on 30-minute checks with offer of bathroom use or transfer to bed at appropriate times. Although the fall investigation event indicated potential causal factors of toileting needs, there was no comprehensive assessment to determine R1's toileting needs and no indication R8's care was revised.</p> <p>R8's fall investigation event dated 11/10/25 at 6:45 p.m., identified R8 had an unwitnessed fall in her room near her bathroom. R8 was in her wheelchair and was attempting to get into bed with wheelchair brakes unlocked. Cause of fall were identified that R8 attempted self-transfer to bed from wheelchair, wheelchair brakes not locked, wearing regular socks without non-skid grippy material. Root cause of the fall was identified as physical function and footwear. Interventions of increase assistance and surveillance and reduce risk of injury (i.e., low bed, floor mat, nonslip socks, lower or remove side rails). Although the fall investigation event indicated potential causal factors toileting needs, wheelchair brakes not being locked and inappropriate footwear there was no indication R8's care plan was revised to include associated interventions. ----review your statement for accuracy</p>	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	<p>Continued from page 14</p> <p>R8's fall investigation report dated 11/29/25 at 2:45 a.m., identified R8 was found on the fall mat beside her bed on her left side. R8 stated she was attempting to get up to the bathroom. R8's fall prevention interventions on report of hourly rounding and signs visible from bed. There was no indication of a comprehensive analysis to identify causal factors and R8's care plan was not revised until 12/18/25 which was 19 days after the fall occurred.</p> <p>R8's fall investigation report dated 12/17/25 at 3:05 p.m., identified R8 was found sitting on the floor in her room. R8 stated she was attempting to plug in her cell phone and leaned forward to pick up her charger on the floor and slid out of the wheelchair. There was no indication of a comprehensive analysis to identify causal factors and no indication R8's care plan was revised.</p> <p>During an interview on 12/19/25 at 12:15 p.m., director of nursing (DON) stated R8's falls had been looked at to attempt to do a "deep dive" of her falls, however, facility had only been looking at "bits and pieces" of the reasons R8 had been having repeat falls and not the "whole picture" to determine appropriate interventions were in place.</p> <p>Review of the facility's Falls and Fall Risk, Managing Policy dated 2/25, identified the facility will identify interventions related to resident's specific risks and causes to try and prevent the resident from falling and minimize the complications from falling.</p> <p>Resident centered approaches to managing falls and fall risk:</p> <ul style="list-style-type: none"> -the staff with the input of the attending physician will implement a resident centered fall prevention plan to reduce the specific risks factors of falls for each resident at risk or with history of falls. -if a systemic evaluation of a residents fall risk identifies several possible interventions, the staff may choose to prioritize interventions. -if falling reoccurs despite initial interventions, staff will implement additional of different interventions or indicate why the current approach remains relevant. 	20830		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20830	Continued from page 15 Monitoring Subsequent falls and fall risk: -the staff will monitor and document Each resident's response to interventions intended to reduce falling or the risk of falling. -If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has resolved. -If the resident continues to fall, staff will reevaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. -The staff and or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk of falling or injury due to falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to elopements, falls, accidents, and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable;	20900	Corrected	01/23/2026

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	<p>Continued from page 16 and</p> <p>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed monitor, comprehensively assess, and develop and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 1 of 1 resident (R4) reviewed for pressure ulcers.</p> <p>Findings include</p> <p>R4's face sheet dated 12/19/25, identified diagnoses of dementia (a severe decline in mental abilities) and Parkinson's Disease (a progressive brain disorder leading to movement issues like tremors, stiffness, and slowness).</p> <p>R4's skin risk assessment with Braden (a healthcare tool for pressure ulcer risk) dated 9/8/25, identified R4 was not at risk for pressure ulcers.</p> <p>R4's Annual Minimum Data Set (MDS) dated 12/9/25, identified R4 received hospice services, needed maximum assistance for bed mobility/transfers, at risk for pressure ulcers, had one stage one pressure ulcer and had moderately impaired cognition.</p> <p>R4's pressure ulcer focus care plan dated 12/8/23, identified R4 was at risk for pressure injury related to poor nutrition, immobility, chairfast and had skin breakdown on heels and coccyx. Goal of R4's skin to remain intact. Corresponding interventions dated 12/8/23 included:</p> <ul style="list-style-type: none"> -Air mattress to bed and cushion in Broda wheelchair to reduce pressure when lying or sitting. -Inspect skin with cares. Report and signs of skin breakdown (sore, tender, red, or broken areas) to charge nurse. Notify physician of problems. Lotion skin with cares. -Keep clean and dry as possible. -Weekly total body skin assessments to be performed and documented by charge nurse. 	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	<p>Continued from page 17</p> <p>-apply skin prep to both heels twice daily and allow to dry and bilateral heel protectors on when in bed. Initiated on 12/2/25.</p> <p>R4's skin alteration form dated 11/24/25, identified that R4 had non-blanchable redness on left heel and right buttocks. Left heel measured 2.5 x 1.0 and right buttocks measured 1.5 x 1.5; the report did not identify the unit of measurement nor any other wound characteristics. Intervention of boots to be ordered by hospice and always worn. Summary of investigation identified heels were being offloaded with pillow and boots to be ordered by hospice. R4's record did not identify documentation of offloading of pillow prior to identification of left heel redness on 11/24/25.</p> <p>Hospice situation, background, assessment, response (SBAR) note dated 11/24/25, identified left heel had non-blanchable bruising measuring 2.5 centimeters (cm) x 1.0 cm; large blister on right heel measuring 5.0 cm x 6.0 cm. R4's hospice note did not identify any other wound characteristics, however ordered skin barrier spray to both heels twice daily and heel boots on at all times.</p> <p>R4's Wound Management Detailed Report dated 11/24/25, identified R4's left heel had a purple bruise that measured 2.5 cm x 1.0 cm. R4's wound management report did not identify any other wound characteristics such as pain, surrounding skin, and drainage. The wound management detailed report did not include the intervention of heel boots that was identified in the skin alteration form and review of R4's care plan indicated the care plan was not revised to include the intervention until 12/2/25 (8 days after the wound was identified).</p> <p>R4's progress note dated 12/1/25, identified a hospice note due to a worsening right heel blister, with less fluid filled, purple in areas, less painful to R4.</p> <p>R4's Wound Management Detailed Report dated 12/4/25, identified left heel wound measured 8.0 cm x 2.0 cm and purple in color. Although the wound had increased from 2.5 cm x 1.0 cm the evaluation identified the wound was stable. R4's wound management report lacked a comprehensive wound assessment that included color, drainage, tissue type, odor, and pain and did not address pressure relieving interventions nor treatments being utilized.</p> <p>R4's progress note dated 12/10/25, indicated a new wound was found on R4's right heel that measured 7.5 x</p>	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	<p>Continued from page 18</p> <p>3.5 (did not identify unit of measurement) and left heel was 4.0 x 2.0 (did not identify unit of measurement). Will order air mattress due to pressure wounds on heels. R4's record did identify a corresponding comprehensive wound assessment of either heel wound.</p> <p>During an interview on 12/19/25 at 11:21 a.m., registered nurse case manager (RN-CM) stated staff nurses are performing the comprehensive wound assessments for all wounds on a resident's scheduled bath day, however, the assessment are not reviewed to ensure the wounds are not worsening, the appropriate treatments/pressure relieving measures are being utilized.</p> <p>During an observation and interview on 12/19/25 at 1:05 p.m. R4 had green heel boots on both feet. RN-CM stated R4's right heel had an unstageable pressure ulcer that measured 3.5 cm x 7.0 cm, dry, covered in eschar (a thick, dark, leathery layer of dead tissue that forms over wounds), dark color, not "blisery in appearance"; R4's left heel was an unstageable pressure ulcer that measured 2.0 cm x 1.6 cm, dry, brown "discolored", "not really boggy but feels mushy" over the wound, surrounding skin pink, no edema around it, skin intact with no pain. RN-CM could not articulate any further details of the description of right or left heel appearance. RN-CM R4's wounds were being treated with skin prep (a spray that creates a breathable protective film on the skin to shield it from friction) twice daily to both heels, heel protectors and an air mattress.</p> <p>R4's Wound Management Detailed Report dated 12/19/25 at 1:30 p.m. identified R4 had a pressure ulcer on left heel that was first identified on 11/24/25 as a bruise. Report identified area appears to be pressure ulcer not a bruise. Wound description of measurements of 1.6 cm c 2.0 cm with no depth, no exudate, no odor, stage identified as unstageable-slough and/or eschar, 50 % of necrotic tissue, surrounding skin pink/normal, skin is more "brown than black" and heel feels slightly mushy but not really boggy.</p> <p>During an interview on 12/19/25 at 12:15 p.m., director of nursing (DON) stated R4's left heel that was identified on 11/24/25 did not have a comprehensive assessment, proper wound identification, nor weekly comprehensive assessment by a registered nurse to determine wound improvement/progression.</p> <p>During an interview on 12/19/25 at 1:48 p.m., physician assistant (PA) stated any resident that is determined</p>	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	<p>Continued from page 19 to be a high risk for developing a pressure ulcer should have interventions in place to prevent the development of a pressure ulcer and any resident admitted to the nursing home without a pressure ulcer should not develop a pressure ulcer and if the resident is admitted with or develops a pressure ulcer that the pressure ulcer is managed to heal with interventions put in place by the facility.</p> <p>Review of the facility's Prevention of Pressure Ulcers/Injuries policy dated 2/25, indicated the following:</p> <p>Skin Inspection:</p> <ul style="list-style-type: none"> -A head to toe skin inspection on all residents is completed weekly by a licensed nurse in alignment with bathing to identify any signs of developing pressure injuries, inspect pressure points, wash the skin after each episode of incontinence, moisture dry skin daily, and reposition resident as indicated on care plan. -A resident with a wound present a comprehensive wound assessment will be completed by a registered nurse weekly <p>Prevention:</p> <ul style="list-style-type: none"> -Moisture: keep skin clean, dry, and free of exposure to urine and fecal matter. -Nutrition: use a screening tool to determine if resident is at risk for under nutrition. <p>Skin inspection:</p> <ul style="list-style-type: none"> -a head to toe skin inspection on all residents will be completed on admission, daily with cares, and weekly by licensed nurse in alignment with bathing. <p>Residents with a wounds:</p> <ul style="list-style-type: none"> -For those residents that have a wound present, a comprehensive wound assessment will be completed by a registered nurse weekly. <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those</p>	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 20 who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0000	INITIAL COMMENTS On 3/18/26, 3/19/26 an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited on 2/9/26. The facility was NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following tags were recited: F686 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. 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.	F0000		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review	F0686		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	<p>Continued from page 1</p> <p>the facility failed monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 2 of 3 residents (R9, R13) reviewed for pressure ulcers. /This caused actual harm to R9 who developed an avoidable stage 3 pressure ulcer on her left second toe. Findings include:</p> <p>R9's face sheet dated 3/19/26, identified diagnoses of Alzheimer's disease and history of neoplasm (cancer) of the skin. R9's quarterly Minimum Data Set (MDS) dated 3/3/26, indicated R9 had severe cognitive impairment, no behaviors, needed partial/moderate assistance for putting on/taking off footwear, independent with transfers and ambulation. R9 was not at risk for pressure ulcers but had one stage 2 pressure ulcer, no venous or arterial ulcers, received pressure ulcer care, and no application of dressings to feet. R9 Braden Scale Assessment (assessment tool used to identify the risk for pressure ulcers) dated 2/27/26, indicated R9 was not at risk for pressure ulcers, however identified R9 had pressure injury on right toe. R9's Activity of Daily Living (ADL) focus care plan for bathing dated 9/24/24, identified R9 had limited ability to complete ADLs related to Alzheimer's Disease. The intervention dated 2/13/26 directed staff to clip resident's toenails weekly with shower/bath. R9's Pressure Ulcer/Injury focus care plan dated 9/25/24, identified R9 was at low risk for skin breakdown and skin is intact. Interventions included the following -Monitor left great hammer toe for breakdown. Monitor corn on 2nd toe right foot. Cover areas with band-aides for protection (dated 12/20/24). -Monitor skin with cares and observe for changes. Notify charge nurse with concerns consult provider if concerns arise (dated 9/25/24). -Weekly total body skin assessment to be performed by charge nurse (dated 9/25/24). Review of R9's record between 1/29/26 through 2/9/26 identified R9 had a history of long thick toenails causing a stage 2 pressure on her right second toe that began on 1/29/26 and was resolved on 3/3/26. R9's progress note dated 2/16/26, identified R9 had a tub bath and toenails unable to be trimmed due to being very thick and needed a podiatry appointment. In review of R9's record between 2/16/26 through 2/28/26 there was no indication the long toenails were trimmed in accordance to the intervention dated 2/13/26 nor evident the great toe was monitored according to the intervention dated 12/20/24. R9's progress note dated 3/1/26, identified R9 had an area on her left foot that "seems to be bothering her." Area assessed and placed foam pad with lamb's wool as well. Will have</p>	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 2 clinical manager follow up tomorrow. Although the progress note identified the area was assessed, R9's record did not include a comprehensive assessment of the bothersome area on R9's left foot. In addition, there was no indication the usage of a foam dressing was transcribed into the treatment orders nor evident the physician was notified. During an interview on 3/18/26 at 3:04 p.m., DON stated she had been working as the charge nurse on 3/1/26 when R9 began to complain about pain in her left foot between her left great and second toe. DON removed R9's shoe and observed a painful, pink/red area on the left second toe. DON explained she had not completed a comprehensive assessment of the pink/red area, such as measuring the redness, and determining if the areas were blanchable or non-blanchable. DON was aware R9 had thick toenails, a hammer toe on her left great toe and a previous pressure ulcer on her right second toe also caused by the hammer toe and long thick nails, but "did not think the redness was much of anything" until she heard it had become an open wound the next day. During a follow up interview on 3/19/26 at 12:18 p.m., DON stated when she identified the area on R9's left foot on 3/1/26 she had a sharp corner/hook to her left great toenail that was pressing directly in the pink/red/painful area, so she trimmed that sharp corner of R9's nail, but not the entire nail to relieve pressure to the left second toe. DON explained she placed a foam pad between R9's left great toe and second toe and thought that would help relieve the pressure. R9's progress note dated 3/2/26, identified R9 had a tub bath and an open area was observed on R9's left 2nd toe. Area cleansed and applied a Duoderm (non-permeable dressing that seal wounds from air to keep wound moist) dressing along with lambswool. R9's left 2nd toe was swollen and red with no drainage. Situation, Background, Assessment, Recommendation (SBAR-physician communication) made out for evaluation for possible infection. In review of R9's record there was no indication the Duoderm treatment was transcribed into the treatment orders. R9's SBAR physician referral form dated 3/2/26, identified R9 had a suspected skin and soft tissue concern. Area had been cleansed and dressing applied. R9 may need antibiotic for infection due to being red and painful. The form did not identify a Duoderm dressing had been applied, and no other wound characteristics such as measurements, drainage, color, or pain had been included. During an interview on 3/18/26 at 1:59 p.m., licensed practical nurse (LPN)-A stated she was the charge nurse 3/2/26 that first observed R9's open wound on her left second toe during a bath skin check. LPN-A stated when she first observed the open area between R9's left great	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 3 toe and second toe it appeared to be a "skin tear", but after cleaning the wound it appeared to be a pressure injury. R9's toenails were very thick, and her left great toenail was pressing directly on where the open wound was on the left second toe. LPN-A explained she had not notified the physician of the open area and had only handed the SBAR to the nurse manager to give the physician on rounds. The facility's Long Term Care Standing Orders dated 6/25/24, that included orders for wound treatments was reviewed in conjunction with the progress note 3/2/26. The Standing Orders did not include nor direct the usage of a Duoderm as a treatment option. The Standing orders directed for "superficial skin redness/open areas: may apply collagen powder/A&D mix daily until healed. If not improving after one week of treatment, notify the provider" and "For any suspected pressure injury, refer to provider for orders." R9's Skin Integrity Incident Report dated 3/2/26 at 1:15 p.m., identified R9 had redness/peeling skin on left second toe that measured 0.5 centimeters (cm) x 0.4 cm, no depth, no active bleeding, smooth wound edges, mild pain, fragile skin, possible contributing factors of "fit of shoe." Interventions of cleanse with soap and water, dressing applied. Further identified "needs toenails trimmed and need for new shoes." Investigation summary dated 3/5/26 identified the great toenail caused breakdown of R9's 2nd toe. R9's physician assistant (PA) nursing home visit note dated 3/3/26, identified R9 had been seen for a pressure ulcer on the left second toe that was reported the day prior (3/2/26). R9 did not verbalize pain, but on examination of the left second toe it was painful. R9 had onychomycotic (a common fungal infection of the fingernails or toenails, causing them to become thickened) with lateral deviation of the left great toe which seems to be placing pressure on the medial (away from the midline) distal (farther away from the trunk of the body) of the left second toe. There was an open wound on the distal left second toe with a Duoderm dressing overlying on it. The skin underneath the dressing was moist and macerated (skin that appears white, soggy, and wrinkled due to prolonged moisture to excessive moisture). Duoderm dressing seemed to be too occlusive and "causing too much moisture so this should be stopped." Order to apply a small amount of calcium alginate (highly absorbent dressing material derived from brown seaweed) to the opening of the left second toe and cover with moleskin (a thick, durable adhesive cotton fabric used to prevent and treat blisters, corn, and chafing by reducing friction) if possible or perhaps a band aid wrapped around the toe to be changed daily. Should have the outside wound consultant examine this as well and give their recommendations. No signs	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 4 of cellulitis noted. Physician order dated 3/3/26 included left 2nd toe treatment directed to cleanse left second toe with soap and water, add calcium alginate in the opening, cover with moleskin or band-aid. R9's Wound Management Detailed Report dated 3/3/26, identified "other wound" on left 2nd inner toe between 1st and second toe, measuring 0.5 cm x 0.2 cm with surrounding skin red, with slight maceration at wound edges, no drainage. The report did not identify the type of wound and indicated the wound status as stable. R9's care plan was revised on 3/4/26 to include the following interventions: -Toenails to be inspected when dressing and trimmed on bath day and as needed to assure no pressure points to surrounding toes. Notify charge nurse with any concerns. -Monitor left second toe for further breakdown and notify nurses or clinical manager of any changes (dated 3/4/26). Review of R9's Treatment Administration Record (TAR) from 2/1/26 through 3/18/26 included an order had been added on 3/4/26 to assess and clip toenails weekly with bath and as needed every Thursday. The TAR on 3/5/26 had a check marked box indicating the task was completed. However, the TAR indicated on 3/12/26, the box was not checked indicating R9's toenails had not been assessed nor clipped according to the order and the care plan. R9's progress note dated 3/6/26 at 12:08 p.m., identified R9 had been seen by wound consultant. The note documented while taking R9's shoes off, it was noted that her socks were balled up in the front of the shoe. R9 had a full thickness divot/opening (no measurements were included). The note indicated the wound consultant recommended adding collagen to the treatment (a dressing that reduces wound fluid to promote tissue regeneration) to help fill the wound and avoid "osteo". The note also included orders to treat the wound with "daily collagen and band aide, lambs wool weave" R9 was fitted for new shoes and awaiting delivery. The note also included care plan updated to have staff check daily to make sure resident is not putting socks in toes of shoes. Review of R9's care plan dated 3/6/26 identified it had been revised to include the aforementioned intervention pertaining to the socks. However, there was no indication the physician had been notified of the wound consultant's assessment and treatment recommendations of adding collagen so that an order could be obtained. Physician order dated 3/6/26 included wound care to left second toe to cleanse with soap and water, add calcium alginate in the opening, cover with moleskin or band aid, document wound conditions in nursing progress notes. R9's physician orders did not include the daily collagen as per the wound consultant's recommendation. R9's March TAR between 3/6/26 through 3/19/26 included the	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 5 physician order as written. The TAR indicated the wound treatment was completed as prescribed without the collagen. R9's Wound Management Detailed Report dated 3/6/26, identified R9 had a stage 3 pressure ulcer on the left 2nd inner toe between first and second toe with measurements of 0.5 cm x 0.2 cm. The wound had light serosanguinous (pinkish watery) drainage, no odor, no tunneling, edges attached to base with well-defined wound edges. Although the report identified the ulcer as a stage 3, the report identified that depth could not be measured but did not classify the wound as unstageable. Review of R9's March TAR identified on 3/6/26 an order had been added to monitor toes on bilateral feet area of skin alteration for changes. If area appears larger in size or skin breaks open, notify charge nurse/nurse manager. Monitor and measure with weekly skin checks until healed. The TAR on 3/12/26 indicated the box was not checked indicating the task was not completed. During an observation and interview on 3/18/26 at 11:30 a.m., registered nurse (RN)-F was performing wound care on R9's left second toe. RN-F removed R9's shoe/sock. R9 had a band-aid on her left second toe along with lamb's wool weaved around her left great and second toe. RN-F then removed the band aide off her left second toe that had a piece of foam and calcium alginate under the band aid. R9 complained of pain in the second toe with the removal of the band-aid. R9's great toe had thick nails that directly pressed against a circular scabbed area on her left second toe. RN-F stated the scabbed area was where R9's stage 3 pressure ulcer was that was caused from her left great toe pressing against her toe. RN-F measured the wound at 0.4 cm x 0.2 cm with no depth. RN-F explained the wound had improved since she had last seen it and thought maybe the treatment could be changed to just a band-aid, but would have to check with the RN-CM. During an interview on 3/18/26 at 3:21 p.m., registered nurse case manager (RN-CM) indicated RN-F gave her verbal report of R9's wound status and referenced the order in the electronic health record (EHR) to change R9's left toe treatment to a band-aid only to change daily, however, RN-CM had not assessed the wound nor called the physician prior to changing the order. RN-CM explained the certified wound nurse had evaluated R9's left second toe wound on 3/6/26 and stated it was a "full thickness wound" from pressure from the left great toe. RN-CM stated the wound nurse had not staged the wound, so she referenced wound material and then identified R9's wound as a stage 3 pressure ulcer. RN-CM explained the wound nurse gave recommendation to add collagen to the opening in the wound, however, RN-CM had not notified the physician to obtain the order to add collagen. R9's Wound Management Detailed Report dated 3/9/26,	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 6 identified stage 3 pressure ulcer with measurements of 0.5 cm x 0.2 cm (depth could not be measured), well defined wound edges, skin surrounding wound was pink/normal, area surrounding wound appears less red, no signs of infection, stable healing status. Review of R9's Treatment Administration Record (TAR) included an order had been added on 3/4/26 to assess and clip toenails weekly with bath and as needed every Thursday. The TAR on 3/5/26 had a check marked box indicating the task was completed. During an interview on 3/19/26 at 1:00 p.m., trained medication aide (TMA)-A stated that normally the bath aide would trim nails on residents that were not diabetic or on blood thinners, but R9's nails were so thick and did not have the right tools. TMA -A explained staff had been telling management that R9 needed to see a podiatrist for some time now. During a follow up interview on 3/19/26 at 11:51 a.m., LPN-A indicated she had written the progress note on 2/16/26 about R9 needing to see a podiatrist. LPN-A had notified RN-CM and infection control registered nurse (IC-RN) on 2/16/26 that she was not able to trim R9's thick toenails during her bath and that R9 "needed to see a podiatrist to get her nails trimmed or her left foot was going to develop a pressure sore too." During an interview on 3/19/26 at 3:22 p.m., RN-CM stated she did not read/review resident progress notes to identify care area concerns on a daily basis. RN-CM explained she had not been aware that on 2/16/26 R9's nails were not able to be trimmed by the nursing staff. RN-CM stated the facility was unable to get R9 into the podiatrist due to not having a podiatrist available, however, had not asked R9's POA to see if she could get her into an outside clinic to have her toenail care done. During an interview on 3/19/26 at 4:30 p.m., DON stated "R9 is finally getting a podiatry appointment." DON explained R9's POA made an appointment at an outside clinic to get her toenails done. During an interview on 3/19/26 at 3:32 p.m., director of nursing (DON) stated it was her expectation that the nurse managers read/review the progress notes daily to identify care area issues in a timely manner, however, she also did not read/review the progress notes on a daily basis, including the progress note on 2/16/26 that identified that R9 needed a podiatry appointment. The DON relied on the nurse managers to perform the task. DON further explained if the progress notes had been reviewed on a regular basis, then it would have been identified that the nurses were not able to trim R9's toenails so the facility could have ensured R9's toenails got trimmed to possibly prevent R9's pressure ulcer on her left second toe. During an interview on 3/19/26 at 1:06 p.m., registered nurse certified wound nurse consultant (RN-WN) stated their company provided wound	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 7 support for the facility. RN-WN stated the representative would come to the facility to round with the nurses to assist with the wound assessment and provide supplies. They do not provide an assessment of the wounds but give support if questions and will order covered wound supplies for needed treatment. RN-WN further explained that the consulting nurse would give verbal recommendations and send a summary to the facility of recommendations, then the facility would need to reach out to their physician to write prescriptions for the recommended treatment orders. During return phone call on 3/20/26 at 1:56 p.m., R9's power of attorney (POA) stated she had become aware that R9 had a previous pressure ulcer on her right toe but now had a pressure ulcer on her left toe. POA explained R9 had thick nails which could be difficult for the staff to trim. POA explained the facility had informed her on 3/19/26 that a podiatrist was recommended and asked if she could make an appointment, so she made an appointment in a neighboring town. The facility had never asked her if she would be willing to take R9 to see podiatry and was not aware the facility did not have a podiatrist or that the podiatrist at the local clinic was not taking new patients. POA had taken R9 to a pharmacy the first part of the month to have her fitted for a diabetic shoe and they made sure they were the correct size. During an interview on 3/18/26 at 2:47 p.m., physician assistant (PA) stated when she evaluated R9's pressure ulcer on 3/3/26 the wound had been covered with a Duoderm dressing, PA removed the dressing and found the wound to be "very macerated." PA explained that type of dressing was not the appropriate dressing for that type of wound and could have made the skin more fragile, so she changed the wound treatment to calcium alginate and a foam dressing, and recommended to have the certified wound nurse evaluate the wound on next rounds to give additional recommendations. PA explained R9's bilateral hammer toes are very deviated and press on her second toes which contributed to the problem. R9 should have had a lot of lamb's wool or even a special shoe to ensure there was no pressure on her toes. PA further explained she identified R9's left second toe wound as a stage 2 pressure ulcer, however, after reviewing some pressure ulcer resources she should have identified the left second toe wound as a stage 3 pressure ulcer. PA expected staff to notify her immediately if a resident develops any wound to obtain appropriate treatment orders for the wound and treatment order for the wounds should not be changed until the order was obtained. R13 R13's face sheet dated 3/19/26, identified diagnoses	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 8 of Alzheimer's disease, heart failure, chronic obstructive heart disease, chronic kidney disease, and morbid obesity. R13's quarterly MDS dated 1/6/26, identified R12 had intact cognition, no behaviors, no rejection of care, used a wheelchair, dependent to roll left to right/transfers/toileting hygiene, always incontinent of urine, occasionally incontinent of bowel, at risk for pressure ulcers, no unhealed pressure ulcers, no arterial/venous ulcers, had pressure reducing device for chair, not on a turning and repositioning program, not receiving pressure ulcer care. R13's Skin Risk Assessment with Braden dated 1/2/26, identified R13 was a moderate risk for pressure ulcers due to being totally dependent with bed mobility, needing to be lifted mechanically, always incontinent of urine, frequently incontinent of bowel, being slightly limited with sensory perception, often being moist, chairfast, very limited with mobility, adequate nutrition, and potential problem with friction/shear. Additional clinical risk factors of sleeping in recliner and the resident limits number of times incontinent pads can be changed. Interventions of pressure reducing device for chair and bed, application of non-surgical dressing other than feet, air mattress placed on bed, declining to rest in bed for offloading. R13's pressure ulcer risk focus dated 1/3/23, identified R13 was at risk for pressure injury related to impaired mobility and lower extremity pain. Goal of skin to remain intact. Interventions dated 1/3/23 as follows: -Weekly total body skin assessment to be performed and documented by the charge nurse. -Pressure redistribution mattress to bed and cushion in wheelchair to reduce pressure when lying or sitting. -Keep clean and dry as possible. Minimize skin exposure to moisture, use absorbent, skin friendly R13's toileting focus care plan dated 1/3/23, identified R12 had limited ability to toilet self-related to immobility. R12 was incontinent with bladder and continent of bowels. Goal to have no skin breakdown related to bladder incontinence. Interventions as follows: -Inspect condition of perineal area after each incontinent episode. Report any redness, rash, or broken area (dated 1/3/23). -Provide incontinence care as needed as needed (dated 1/3/23). -Toileting: use 3X green briefs at all times with provider recommendation to use figure 8 (type of incontinent product) during the day only. If R13 insists on figure 8 pad at all times, encourage her not to and explain reasons (skin breakdown). Apply figure 8 pad if she continues to insist on double briefing. Bed pan in bed when needed for bowel movement (dated 9/11/25). R13's progress note dated 3/9/26, identified R13 had two non-blanchable (redness on skin that does not turn white when pressed indicating a stage 1 pressure	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 9 injury) areas on bilateral buttocks near the gluteal cleft. Right side measured 2.0 cm x 1.0 cm and left side measured 2.5 cm x 1.5 cm. Barrier cream applied. In review of R13's record there was no indication the physician had been notified nor evident the care plan was revised. R13's Wound Management Detailed Report dated 3/9/26, identified R13 had stage 1 pressure ulcer on right and left buttock that measured 2.0 cm x 1.0 cm, a dark red non-blanchable area R13's Wound Management Detailed Report dated 3/10/26, identified R13 had stage 1 pressure ulcer on left buttock that measured 0.9 cm x 1.2 cm, a dark red non-blanchable area. Area of non-blanchable redness to buttocks that measured 1.6 cm x 5.0 cm. Barrier cream applied by nursing assistants. R13 sits and sleeps in recliner and incontinent of urine. R13 is resistive to frequent brief changes but agreed to rest in bed to pressure offload twice daily for 2 hours each time but will monitor (and may alter time) for what is tolerated by resident. Provider will see on next rounds. R13's progress note dated 3/10/26, included summarization of the wound detail reports and reiterated R13's patterns of sleep habits, resistiveness, and incontinence as well as the ongoing plan as documented. The note also included R13 is non-ambulatory and transfers with use of full body mechanical lift. R13's pressure ulcer/injury focus care plan dated 3/10/26, identified R13 was found to have what appears to be two stage 1 pressure sores on both of her buttocks near the gluteal cleft (deep skin groove between the buttocks). Goal of open are to heal without complications. Interventions dated 3/10/26 as follows: -Notify nurse management staff and provider of open area. Evaluate possible cause of open area on skin and implement interventions to prevent further injury. -Provide treatment to protect skin as advised. Monitor open area for changes and notify provider of changes. -Review current nutritional intake and consider additional protein or calorie supplementation. -Review current skin treatments and adjust as needed. Review current repositioning schedule and adjust as needed. Review current toileting schedule and adjust as needed. R13's occupational therapy (OT) notes dated 3/11/26 identified R13 had an evaluation for repositioning and skin integrity recommendations due to concerns for a new right buttocks that had moderate redness and an eraser size water blister on right medial gluteal fold and decreased upright positioning while seated in her wheelchair with a lateral lean on a worn wheelchair seat cushion seat. OT note identified R13 spends greater that 75 % of day sitting upright in wheelchair or in recliner only repositioning to bed with maximum encouragement. R13's	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 10 progress note dated 3/11/26, identified therapy recommendations for continence management: full body mechanical lift with assist of two to roll in bed to check and change brief every 2-3 hours for skin integrity, cleansing skin and applying barrier cream. Positioning: assist to reposition on side lying two times per day for two hours as tolerated in bed with pillows for management of buttocks skin integrity. Wheelchair: assist to reposition neutral trunk with left lateral support and gel/foam cushion wheelchair cushion. R13's toileting care plan revised on 3/11/26 instructed to use two assist with the full body mechanical lift to assist of two staff to roll in bed to check and change incontinent brief every 2-3 hours for skin integrity, cleansing skin, and applying barrier cream. R13's OT note dated 3/12/26, indicated there had been a previous recommendation for R13 to use a cushion in her recliner, but nursing reported R13 had not been sitting on it while in the recliner for some time and was not sure what happened to it. Recommendations given to have staff place wheelchair foam/gel cushion in recliner when up in recliner for increased skin integrity. R13's care plan was revised on 3/12/26 to have pressure cushion to recliner and wheelchair and revised on 3/13/26 to include assist to reposition side laying every morning as tolerated in bed with pillows for management of buttock skin integrity. R13's physician visit note dated 3/13/26, identified R13 had been evaluated due to skin erosion on buttocks. R13 spends most of her time in either the recliner or wheelchair. Nursing staff attempt to have R13 lie in her bed twice daily to offload pressure off her bottom, but she does not like to do this in the evenings because she falls asleep when she is in bed and then cannot sleep during the night. R13 had a pressure offloading cushion in her wheelchair and is supposed to be moved to her recliner chair whenever she sits in her recliner, however, the cushion was still in her wheelchair during the visit. R13 had a stage 2 pressure injury to the sacral region and order to begin treatment of mixing collagen powder with saline or a &d (an over-the-counter skin protectant) ointment to make a paste and apply this to the rough eroded areas over the coccyx daily. R13's physician orders dated 3/13/26 directed wound care coccyx: mix collagen powder in saline or A&D and make a paste. Apply to macerated rough areas over coccyx and inner buttocks. Cover with Vaseline gauze and change daily or sooner if gauze is soiled or dislodged. Review of R13's March 2026 treatment administration record (TAR) identified a physician order to begin on 3/13/26 for wound care coccyx: mix collagen powder in saline or A&D and make a paste.	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 11 Apply to macerated rough areas over coccyx and inner buttocks. Cover with Vaseline gauze and change daily or sooner if gauze is soiled or dislodged daily. Review of R13's March TAR indicated the wound care was not completed on 3/13/26 and on 3/14/26. R13's OT note dated 3/17/26, identified R13 reported staff had been placing pressure reduction cushion in recliner, however, the cushion had been slipping and OT recommended adding a dycem (antislip) mat under the cushion to prevent slipping. R13's care plan was revised on 3/17/26 to place pressure relieving cushion in wheelchair or recliner (whichever chair R13 is sitting in) with blue dycem underneath. R13 should always have a cushion under her. R13's Wound Management Detailed Report dated 3/18/26, identified stage 1 pressure ulcer on left buttock measuring 1.5 cm x 0.6 cm, healing status stable, denies pain, R13 pressure offloading once daily in the morning and receiving treatment of collagen and A&D ointment. R1's right buttocks identified as a stage 1 pressure ulcer measuring 0.8 cm x 1.5 cm, stable wound with interventions of offloading and collagen/A&D. Left buttocks wound appears larger this week, but this is due to blistered area that is gone leaving behind some scaling peeling skin. The whole area was measured. This appears to be healing well; it is dry and showing no signs of infection. R13 is offloading once daily in the mornings, as the after supper one was stopped per resident preference. R13's previous Wound Management Detailed Reports of the left buttocks did not identify any presence of blisters. R13's OT note dated 3/18/26, identified nursing reported R13's right gluteal fold's water blister had popped last week and dry tissue healing and R13 was repositioning in bed every morning for approximately two hours but only in the afternoon and evening twice in the past week with R13 spending most of time in wheelchair or sleeping in the recliner at night. During an interview on 3/19/26 at 12:09 p.m., physical therapy director (PT-D) stated she had heard R13 had skin breakdown on her buttocks and requested to have occupational therapy (OT) evaluate and treat for wheelchair positioning and pressure reducing measures to attempt to heal the breakdown. On 3/11/26 OT performed an evaluation of R13's wheelchair positioning due to skin integrity concerns for R13's right buttocks/medial gluteal folds. There was an eraser sized water blister on right medial gluteal fold and R13 had decreased upright positioning with moderate left lateral lean. OT also found that R13's wheelchair cushion was "worn". The foam cushion that was in her wheelchair was removed and changed to a "gel foam" cushion to offer increase pressure reduction to her bottom. OT recommendations updated to reflect the following: side lying when	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 12 repositioning with pillows as tolerated every 1-2 hours, management of incontinence/skin integrity to have staff change incontinence product at "moderate wetness." During an interview on 3/18/26 at 1:48 p.m., nursing assistant (NA)-S stated R13 liked to sleep in her recliner, however, since she had a red area on her bottom staff were supposed to have her lay in bed for a couple hours in the morning. NA's put her in bed around 9:30 a.m. until 11:30 a.m. each day, so she can be up in time for the noon meal. NA-S explained R13 sometimes did not like to be changed so she is supposed to wear a "nighttime" green pad at all times to help keep the moisture off here bottom. During a continuous observation on 3/19/26 from 8:30 a.m. until 10:05 a.m., R13 was sitting in her recliner with her feet elevated. Her wheelchair that was in her room had a cushion on the seat. During the continuous observation, no staff entered R13's room to offer repositioning or to check R13's incontinent brief. During an interview on 3/19/26 at 9:04 a.m., RN-F stated at times R13 did refuse to reposition, however, was unaware if staff had offered R13 to lay in bed today (3/19/26). Yesterday R13 refused repositioning so RN-F provided R13 with education on the risks of skin break down as a result however had not documented had not documented the education in R13's record. During an interview on 3/19/26 at 9:44 a.m., R13 was sitting in her recliner. R13 stated she had been informed she had a sore on "bottom"; however, staff had not given details on what the sore was or what it looked like. R13 reported right now she was not sitting on a cushion, and she had been sitting in the recliner since the evening the night before. R13 had not been checked or changed during the night shift and did not recall being offered to lay in bed or be changed. R13 explained staff had talked to her about her sore on her bottom and recommended she lay in bed to get off her bottom at least a couple of times a day for a few hours, so she agreed that after her am meal she would lay in bed at around 9:30 a.m. until 11:30 a.m., so she could be up in time for lunch. R13 stated, "see staff are late getting me in bed today." However, no one from the dayshift had offered to reposition her either, so she was sitting since last night. R13 explained she has refused to lay in bed at times, but it was at times when she was going to attend things like activities that she did not want to miss. When she did tell staff she did not want to reposition, staff did not offer a later time. "I don't want to get a bedsore and want to make sure it does not get worse, but staff need to make sure they are getting me changed and put me in bed during the correct times then." During an observation and interview on 3/19/26 at 10:05 a.m., NA-S entered R13's room and explained to R13 she	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 13 needed to get her ready for the day. NA-S started with dressing R13's upper body. NA-S explained to R13 she should have been in "a lot sooner" to get her into bed, but just "did not have time." NA-S stated R13 was supposed to lay in her bed around 9:30 a.m. until 11:30 a.m. to get off the "sore on her bottom." NA-T then entered R13's room with a full body mechanical lift, put the sling under R13, and lifted her off the recliner revealing no pressure reduction cushion had been placed. A blue sheet of dycem that she had been sitting on was stuck to the back of R13's thighs that NA-D removed. NA-D stated R13 should have not been sitting directly on the dycem and it was supposed to be under the seat cushion, however, the cushion was still on her wheelchair seat. NA-S stated the night aide had told her she was not aware the pressure reduction cushion was supposed to be moved from R13's wheelchair seat to her recliner. R13 was then lowered into her bed, NAs turned her on her left side the removed her incontinent brief. NA-S explained R13 was wearing the wrong type of brief, and she should have been in a "green/overnight" brief, but the facility had run out of so staff used a daytime brief which was "completely saturated." NA-S then began to perform peri care to R13's buttocks which had a thick layer of a white substance. NA-S stated someone had placed "Z-guard (which was a kind of barrier cream) to R13's bottom, but it was applied "too thick." As NA-S cleaned R13's bottom there was one open wound on both the right and left buttocks that were macerated. RN-F then entered R13's room and explained R13's bottom "looked worse" since the last time she had seen it. RN-F described R13's left buttocks wound as a stage 2 pressure ulcer measuring 2.0 cm x 1.9 cm with maceration around the wound: RN-F described R13's right buttocks wound as a stage 2 pressure ulcer measuring 2.5 cm x 1.5 cm with maceration around the wound. RN-F further explained wounds worsened because R13 was not sitting on her cushion in her recliner and not having the correct brief exposed the skin to excess moisture. R13's progress note dated 3/19/26 at 3:19 p.m. was identified as a late entry for 3/18/26 at 7:30 p.m. indicated R13 refused to offload into bed on p.m. shift. R13 refused to have cushion on in wheelchair moved to recliner. Stated it was "uncomfortable" how it positions her in the recliner and she does not like that "thing". R13 was provided education on importance of offloading in bed and using the cushion to take some pressure off her bottom to help the skin from further breakdown. R13's record did not identify R13 was reapproached and offered to reposition or apply cushion in her recliner after 7:30 p.m. R13's TAR reviewed 3/1/26	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 14 through 3/18/26, included an order that R13 agreed to get out of chair once per night to have her brief changed. R13 understands this requires getting placed in bed for the brief change and then placed back in her recliner. R13's TAR identified R13 refused 15 times; R13's TAR identified on 3/18/26 this was refused at 11:32 p.m. Review of R13's record when R13 refused there was no documentation of re-approaching to offer reposition/toileting and no documentation of education provided of risk of skin breakdown (except the education documented in the late entry progress note on 3/19/26 for 3/18/26 at 7:30 p.m.) During an interview on 3/18/26 at 1:59 p.m., LPN-A stated if R13 was seated in her recliner she was supposed to have a gel cushion underneath her, however, there are many times staff forget to place the cushion in her recliner before she sits in it and need to have "constant reminders to staff." LPN-A explained R13 will refuse to be repositioned at times, however, if you reapproach later, she will comply. During an interview on 3/19/26 at 12:45 p.m., RN-CM stated she has assessed R13's right and left buttocks wounds and they had deteriorated from a stage 1 from the assessment that was completed on 3/18/26 to both the right and left buttocks wounds being stage 2 pressure ulcers now and is requesting treatment orders for the wounds. RN-CM stated they had a care conference with R13, and she has agreed to lay in bed now for the night versus only spending the night in her recliner. During an interview on 3/19/26 at 12:18 p.m., DON stated R13's right and left buttocks had worsened since being assessed on 3/18/25 and are currently two stage 2 pressure ulcers. DON further explained R13 should not have been placed directly on the dycem and the pressure reducing cushion place in her recliner should have been placed in bed for two hours after breakfast like her pressure ulcer prevention intervention on her care plan identified to. R13 should have also had incontinence care every 2 hours to prevent her skin being subjected to being wet for an extended period of time and this put her at risk for further breakdown. During an interview on 3/20/26 at 4:23 p.m., incontinence product representative (INC-R) stated the green incontinence products are meant for nighttime due to the increase absorbance of the pad to keep moisture away from a resident's skin. If a resident's care plan identified that they were to use the green pad (which would be the extended wear briefs) at all times per recommendations it was probably due to the residents not wanting to allow products to change often. INC-R explained if a resident were to be place in a daytime product and if the product was not changed for an extended period of time and allowed the indicator of	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
F0686 SS = G	Continued from page 15 the brief to go over 75% then that would put the resident at risk for pressure ulcers. During an interview on 3/20/26 at 6:25 p.m., medical director (MD) stated she expected when staff identified any change in a resident skin integrity that would come from pressure to implement interventions immediately such as repositioning, call the physician/physician assistant to get treatment orders for the wound to promote healing, and to implement the care plan interventions that are in place for residents at risk for pressure ulcers. Review of the facility's Skin Integrity Policy dated 2/26, identified it was the purpose to ensure that the resident does not develop pressure ulcers unless clinically unavoidable. The facility was committed to providing care and services consistent with professional standards of practice to: -Promote the prevention of pressure ulcer/injury development. -Promote the healing of existing pressure ulcers/injury. -Prevent development of additional pressure ulcers/injury. Prevention of skin injury: -Adhere to client's individualized skin and/or wound management plan. -Report to case manager and if appropriate the provider of any abnormalities to the resident's skin or wound areas and document in a progress note. -Notify family/designee of abnormalities. Risk Assessment Process: -All residents will be screened by a registered nurse upon admission, weekly for the first four weeks, monthly, and with change of condition for pressure ulcer risk/tissue tolerance by using the Skin Care Assessment with Braden Scale. -A head to toe skin inspection on all residents will be completed upon admission, daily with cares by caregivers, and weekly by a licensed nurse in alignment with bathing. With new findings documented in the resident's electronic health record on the appropriate event as well as charge nurse with team members to review root causes and address further interventions to prevent skin alterations from happening again. New findings will be reported to the physician/practitioner and family/designee. -For residents that have a wound present, a comprehensive wound assessment will be completed by registered nurse every week. Treatment/Management -The practitioner will order pertinent wound treatment, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings and application of topical agents. -The practitioner will help identify medical interventions related to wound management. -Wound consultation will be sought as needed.	F0686		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 3/18/26, 3/19/26 an onsite revisit was completed to follow up on licensing orders issued from the survey exited 2/9/26. The correction order(s) issued at 900 were NOT corrected. The uncorrected order(s) will remain in effect and will be reviewed at the next onsite visit. The order(s) will be reviewed for possible penalty assessment.</p>	20000		

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20000	<p>Continued from page 1 The complaint H54291720C (2694230), which was found to be out of compliance and issued at (900) at the time of the survey, remained out of compliance.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	20000		
20900	<p>Rehab - Pressure Ulcers</p> <p>CFR(s): MN Rule 4658.0525 Subp. 3</p> <p>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:</p>	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	<p>Continued from page 2</p> <p>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and</p> <p>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 2 of 3 residents (R9, R13) reviewed for pressure ulcers. /This caused actual harm to R9 who developed an avoidable stage 3 pressure ulcer on her left second toe.</p> <p>Findings include: R9's face sheet dated 3/19/26, identified diagnoses of Alzheimer's disease and history of neoplasm (cancer) of the skin. R9's quarterly Minimum Data Set (MDS) dated 3/3/26, indicated R9 had severe cognitive impairment, no behaviors, needed partial/moderate assistance for putting on/taking off footwear, independent with transfers and ambulation. R9 was not at risk for pressure ulcers but had one stage 2 pressure ulcer, no venous or arterial ulcers, received pressure ulcer care, and no application of dressings to feet. R9 Braden Scale Assessment (assessment tool used to identify the risk for pressure ulcers) dated 2/27/26, indicated R9 was not at risk for pressure ulcers, however identified R9 had pressure injury on right toe. R9's Activity of Daily Living (ADL) focus care plan for bathing dated 9/24/24, identified R9 had limited ability to complete ADLs related to Alzheimer's Disease. The intervention dated 2/13/26 directed staff to clip resident's toenails weekly with shower/bath. R9's Pressure Ulcer/Injury focus care plan dated 9/25/24, identified R9 was at low risk for skin breakdown and skin is intact. Interventions included the following -Monitor left great hammer toe for breakdown. Monitor corn on 2nd toe right foot. Cover areas with band-aides for protection (dated 12/20/24). -Monitor skin with cares and observe for changes. Notify charge nurse with concerns consult provider if concerns arise (dated 9/25/24). -Weekly total body skin assessment to be</p>	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 3 performed by charge nurse (dated 9/25/24). Review of R9's record between 1/29/26 through 2/9/26 identified R9 had a history of long thick toenails causing a stage 2 pressure on her right second toe that began on 1/29/26 and was resolved on 3/3/26. R9's progress note dated 2/16/26, identified R9 had a tub bath and toenails unable to be trimmed due to being very thick and needed a podiatry appointment. In review of R9's record between 2/16/26 through 2/28/26 there was no indication the long toenails were trimmed in accordance to the intervention dated 2/13/26 nor evident the great toe was monitored according to the intervention dated 12/20/24. R9's progress note dated 3/1/26, identified R9 had an area on her left foot that "seems to be bothering her." Area assessed and placed foam pad with lamb's wool as well. Will have clinical manager follow up tomorrow. Although the progress note identified the area was assessed, R9's record did not include a comprehensive assessment of the bothersome area on R9's left foot. In addition, there was no indication the usage of a foam dressing was transcribed into the treatment orders nor evident the physician was notified. During an interview on 3/18/26 at 3:04 p.m., DON stated she had been working as the charge nurse on 3/1/26 when R9 began to complain about pain in her left foot between her left great and second toe. DON removed R9's shoe and observed a painful, pink/red area on the left second toe. DON explained she had not completed a comprehensive assessment of the pink/red area, such as measuring the redness, and determining if the areas were blanchable or non-blanchable. DON was aware R9 had thick toenails, a hammer toe on her left great toe and a previous pressure ulcer on her right second toe also caused by the hammer toe and long thick nails, but "did not think the redness was much of anything" until she heard it had become an open wound the next day. During a follow up interview on 3/19/26 at 12:18 p.m., DON stated when she identified the area on R9's left foot on 3/1/26 she had a sharp corner/hook to her left great toenail that was pressing directly in the pink/red/painful area, so she trimmed that sharp corner of R9's nail, but not the entire nail to relieve pressure to the left second toe. DON explained she placed a foam pad between R9's left great toe and second toe and thought that would help relieve the pressure. R9's progress note dated 3/2/26, identified R9 had a tub bath and an open area was observed on R9's left 2nd toe. Area cleansed and applied a Duoderm (non-permeable dressing that seal wounds from air to keep wound moist) dressing along with lambswool. R9's left 2nd toe was swollen and red with no drainage. Situation, Background, Assessment, Recommendation (SBAR-physician communication) made out	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 4 for evaluation for possible infection. In review of R9's record there was no indication the Duoderm treatment was transcribed into the treatment orders. R9's SBAR physician referral form dated 3/2/26, identified R9 had a suspected skin and soft tissue concern. Area had been cleansed and dressing applied. R9 may need antibiotic for infection due to being red and painful. The form did not identify a Duoderm dressing had been applied, and no other wound characteristics such as measurements, drainage, color, or pain had been included. During an interview on 3/18/26 at 1:59 p.m., licensed practical nurse (LPN)-A stated she was the charge nurse 3/2/26 that first observed R9's open wound on her left second toe during a bath skin check. LPN-A stated when she first observed the open area between R9's left great toe and second toe it appeared to be a "skin tear", but after cleaning the wound it appeared to be a pressure injury. R9's toenails were very thick, and her left great toenail was pressing directly on where the open wound was on the left second toe. LPN-A explained she had not notified the physician of the open area and had only handed the SBAR to the nurse manager to give the physician on rounds. The facility's Long Term Care Standing Orders dated 6/25/24, that included orders for wound treatments was reviewed in conjunction with the progress note 3/2/26. The Standing Orders did not include nor direct the usage of a Duoderm as a treatment option. The Standing orders directed for "superficial skin redness/open areas: may apply collagen powder/A&D mix daily until healed. If not improving after one week of treatment, notify the provider" and "For any suspected pressure injury, refer to provider for orders." R9's Skin Integrity Incident Report dated 3/2/26 at 1:15 p.m., identified R9 had redness/peeling skin on left second toe that measured 0.5 centimeters (cm) x 0.4 cm, no depth, no active bleeding, smooth wound edges, mild pain, fragile skin, possible contributing factors of "fit of shoe." Interventions of cleanse with soap and water, dressing applied. Further identified "needs toenails trimmed and need for new shoes." Investigation summary dated 3/5/26 identified the great toenail caused breakdown of R9's 2nd toe. R9's physician assistant (PA) nursing home visit note dated 3/3/26, identified R9 had been seen for a pressure ulcer on the left second toe that was reported the day prior (3/2/26). R9 did not verbalize pain, but on examination of the left second toe it was painful. R9 had onychomycotic (a common fungal infection of the fingernails or toenails, causing them to become thickened) with lateral deviation of the left great toe which seems to be placing pressure on the medial (away from the midline) distal (farther away from the trunk of the body) of the	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 5 left second toe. There was an open wound on the distal left second toe with a Duoderm dressing overlying on it. The skin underneath the dressing was moist and macerated (skin that appears white, soggy, and wrinkled due to prolonged moisture to excessive moisture). Duoderm dressing seemed to be too occlusive and "causing too much moisture so this should be stopped." Order to apply a small amount of calcium alginate (highly absorbent dressing material derived from brown seaweed) to the opening of the left second toe and cover with moleskin (a thick, durable adhesive cotton fabric used to prevent and treat blisters, corn, and chafing by reducing friction) if possible or perhaps a band aid wrapped around the toe to be changed daily. Should have the outside wound consultant examine this as well and give their recommendations. No signs of cellulitis noted. Physician order dated 3/3/26 included left 2nd toe treatment directed to cleanse left second toe with soap and water, add calcium alginate in the opening, cover with moleskin or band-aid. R9's Wound Management Detailed Report dated 3/3/26, identified "other wound" on left 2nd inner toe between 1st and second toe, measuring 0.5 cm x 0.2 cm with surrounding skin red, with slight maceration at wound edges, no drainage. The report did not identify the type of wound and indicated the wound status as stable. R9's care plan was revised on 3/4/26 to include the following interventions: -Toenails to be inspected when dressing and trimmed on bath day and as needed to assure no pressure points to surrounding toes. Notify charge nurse with any concerns. -Monitor left second toe for further breakdown and notify nurses or clinical manager of any changes (dated 3/4/26). Review of R9's Treatment Administration Record (TAR) from 2/1/26 through 3/18/26 included an order had been added on 3/4/26 to assess and clip toenails weekly with bath and as needed every Thursday. The TAR on 3/5/26 had a check marked box indicating the task was completed. However, the TAR indicated on 3/12/26, the box was not checked indicating R9's toenails had not been assessed nor clipped according to the order and the care plan. R9's progress note dated 3/6/26 at 12:08 p.m., identified R9 had been seen by wound consultant. The note documented while taking R9's shoes off, it was noted that her socks were balled up in the front of the shoe. R9 had a full thickness divot/opening (no measurements were included). The note indicated the wound consultant recommended adding collagen to the treatment (a dressing that reduces wound fluid to promote tissue regeneration) to help fill the wound and avoid "osteo". The note also included orders to treat the wound with "daily collagen and band aide, lambs wool weave" R9 was fitted for new shoes and awaiting delivery. The note also included	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 6 care plan updated to have staff check daily to make sure resident is not putting socks in toes of shoes. Review of R9's care plan dated 3/6/26 identified it had been revised to include the aforementioned intervention pertaining to the socks. However, there was no indication the physician had been notified of the wound consultant's assessment and treatment recommendations of adding collagen so that an order could be obtained. Physician order dated 3/6/26 included wound care to left second toe to cleanse with soap and water, add calcium alginate in the opening, cover with moleskin or band aid, document wound conditions in nursing progress notes. R9's physician orders did not include the daily collagen as per the wound consultant's recommendation. R9's March TAR between 3/6/26 through 3/19/26 included the physician order as written. The TAR indicated the wound treatment was completed as prescribed without the collagen. R9's Wound Management Detailed Report dated 3/6/26, identified R9 had a stage 3 pressure ulcer on the left 2nd inner toe between first and second toe with measurements of 0.5 cm x 0.2 cm. The wound had light serosanguinous (pinkish watery) drainage, no odor, no tunneling, edges attached to base with well-defined wound edges. Although the report identified the ulcer as a stage 3, the report identified that depth could not be measured but did not classify the wound as unstageable. Review of R9's March TAR identified on 3/6/26 an order had been added to monitor toes on bilateral feet area of skin alteration for changes. If area appears larger in size or skin breaks open, notify charge nurse/nurse manager. Monitor and measure with weekly skin checks until healed. The TAR on 3/12/26 indicated the box was not checked indicating the task was not completed. During an observation and interview on 3/18/26 at 11:30 a.m., registered nurse (RN)-F was performing wound care on R9's left second toe. RN-F removed R9's shoe/sock. R9 had a band-aid on her left second toe along with lamb's wool weaved around her left great and second toe. RN-F then removed the band aide off her left second toe that had a piece of foam and calcium alginate under the band aid. R9 complained of pain in the second toe with the removal of the band-aid. R9's great toe had thick nails that directly pressed against a circular scabbed area on her left second toe. RN-F stated the scabbed area was where R9's stage 3 pressure ulcer was that was caused from her left great toe pressing against her toe. RN-F measured the wound at 0.4 cm x 0.2 cm with no depth. RN-F explained the wound had improved since she had last seen it and thought maybe the treatment could be changed to just a band-aid, but would have to check with the RN-CM. During an interview on 3/18/26 at 3:21 p.m., registered nurse case manager (RN-CM) indicated	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 7 RN-F gave her verbal report of R9's wound status and referenced the order in the electronic health record (EHR) to change R9's left toe treatment to a band-aid only to change daily, however, RN-CM had not assessed the wound nor called the physician prior to changing the order. RN-CM explained the certified wound nurse had evaluated R9's left second toe wound on 3/6/26 and stated it was a "full thickness wound" from pressure from the left great toe. RN-CM stated the wound nurse had not staged the wound, so she referenced wound material and then identified R9's wound as a stage 3 pressure ulcer. RN-CM explained the wound nurse gave recommendation to add collagen to the opening in the wound, however, RN-CM had not notified the physician to obtain the order to add collagen. R9's Wound Management Detailed Report dated 3/9/26, identified stage 3 pressure ulcer with measurements of 0.5 cm x 0.2 cm (depth could not be measured), well defined wound edges, skin surrounding wound was pink/normal, area surrounding wound appears less red, no signs of infection, stable healing status. Review of R9's Treatment Administration Record (TAR) included an order had been added on 3/4/26 to assess and clip toenails weekly with bath and as needed every Thursday. The TAR on 3/5/26 had a check marked box indicating the task was completed. During an interview on 3/19/26 at 1:00 p.m., trained medication aide (TMA)-A stated that normally the bath aide would trim nails on residents that were not diabetic or on blood thinners, but R9's nails were so thick and did not have the right tools. TMA -A explained staff had been telling management that R9 needed to see a podiatrist for some time now. During a follow up interview on 3/19/26 at 11:51 a.m., LPN-A indicated she had written the progress note on 2/16/26 about R9 needing to see a podiatrist. LPN-A had notified RN-CM and infection control registered nurse (IC-RN) on 2/16/26 that she was not able to trim R9's thick toenails during her bath and that R9 "needed to see a podiatrist to get her nails trimmed or her left foot was going to develop a pressure sore too." During an interview on 3/19/26 at 3:22 p.m., RN-CM stated she did not read/review resident progress notes to identify care area concerns on a daily basis. RN-CM explained she had not been aware that on 2/16/26 R9's nails were not able to be trimmed by the nursing staff. RN-CM stated the facility was unable to get R9 into the podiatrist due to not having a podiatrist available, however, had not asked R9's POA to see if she could get her into an outside clinic to have her toenail care done. During an interview on 3/19/26 at 4:30 p.m., DON stated "R9 is finally getting a podiatry appointment." DON explained R9's POA made an appointment at an outside clinic to get her toenails done. During an interview on 3/19/26	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 8 at 3:32 p.m., director of nursing (DON) stated it was her expectation that the nurse managers read/review the progress notes daily to identify care area issues in a timely manner, however, she also did not read/review the progress notes on a daily basis, including the progress note on 2/16/26 that identified that R9 needed a podiatry appointment. The DON relied on the nurse managers to perform the task. DON further explained if the progress notes had been reviewed on a regular basis, then it would have been identified that the nurses were not able to trim R9's toenails so the facility could have ensured R9's toenails got trimmed to possibly prevent R9's pressure ulcer on her left second toe. During an interview on 3/19/26 at 1:06 p.m., registered nurse certified wound nurse consultant (RN-WN) stated their company provided wound support for the facility. RN-WN stated the representative would come to the facility to round with the nurses to assist with the wound assessment and provide supplies. They do not provide an assessment of the wounds but give support if questions and will order covered wound supplies for needed treatment. RN-WN further explained that the consulting nurse would give verbal recommendations and send a summary to the facility of recommendations, then the facility would need to reach out to their physician to write prescriptions for the recommended treatment orders. During return phone call on 3/20/26 at 1:56 p.m., R9's power of attorney (POA) stated she had become aware that R9 had a previous pressure ulcer on her right toe but now had a pressure ulcer on her left toe. POA explained R9 had thick nails which could be difficult for the staff to trim. POA explained the facility had informed her on 3/19/26 that a podiatrist was recommended and asked if she could make an appointment, so she made an appointment in a neighboring town. The facility had never asked her if she would be willing to take R9 to see podiatry and was not aware the facility did not have a podiatrist or that the podiatrist at the local clinic was not taking new patients. POA had taken R9 to a pharmacy the first part of the month to have her fitted for a diabetic shoe and they made sure they were the correct size. During an interview on 3/18/26 at 2:47 p.m., physician assistant (PA) stated when she evaluated R9's pressure ulcer on 3/3/26 the wound had been covered with a Duoderm dressing, PA removed the dressing and found the wound to be "very macerated." PA explained that type of dressing was not the appropriate dressing for that type of wound and could have made the skin more fragile, so she changed the wound treatment to calcium alginate and a foam dressing, and recommended to have the certified wound nurse	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 9 evaluate the wound on next rounds to give additional recommendations. PA explained R9's bilateral hammer toes are very deviated and press on her second toes which contributed to the problem. R9 should have had a lot of lamb's wool or even a special shoe to ensure there was no pressure on her toes. PA further explained she identified R9's left second toe wound as a stage 2 pressure ulcer, however, after reviewing some pressure ulcer resources she should have identified the left second toe wound as a stage 3 pressure ulcer. PA expected staff to notify her immediately if a resident develops any wound to obtain appropriate treatment orders for the wound and treatment order for the wounds should not be changed until the order was obtained. R13 R13's face sheet dated 3/19/26, identified diagnoses of Alzheimer's disease, heart failure, chronic obstructive heart disease, chronic kidney disease, and morbid obesity. R13's quarterly MDS dated 1/6/26, identified R12 had intact cognition, no behaviors, no rejection of care, used a wheelchair, dependent to roll left to right/transfers/toileting hygiene, always incontinent of urine, occasionally incontinent of bowel, at risk for pressure ulcers, no unhealed pressure ulcers, no arterial/venous ulcers, had pressure reducing device for chair, not on a turning and repositioning program, not receiving pressure ulcer care. R13's Skin Risk Assessment with Braden dated 1/2/26, identified R13 was a moderate risk for pressure ulcers due to being totally dependent with bed mobility, needing to be lifted mechanically, always incontinent of urine, frequently incontinent of bowel, being slightly limited with sensory perception, often being moist, chairfast, very limited with mobility, adequate nutrition, and potential problem with friction/shear. Additional clinical risk factors of sleeping in recliner and the resident limits number of times incontinent pads can be changed. Interventions of pressure reducing device for chair and bed, application of non-surgical dressing other than feet, air mattress placed on bed, declining to rest in bed for offloading. R13's pressure ulcer risk focus dated 1/3/23, identified R13 was at risk for pressure injury related to impaired mobility and lower extremity pain. Goal of skin to remain intact. Interventions dated 1/3/23 as follows: -Weekly total body skin assessment to be performed and documented by the charge nurse. -Pressure redistribution mattress to bed and cushion in wheelchair to reduce pressure when lying or sitting. -Keep clean and dry as possible. Minimize skin exposure to moisture, use absorbent, skin friendly R13's toileting focus care plan dated 1/3/23, identified R12 had limited ability to toilet self-related to immobility. R12 was incontinent with bladder and	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 10 continent of bowels. Goal to have no skin breakdown related to bladder incontinence. Interventions as follows: -Inspect condition of perineal area after each incontinent episode. Report any redness, rash, or broken area (dated 1/3/23). -Provide incontinence care as needed as needed (dated 1/3/23). -Toileting: use 3X green briefs at all times with provider recommendation to use figure 8 (type of incontinent product) during the day only. If R13 insists on figure 8 pad at all times, encourage her not to and explain reasons (skin breakdown). Apply figure 8 pad if she continues to insist on double briefing. Bed pan in bed when needed for bowel movement (dated 9/11/25). R13's progress note dated 3/9/26, identified R13 had two non-blanchable (redness on skin that does not turn white when pressed indicating a stage 1 pressure injury) areas on bilateral buttocks near the gluteal cleft. Right side measured 2.0 cm x 1.0 cm and left side measured 2.5 cm x 1.5 cm. Barrier cream applied. In review of R13's record there was no indication the physician had been notified nor evident the care plan was revised. R13's Wound Management Detailed Report dated 3/9/26, identified R13 had stage 1 pressure ulcer on right and left buttock that measured 2.0 cm x 1.0 cm, a dark red non-blanchable area R13's Wound Management Detailed Report dated 3/10/26, identified R13 had stage 1 pressure ulcer on left buttock that measured 0.9 cm x 1.2 cm, a dark red non-blanchable area. Area of non-blanchable redness to buttocks that measured 1.6 cm x 5.0 cm. Barrier cream applied by nursing assistants. R13 sits and sleeps in recliner and incontinent of urine. R13 is resistive to frequent brief changes but agreed to rest in bed to pressure offload twice daily for 2 hours each time but will monitor (and may alter time) for what is tolerated by resident. Provider will see on next rounds. R13's progress note dated 3/10/26, included summarization of the wound detail reports and reiterated R13's patterns of sleep habits, resistiveness, and incontinence as well as the ongoing plan as documented. The note also included R13 is non-ambulatory and transfers with use of full body mechanical lift. R13's pressure ulcer/injury focus care plan dated 3/10/26, identified R13 was found to have what appears to be two stage 1 pressure sores on both of her buttocks near the gluteal cleft (deep skin groove between the buttocks). Goal of open are to heal without complications. Interventions dated 3/10/26 as follows: -Notify nurse management staff and provider of open area. Evaluate possible cause of open area on skin and implement interventions to prevent further injury. -Provide treatment to protect skin as advised. Monitor open area for changes and notify provider of	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 11 changes. -Review current nutritional intake and consider additional protein or calorie supplementation. -Review current skin treatments and adjust as needed. Review current repositioning schedule and adjust as needed. Review current toileting schedule and adjust as needed. R13's occupational therapy (OT) notes dated 3/11/26 identified R13 had an evaluation for repositioning and skin integrity recommendations due to concerns for a new right buttocks that had moderate redness and an eraser size water blister on right medial gluteal fold and decreased upright positioning while seated in her wheelchair with a lateral lean on a worn wheelchair seat cushion seat. OT note identified R13 spends greater than 75 % of day sitting upright in wheelchair or in recliner only repositioning to bed with maximum encouragement. R13's progress note dated 3/11/26, identified therapy recommendations for continence management: full body mechanical lift with assist of two to roll in bed to check and change brief every 2-3 hours for skin integrity, cleansing skin and applying barrier cream. Positioning: assist to reposition on side lying two times per day for two hours as tolerated in bed with pillows for management of buttocks skin integrity. Wheelchair: assist to reposition neutral trunk with left lateral support and gel/foam cushion wheelchair cushion. R13's toileting care plan revised on 3/11/26 instructed to use two assist with the full body mechanical lift to assist of two staff to roll in bed to check and change incontinent brief every 2-3 hours for skin integrity, cleansing skin, and applying barrier cream. R13's OT note dated 3/12/26, indicated there had been a previous recommendation for R13 to use a cushion in her recliner, but nursing reported R13 had not been sitting on it while in the recliner for some time and was not sure what happened to it. Recommendations given to have staff place wheelchair foam/gel cushion in recliner when up in recliner for increased skin integrity. R13's care plan was revised on 3/12/26 to have pressure cushion to recliner and wheelchair and revised on 3/13/26 to include assist to reposition side laying every morning as tolerated in bed with pillows for management of buttock skin integrity. R13's physician visit note dated 3/13/26, identified R13 had been evaluated due to skin erosion on buttocks. R13 spends most of her time in either the recliner or wheelchair. Nursing staff attempt to have R13 lie in her bed twice daily to offload pressure off her bottom, but she does not like to do this in the evenings because she falls asleep when she is in bed and then cannot sleep during the night. R13 had a pressure offloading cushion in her wheelchair and is supposed to be moved to her recliner chair whenever she	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 12 sits in her recliner, however, the cushion was still in her wheelchair during the visit. R13 had a stage 2 pressure injury to the sacral region and order to begin treatment of mixing collagen powder with saline or a &d (an over-the-counter skin protectant) ointment to make a paste and apply this to the rough eroded areas over the coccyx daily. R13's physician orders dated 3/13/26 directed wound care coccyx: mix collagen powder in saline or A&D and make a paste. Apply to macerated rough areas over coccyx and inner buttocks. Cover with Vaseline gauze and change daily or sooner if gauze is soiled or dislodged. Review of R13's March 2026 treatment administration record (TAR) identified a physician order to begin on 3/13/26 for wound care coccyx: mix collagen powder in saline or A&D and make a paste. Apply to macerated rough areas over coccyx and inner buttocks. Cover with Vaseline gauze and change daily or sooner if gauze is soiled or dislodged daily. Review of R13's March TAR indicated the wound care was not completed on 3/13/26 and on 3/14/26. R13's OT note dated 3/17/26, identified R13 reported staff had been placing pressure reduction cushion in recliner, however, the cushion had been slipping and OT recommended adding a dycem (antislip) mat under the cushion to prevent slipping. R13's care plan was revised on 3/17/26 to place pressure relieving cushion in wheelchair or recliner (whichever chair R13 is sitting in) with blue dycem underneath. R13 should always have a cushion under her. R13's Wound Management Detailed Report dated 3/18/26, identified stage 1 pressure ulcer on left buttock measuring 1.5 cm x 0.6 cm, healing status stable, denies pain, R13 pressure offloading once daily in the morning and receiving treatment of collagen and A&D ointment. R1's right buttocks identified as a stage 1 pressure ulcer measuring 0.8 cm x 1.5 cm, stable wound with interventions of offloading and collagen/A&D. Left buttocks wound appears larger this week, but this is due to blistered area that is gone leaving behind some scaling peeling skin. The whole area was measured. This appears to be healing well; it is dry and showing no signs of infection. R13 is offloading once daily in the mornings, as the after supper one was stopped per resident preference. R13's previous Wound Management Detailed Reports of the left buttocks did not identify any presence of blisters. R13's OT note dated 3/18/26, identified nursing reported R13's right gluteal fold's water blister had popped last week and dry tissue healing and R13 was repositioning in bed every morning for approximately two hours but only in the afternoon and evening twice in the past week with R13 spending most of time in wheelchair or sleeping in the recliner at night. During an interview	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 13 on 3/19/26 at 12:09 p.m., physical therapy director (PT-D) stated she had heard R13 had skin breakdown on her buttocks and requested to have occupational therapy (OT) evaluate and treat for wheelchair positioning and pressure reducing measures to attempt to heal the breakdown. On 3/11/26 OT performed an evaluation of R13's wheelchair positioning due to skin integrity concerns for R13's right buttocks/medial gluteal folds. There was an eraser sized water blister on right medial gluteal fold and R13 had decreased upright positioning with moderate left lateral lean. OT also found that R13's wheelchair cushion was "worn". The foam cushion that was in her wheelchair was removed and changed to a "gel foam" cushion to offer increase pressure reduction to her bottom. OT recommendations updated to reflect the following: side lying when repositioning with pillows as tolerated every 1-2 hours, management of incontinence/skin integrity to have staff change incontinence product at "moderate wetness." During an interview on 3/18/26 at 1:48 p.m., nursing assistant (NA)-S stated R13 liked to sleep in her recliner, however, since she had a red area on her bottom staff were supposed to have her lay in bed for a couple hours in the morning. NA's put her in bed around 9:30 a.m. until 11:30 a.m. each day, so she can be up in time for the noon meal. NA-S explained R13 sometimes did not like to be changed so she is supposed to wear a "nighttime" green pad at all times to help keep the moisture off here bottom. During a continuous observation on 3/19/26 from 8:30 a.m. until 10:05 a.m., R13 was sitting in her recliner with her feet elevated. Her wheelchair that was in her room had a cushion on the seat. During the continuous observation, no staff entered R13's room to offer repositioning or to check R13's incontinent brief. During an interview on 3/19/26 at 9:04 a.m., RN-F stated at times R13 did refuse to reposition, however, was unaware if staff had offered R13 to lay in bed today (3/19/26). Yesterday R13 refused repositioning so RN-F provided R13 with education on the risks of skin break down as a result however had not documented had not documented the education in R13's record. During an interview on 3/19/26 at 9:44 a.m., R13 was sitting in her recliner. R13 stated she had been informed she had a sore on "bottom"; however, staff had not given details on what the sore was or what it looked like. R13 reported right now she was not sitting on a cushion, and she had been sitting in the recliner since the evening the night before. R13 had not been checked or changed during the night shift and did not recall being offered to lay in bed or be changed. R13 explained staff had talked to her about her sore on her bottom and recommended she lay in bed to get off her bottom at least a couple of times a day for a few	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	<p>Continued from page 14</p> <p>hours, so she agreed that after her am meal she would lay in bed at around 9:30 a.m. until 11:30 a.m., so she could be up in time for lunch. R13 stated, "see staff are late getting me in bed today." However, no one from the dayshift had offered to reposition her either, so she was sitting since last night. R13 explained she has refused to lay in bed at times, but it was at times when she was going to attend things like activities that she did not want to miss. When she did tell staff she did not want to reposition, staff did not offer a later time. "I don't want to get a bedsore and want to make sure it does not get worse, but staff need to make sure they are getting me changed and put me in bed during the correct times then."</p> <p>During an observation and interview on 3/19/26 at 10:05 a.m., NA-S entered R13's room and explained to R13 she needed to get her ready for the day. NA-S started with dressing R13's upper body. NA-S explained to R13 she should have been in "a lot sooner" to get her into bed, but just "did not have time." NA-S stated R13 was supposed to lay in her bed around 9:30 a.m. until 11:30 a.m. to get off the "sore on her bottom." NA-T then entered R13's room with a full body mechanical lift, put the sling under R13, and lifted her off the recliner revealing no pressure reduction cushion had been placed. A blue sheet of dycem that she had been sitting on was stuck to the back of R13's thighs that NA-D removed. NA-D stated R13 should have not been sitting directly on the dycem and it was supposed to be under the seat cushion, however, the cushion was still on her wheelchair seat. NA-S stated the night aide had told her she was not aware the pressure reduction cushion was supposed to be moved from R13's wheelchair seat to her recliner. R13 was then lowered into her bed, NAs turned her on her left side the removed her incontinent brief. NA-S explained R13 was wearing the wrong type of brief, and she should have been in a "green/overnight" brief, but the facility had run out of so staff used a daytime brief which was "completely saturated." NA-S then began to perform peri care to R13's buttocks which had a thick layer of a white substance. NA-S stated someone had placed "Z-guard (which was a kind of barrier cream) to R13's bottom, but it was applied "too thick." As NA-S cleaned R13's bottom there was one open wound on both the right and left buttocks that were macerated. RN-F then entered R13's room and explained R13's bottom "looked worse" since the last time she had seen it. RN-F described R13's left buttocks wound as a stage 2 pressure ulcer measuring 2.0 cm x 1.9 cm with maceration around the wound: RN-F described R13's right buttocks wound as a stage 2 pressure ulcer measuring 2.5 cm x 1.5 cm with maceration around the wound. RN-F further</p>	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 15 explained wounds worsened because R13 was not sitting on her cushion in her recliner and not having the correct brief exposed the skin to excess moisture. R13's progress note dated 3/19/26 at 3:19 p.m. was identified as a late entry for 3/18/26 at 7:30 p.m. indicated R13 refused to offload into bed on p.m. shift. R13 refused to have cushion on in wheelchair moved to recliner. Stated it was "uncomfortable" how it positions her in the recliner and she does not like that "thing". R13 was provided education on importance of offloading in bed and using the cushion to take some pressure off her bottom to help the skin from further breakdown. R13's record did not identify R13 was reapproached and offered to reposition or apply cushion in her recliner after 7:30 p.m. R13's TAR reviewed 3/1/26 through 3/18/26, included an order that R13 agreed to get out of chair once per night to have her brief changed. R13 understands this requires getting placed in bed for the brief change and then placed back in her recliner. R13's TAR identified R13 refused 15 times; R13's TAR identified on 3/18/26 this was refused at 11:32 p.m. Review of R13's record when R13 refused there was no documentation of re-approaching to offer reposition/toileting and no documentation of education provided of risk of skin breakdown (except the education documented in the late entry progress note on 3/19/26 for 3/18/26 at 7:30 p.m.) During an interview on 3/18/26 at 1:59 p.m., LPN-A stated if R13 was seated in her recliner she was supposed to have a gel cushion underneath her, however, there are many times staff forget to place the cushion in her recliner before she sits in it and need to have "constant reminders to staff." LPN-A explained R13 will refuse to be repositioned at times, however, if you reapproach later, she will comply. During an interview on 3/19/26 at 12:45 p.m., RN-CM stated she has assessed R13's right and left buttocks wounds and they had deteriorated from a stage 1 from the assessment that was completed on 3/18/26 to both the right and left buttocks wounds being stage 2 pressure ulcers now and is requesting treatment orders for the wounds. RN-CM stated they had a care conference with R13, and she has agreed to lay in bed now for the night versus only spending the night in her recliner. During an interview on 3/19/26 at 12:18 p.m., DON stated R13's right and left buttocks had worsened since being assessed on 3/18/25 and are currently two stage 2 pressure ulcers. DON further explained R13 should not have been placed directly on the dycem and the pressure reducing cushion place in her recliner should have been placed in bed for two hours after breakfast like her pressure ulcer prevention intervention on her care plan identified to. R13 should have also had	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	Continued from page 16 incontinence care every 2 hours to prevent her skin being subjected to being wet for an extended period of time and this put her at risk for further breakdown. During an interview on 3/20/26 at 4:23 p.m., incontinence product representative (INC-R) stated the green incontinence products are meant for nighttime due to the increase absorbance of the pad to keep moisture away from a resident's skin. If a resident's care plan identified that they were to use the green pad (which would be the extended wear briefs) at all times per recommendations it was probably due to the residents not wanting to allow products to change often. INC-R explained if a resident were to be place in a daytime product and if the product was not changed for an extended period of time and allowed the indicator of the brief to go over 75% then that would put the resident at risk for pressure ulcers. During an interview on 3/20/26 at 6:25 p.m., medical director (MD) stated she expected when staff identified any change in a resident skin integrity that would come from pressure to implement interventions immediately such as repositioning, call the physician/physician assistant to get treatment orders for the wound to promote healing, and to implement the care plan interventions that are in place for residents at risk for pressure ulcers. Review of the facility's Skin Integrity Policy dated 2/26, identified it was the purpose to ensure that the resident does not develop pressure ulcers unless clinically unavoidable. The facility was committed to providing care and services consistent with professional standards of practice to: -Promote the prevention of pressure ulcer/injury development. -Promote the healing of existing pressure ulcers/injury. -Prevent development of additional pressure ulcers/injury. Prevention of skin injury: -Adhere to client's individualized skin and/or wound management plan. -Report to case manager and if appropriate the provider of any abnormalities to the resident's skin or wound areas and document in a progress note. -Notify family/designee of abnormalities. Risk Assessment Process: -All residents will be screened by a registered nurse upon admission, weekly for the first four weeks, monthly, and with change of condition for pressure ulcer risk/tissue tolerance by using the Skin Care Assessment with Braden Scale. -A head to toe skin inspection on all residents will be completed upon admission, daily with cares by caregivers, and weekly by a licensed nurse in alignment with bathing. With new findings documented in the resident's electronic health record on the appropriate event as well as charge nurse with team members to review root causes and address further interventions	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 125 5TH AVENUE SOUTHEAST , SPRING GROVE, Minnesota, 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
20900	<p>Continued from page 17 to prevent skin alterations from happening again. New findings will be reported to the physician/practitioner and family/designee. -For residents that have a wound present, a comprehensive wound assessment will be completed by registered nurse every week.</p> <p>Treatment/Management -The practitioner will order pertinent wound treatment, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings and application of topical agents. -The practitioner will help identify medical interventions related to wound management.</p> <p>-Wound consultation will be sought as needed.SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	20900		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 30, 2026

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

RE: CCN: 245429
Cycle Start Date: **December 19, 2025**

Dear Administrator:

On January 2, 2026, we informed you that we may impose enforcement remedies.

On February 23, 2026, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 10, 2026.

On March 19, 2026, the Minnesota Department of Health completed a second revisit, and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

At the time of this second revisit, we identified the following:

Corrected tags at F689 (830), F609, F607

Recited tags at F686 (900)

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 10, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 10, 2026.

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.

As we notified you in our letter of February 23, 2026, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 10, 2026.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

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

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)); and/or
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

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

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

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

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 June 19, 2026 (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.

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:

tamika.brown@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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@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.

Feel free to contact me if you have questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 3, 2026

Administrator
Tweeten Lutheran Health Care Center
125 5TH AVENUE SOUTHEAST
SPRING GROVE, MN 55974

RE: CCN: 245429

Cycle Start Date: December 19, 2025

Dear Administrator:

On February 23, 2026, we notified you a remedy was imposed. On May 14, 2026, 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 May 11, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 10, 2026 be discontinued as of May 11, 2026. (42 CFR 488.417 (b))

In our letter of February 23, 2026, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 10, 2026. 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,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

**NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES**

Electronically Delivered
June 3, 2026

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

RE: 1DE9ES-H2, 1DE9ES-H3, 1DE9ES-H4

Dear Administrator:

On March 18, 2026, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of\$ 700.00 was electronically issued to the above facility.

On March 19, 2026, survey staff of the Minnesota Department of Health Licensing and Certification Program completed a reinspection of your facility to determine correction of orders found on the survey completed on February 9, 2026, with orders received by you electronically on March 18, 2026.

State licensing orders issued pursuant to the last survey completed on February 9, 2026, were found not corrected at the time of the revisit on March 19, 2026, and subject to a continued daily penalty assessment in the amount of\$ 350.00.

An acknowledgement was electronically received by the Department stating that the violation had been corrected. A second reinspection was held on May 4, 2026, and it was determined that compliance with the licensing rules was attained on April 17, 2026 - forty days after the fine was imposed.

Therefore, the total amount of the assessment is\$ 14,350.00. In accordance with Minnesota Statutes,§ 144A.10, subdivision 7, the costs of the reinspection's, totaling\$ 1,624.00, are to be added to the total amount of the assessment. You are required to submit a check made payable to the Minnesota Department of Health in the amount of\$ 15,974.00 within 15 days of receipt of this notice.

Please send a copy of this letter and the check to:

Department of Health
Health Regulation Division,
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst

Federal Enforcement I Health Regulation Division Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

cc: Shellae Dietrich, Program Assurance Supervisor

Kami Fiske-Downing, Licensing and Certification Program

HRD Deposit Team