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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tweeten Lutheran Health Care Center	125 5th Avenue Southeast Spring Grove, MN 55974

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.Findings include 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). R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 was dependent for transfer and had moderate cognitive impairment.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. 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). R6's admission Minimum Data Set (MDS) dated [DATE], identified R6 was dependent with toileting hygiene/transfers and had intact cognition. 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. 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. Review of the facility's Abuse Potential/Vulnerable Adult/Quality Assurance Performance Improvement Policy dated 7/25, identified the following: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. 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. -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.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: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. Findings include: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). R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 was dependent for transfer and had moderate cognitive impairment.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. 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. 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. R6's face sheet dated 12/19/25, identified diagnoses of heart failure, diabetes mellitus, and atrial fibrillation. R6's admission Minimum Data Set (MDS) dated [DATE], identified R6 was dependent with toileting hygiene/transfers and had intact cognition. 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. 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.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.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.Findings include: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). R2's admission Minimum Data Set (MDS) dated [DATE], 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.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. 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. 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. 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.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. 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. 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. Implementation: -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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.Findings include:R8's face sheet dated 12/19/25, identified diagnoses of malignant neoplasm (cancer) of the lung and brain. R8's admission Minimum Data Set (MDS) dated [DATE], identified R8 needed maximum assist for transfers, had a fall 2-6 months prior to entry and had moderate cognitive impairment.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:-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.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.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. 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. 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. 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. 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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.Findings include: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.R1's admission Minimum Data Set (MDS) dated [DATE], 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.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. 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. 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. 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. During an interview on 12/19/25 at 1:57 p.m., physician 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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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.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: -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. 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.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. 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). 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. 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. 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. 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.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 blistery 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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 home and nursing aware that if R1 needed to be admitted to the secured memory care unit this can be done. R1's elopement evaluation dated 12/2/25, identified R1was 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. R1's progress note dated 12/2/25, identified wander/elopement alarm applied to left ankle for safety.R1's admission Minimum Data Set (MDS) dated [DATE], 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.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.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. 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. 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 3/4 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. 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. 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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tweeten Lutheran Health Care Center	125 5th Avenue Southeast Spring Grove, MN 55974

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 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. Findings include:Review of the nurse staff posting on 12/13/25 identified a census of 36 residents with staffing listed as followed:-night shift-1 licensed practical nurse (LPN) for 8 hours.-day shift-1 RN for 8 hours.-evening shift-1 LPN for 8 hours.Review of the nursing schedule on 12/13/25, identified an LPN had been scheduled for all shifts during the 24-hour period. 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. 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;current resident census.