Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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	04/02/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded high risk issues related to pressure ulcers by developing and implementing action plans for process improvement. This deficient practice had the potential to affect all 33 residents that resident in the facility. Review of QAPI minutes from December 2025 through March of 2025 identified across all months the facility consistently collected and reported data related to pressure ulcers; however, the documents did not address or include root cause analysis, prioritization of high-risk or recurring issues, development of performance improvement projects, implementation of corrective actions, and monitoring if interventions for effectiveness. Quality documents included the following: The December QAPI meeting demonstrated the facility had a process for collecting and reporting quality data across multiple departments. Specific measures were identified, including 2 bruises and a medication error involving incorrect medication administration, infection control data showing 4 total infections (2 pneumonia, 2 UTI), 19 audits completed, PPE compliance at 87.7%, and 63.9% influenza vaccination rate, and nursing audit findings including 6.57% of call lights not answered timely and bowel/bladder documentation completion rates between 67% and 89.7%. Additional clinical indicators were identified through MDS review, including areas flagged at or above threshold such as falls, antipsychotic medication use, UTI, worsened bowel/bladder function, and increased ADL assistance, with additional triggered areas including pressure ulcers, falls with major injury, anxiety/hypnotic use, behavioral symptoms, and excess weight loss. There was no evidence of prioritization of which of these identified risks represented the highest concern, no documented root cause analysis to determine underlying system contributors (e.g., staffing, care processes, environment, or documentation practices), and no indication that interdisciplinary action plans were developed in response to the identified measures. Additionally, the meeting did not reflect assignment of responsibility, implementation timelines, or a structured plan for re-evaluation to determine effectiveness of any interventions. Despite identification of these multiple clinical risk indicators, the facility did not document analysis of the underlying causes of the identified concerns, prioritization of high-risk areas such as pressure ulcers, or development of an action plan or performance improvement activity, and the meeting did not reflect interdisciplinary interventions or a structured approach to monitor effectiveness of any changes.The January QAPI meeting continued to reflect collection and reporting of quality indicators, including 14 falls for December exceeding the facility goal of 9 or less, 10 bruises (1 reportable). Infection prevention identified 5 infections with 20% compliance with gown usage and 60% glove compliance, while nursing services demonstrated decline in documentation with bowel and bladder documentation ranging from 37.8% to 76.7%, and identified CNA documentation and charting as needing improvement. Pharmacy data identified increased antipsychotic and antidepressant use above national averages, and MDS indicators continued to flag falls, psychotropic use, UTIs, ADL decline, and mobility decline, with pressure ulcers again noted as a triggered area below 75%. Despite repeated identification of these concerns from the prior month, there was no documentation of root cause analysis, prioritization, or action planning, and no evidence that pressure (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ulcers or other recurring risks were addressed through a formal performance improvement processThe February QAPI meeting demonstrated continued monitoring of clinical indicators across departments. Nursing reports identified 12 falls for January with a goal of 5 or less, including 1 major injury and 1 VA-reportable event, as well as 12 skin events for the month, nonreportable, 8 bruises with 1 reportable. Infection prevention identified 8 infections total, 9 residents on advanced barrier precautions, 100% compliance on gowns, 86% compliance with hand hygiene, 100% compliance with gloves, 40% compliance with masks, and 18 audits conducted with 83.9% compliance. Nursing services identified 7.48% of call lights not answered within 10 minutes and bowel and bladder documentation completed between 22.9% and 92.6%, with notation that weekly skin audits were compliant but wound management still needed work. MDS/CASPER data identified areas flagged at or above 75% including falls, antipsychotic medication use, UTI, new or worsened bowel/bladder, increased ADL help, and decline in independent mobility, with additional areas triggered below 75% including pressure ulcers, falls with major injury, antianxiety/hypnotic use, depression symptoms, behavior symptoms affecting others, and excess weight loss. Despite continued identification of skin integrity concerns and pressure ulcers across multiple data sources, the facility did not document analysis of contributing factors, prioritization of skin integrity or pressure ulcer risk, or development and implementation of an action plan, and the meeting did not reflect evaluation of the effectiveness of any interventions or sustained performance improvement efforts.The March QAPI meeting continued to reflect ongoing identification of clinical and operational concerns. Nursing reports identified 12 falls for February with a goal of 5 or less, including 1 major injury and 1 VA-reportable event, as well as 13 skin events reported for the month, none reportable, 2 bruises, and 1 medication error involving a missed dose due to misreading an order. Infection prevention and control identified 6 infections total (3 cellulitis/soft tissue, 2 UTI, and 1 pneumonia), with 8 residents on enhanced barrier precautions and 66.6% compliance on gowns. Nursing services identified 5.5% of call lights not answered within 10 minutes, noted as an improvement from the prior month, and bowel and bladder documentation ranging between 22.9% and 92.6%. Pharmacy services reported the facility remained above national benchmarks for antianxiety, antipsychotic, and antidepressant medications. Additional concerns identified during the meeting included communication gaps. MDS/CASPER data continued to identify areas flagged at or above 75%, including falls, antipsychotic medication use, UTI, new or worsened bowel/bladder, increased ADL assistance, and decline in independent mobility, with additional triggered areas below 75% including pressure ulcers, falls with major injury, antianxiety/hypnotic use, depression, behavioral symptoms affecting others, and excess weight loss. Despite repeated identification of pressure ulcers and skin integrity concerns across multiple months, the facility did not document root cause analysis, prioritization of this recurring issue, or development of corrective action plans, and there was no evidence of monitoring for effectiveness or sustained system changes to address these concerns.During an interview on 4/2/26 at 5:16 p.m., the facility infection preventionist/quality assurance nurse (IPQA) stated she has been in the position for 3 months and received minimal training in the QAPI process and was not able to articulate how the committee functioned, unsure of her role, and what was required in accordance with the regulations. After a recent complaint survey, IPQA requested education from the director of nursing (DON) so that she could ensure an affective quality program however the DON told the IPQA not to worry because a QAPI program was already in place. The IPQA stated the facility did have a quality assurance committee that meets monthly. During the meeting a power point was shared with all the members to enter their collected data. Although data was collected and presented at the information doesn't go anywhere else. The root cause for high incident rates is not analyzed. The committee identified pressure ulcers as a problem area however attributed the increased pressure injury rate to improved nursing documentation. The IPQA could not provide a written action plan for any areas identified during the meeting that were discussed. A policy titled Quality Assurance and Performance Improvement revised 3/2024 indicated the following: The purpose of a Quality Assurance and performance Improvement plan is to identify, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	track, organize, analyze, and improve healthcare outcomes at the facility towards a healthy populations of residents and staff, who are functioning at their best possible ability level. A QAPI process is based on five key elements, design and scope, governance and leadership, feedback, data systems and monitoring, performance improvement, systematic analysis and systemic action. The facilities QAPI program is designed to address root cause and systems in all areas of clinic care, resident life, quality of live, quality of care, environment, and to every practicable extent promote a high quality of life and offering of choices to our residents. It is imperative that in design the QAPI plan is accessible and understood by all staff to be an integral part of the facility function. Clinical care quality as addressed in our QAPI program with interdepartmental team involvement to meet residents needs. We assess performance of clinical care through audit clinical records internally, monitor delivery of care, mentoring and orientation processes, track care outcomes through standardized reports (CASPER, MNQI, MN nursing home compare, CMS five star system including PBJ data), state survey results. The administrator and board of directors are responsible and accountable for the develoment, implementation, and monitoring of the QAPI program. The facility has a designated QAPI nurse staff member who is responsible for assisting with change efforts, guiding system improvements, conducting training, promoting initiatives, devlopement policies and protocols, establishing continuity, reviewing reports and research, and setting facility culture expectations for quality, while ensuring resident rights and choice are paramount. As an affiliate facility in the {managing health system}, the QAPI nurse accesses the {health system} survey readiness and quality improvement departmental contacts for mentorship and support leadership as reasonable. Feedback, systems, and monitoring: The facility utilizes a system that monitors care and services in all areas and draws data from multiple sources. Some data sources include: input from stakeholders, adverse events, performance indicators, survey findings, and complaints. Adverse events are reported through electronic charting system and include pressure ulcerations. Performance indicators include quality reports, five start rating reports, trending form data, and continuous readiness rounding results. Survey Findings are useful to set a clear path from noncompliance to compliance and awareness. Survey data is received, a plan of correction put into place and tracking created to ensure we achieve improvement based on this feedback. Complaints it is the facilities goal to create an environment where complaints and be brought freely and problem solving an be undertaken withing our setting. when a complaint is made, the facility works closely with regulators to address concern when appropriate, provide any necessary data to support or refute quality issue, engage fully to correct concern, focus on systems toward improvement in quality, and follow concern to ensure correction and improvement will occur Performance improvement projects: A performance improvement project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide. It involves gathering information to clarify issues or problems and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. The facility conducts performance improvement projects based on a system focused approach and designed to address systems across the care and service areas provided. A PIP should lead to change and guide corrective actions within systems, across affected departments and groups, and impact the quality of life and quality of care for those in the resident community. When feedback is obtained which shows an area my qualify for improvement efforts the facility will take into consideration that concern and determine where to focus efforts. With input from leadership and stakeholders, the facility selects opportunity for improvement. In choosing a performance improvement project, the facility prioritizes focus areas based on high risk to resident or staff safety, high volume problem prone areas, poor quality outcome compared to bench marking. A project plan is intended to assist in focusing a project by setting the goals, scope, time frame, milestones, team roles, and responsibilities. The QA committee will chose a PIP team that is interdisciplinary involved in the processes or work to be improved, and lead by a qualified person who is able to direct the work. PIP progress is recorded in minutes of PIP meetings. Systematic analysis (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and systemic action.: identifying root cause is the first step in improving performance of a system failure. After identifying root causes, the facility seeks to implement changes and corrective actions that result in lasting improvements. Linking interventions to the root cause will be the most likely method to prevent further recurrence of the problem. To be effective, changes should target the elimination of mitigation of the root causes, offer long term solutions, and have a positive impact on other processes or systems. Interventions are to be achievable, objective and measurable. The facility may use the following models to guide discussion, thinking and processes towards identifying root cause: root cause analysis outlines, plan-do-study-act review. When appropriate, a pilot test of a broad change will be made, feedback obtained, and used to determine if the change is effective. When interventions are enacted, the ongoing response and measure of the effectiveness are to be included on the PIP document or in the format of minutes and assignments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to provide resident preference for positioning for 1 of 1 resident (R4) who was reviewed for pressure ulcers. Findings Include:R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], resident has severe cognitive impairment, is dependent on facility staff for toileting, showering/bathing, dressing, personal hygiene, and position changes and transfers. R4 requires set up/clean up assistance with eating and oral hygiene. R4 is usually understood but has difficulty communicating some words or finishing thoughts but is able if prompted or given times. R4 has unclear speech, with slurred or mumbled words. R4's diagnosis included Parkinson's (progressive neurological disorder leading to movement difficulties), dementia with Lewy bodies (buildup of proteins that lead to a decline in mental abilities, visual hallucinations, language difficulties, and impaired reasoning), pressure ulcer of right heal (injuries to skin and underlying tissue, usually over bony prominences, caused by prolonged pressure, friction, or shear). R4's care plan titled bilateral heel and low back pain that does interfere with day-to-day activities and sleep dated 2/26/23, interventions included:-administer medications as ordered, monitor for effectiveness-if R4 should show or verbalize symptoms of pain, investigate cause and explore interventions to relieve discomfort-monitor for signs and symptoms of pain including facial grimacing, crying, or tearfulness, guarding, or posturing, or verbally stating pain or discomfort. During an observation on 3/31/26 at 9:28 a.m., R4 looked visibly uncomfortable, rocking back and forth, trying to move his feet, and slight grimace. During an observation on 3/31/26 at 10:18 a.m., R4 put on his call light. Nursing assistant (NA)-E responded to R4's call light. R4 asked NA-E to reposition his feet; NA-E stated his feet needed to stay where they are; did not reposition his feet per his request. NA-E told resident to sit back and relax, R4 stated he was uncomfortable. NA-E again told resident to lean back in his chair. R4 touched his legs and asked again to have his legs and feet repositioned. NA-E stated again his feet needed to stay where they were; refused his request for a position change. During an interview on 3/31/26 at 1:01 p.m., NA-E stated she did not remember refusing to assist R4 with a requested position change. NA-E stated R4 would be unable to reposition himself without assistance. NA-E stated it is important to assist R4 because he is unable to reposition himself and she wants him to be comfortable. During an interview on 3/31/26 at 1:07 p.mp, licensed practical nurse (LPN)-A stated R4 was unable to reposition himself; requiring assistance from facility staff. LPN-A stated a refusal to reposition him would be inappropriate; the resident request to reposition should be honored. LPN-A stated she would expect staff to assist him with repositioning if he requested it. LPN-A stated it is important R4 is comfortable, and his positioning preferences should be honored. During an interview on 3/31/26 at 1:20 p.m., registered nurse (RN)-D stated it was inappropriate for staff to refuse repositioning to R4. RN-D stated she would expect staff to reposition R4 upon his request. RN-D confirmed R4 needs assistance for all repositioning. RN-D stated it was important to honor R4's requested positioning and preferences. A facility policy titled Resident Rights and Guidelines for All Nursing Procedures dated 02/25, facility staff received training regarding resident freedom of choice. A facility policy titled Activities of Daily Living, supporting dated 02/25, residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Appropriate care and services will be provided for residents who are unable to carry out ADL's independently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to timely provide the required liability and appeal rights notices prior to discharge from Medicare Part A services for 1 of 3 residents (R40) reviewed for beneficiary notices.R40's last day of covered Medicare Part A Skilled Services was 3/4/26, as identified on the form CMS-20052 (SNF [skilled nursing facility] Beneficiary Protection Notification Review). The form also indicated the faciilty/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. Section 2 indicated the Notice of Medicare Non-Coverage (NOMNC, form CMS-10123) was not issues because Resident discharge immediately after LCD.R40's progress notes dated 2/26/26 recorded as a late entry on 3/2/26 indicated a last covered date from physical therapy on 3/2/26 and occupational therapy on 3/3/26 with R40 discharging home 3/4/26. On 3/3/26 the progress notes indicated R40's family will arrive on 3/4 to bring R40 home on discharge. On 3/4/26 progress notes indicated discharge paperwork was discussed with R40's family and R40 was discharged home. The progress notes do not indicate R40's POA received the required NOMNC. R40's physical therapy discharge summary signed 3/2/26 indicated R40 will continue to need stand by assist to ensure he has assistance with all mobility. Discharge instructions indicated R40's daughter understood R40 was a fall risk and will have 24 hour care. Discharge reason indicated therapist decision. R40's occupational therapy Discharge summary dated [DATE] indicated R40 will require continued 24 hour care with assist of family with all activities of daily living and safety with front wheeled walker transfers recommended to live with daughter . R40's Notice of Medicare Non-Coverage (NOMNC, form CMS-10123) was requested but not received. During an interview on 4/1/26 at 9:28 a.m., family member (FM)-A stated R40 was discharged from the facility due to preference and funding reasons. FM-A was unfamiliar with a NOMNC and questioned if the from was send in the mail from Medicare or from the facility. FM-A was not aware of the option to appeal Medicare coverage ending. During an interview on 4/1/26 at 9:55 a.m. the business office representative ([NAME]) stated when the facility knows a resident's LCD is approaching, they issue a NOMNC a couple days before. During a follow-up interview on 4/1/26 at 2:04 the [NAME] stated the facility did not issue the NOMNC due to R40 discharging home and there was confusion if the NOMNC need to be issued or not. The [NAME] stated the NOMNC should have been issued. A NOMNC policy was requested but not received.

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	04/02/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to obtain careplanned baseline side effect monitoring for 1 of 2 residents (R15) reviewed for antipsychotic medication use.Findings include: R15's face sheet indicated an admission date of 10/17/25. R15's quarterly Minimum Data Set (MDS) dated [DATE] indicated R15 was moderately cognitively impaired however could not complete the assessment. R15 also exhibited fluctuating disorganized thinking with daily behaviors not directed at others. The MDS also indicated R15 takes antipsychotic (medication used to treat mental health conditions), antianxiety, and antidepressants. R15's diagnoses included vascular dementia with moderate psychotic disturbances, psychotic disorder, and non-traumatic brain dysfunction.R15's medication administration record indicated R15 received olanzapine (antipsychotic medication) 5 milligrams (mg) every morning from admission [DATE]) until 10/19/25. From 10/20/25 until 11/5/25 R15 received Olanzapine 5 mg twice a day. From 11/5/25-1/20/26 R15 received olanzapine 10 mg twice a day. Starting 1/20/26 R15 received olanzapine 5 mg in the morning and 10 mg in the evening. R15's pharmacy review care plan dated 10/17/25 indicated R15 was receiving an antipsychotic medication and should have an assessment for tardive dyskinesia (abnormal involuntary movements) per physician.R15's medical record does not contain a baseline tardive dyskinesia assessment. During an interview on 4/1/26 at 12:05 p.m., the facility nursing manager, registered nurse (RN)-A, stated resident's who receive antipsychotic medications have abnormal involuntary movement scale (AIMS) assessment [an assessment done to measure symptoms of tardive dyskinesia] done on admission and every 6 months. RN-A confirmed R15 medical records did not indicate an AIMS assessment was done and confirmed R15 should have had a baseline AIMS assessment done upon admission. A policy titled Psychotropic Drug Use dated 2/2025 indicated baseline Tardive dyskinesia assessment will be completed with re-assessment every six months and as needed for antipsychotic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to monitor and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 2 of 2 residents (R4, R24) reviewed for pressure ulcers. Findings include: R4's diagnosis included Parkinson's (progressive neurological disorder leading to movement difficulties), dementia with Lewy bodies (buildup of proteins that lead to a decline in mental abilities, visual hallucinations, language difficulties, and impaired reasoning), pressure ulcer of right heal (injuries to skin and underlying tissue, usually over bony prominences, caused by prolonged pressure, friction, or shear). R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], resident has severe cognitive impairment, is dependent on facility staff for toileting, showering/bathing, dressing, personal hygiene, and position changes and transfers. R4 requires set up/clean up assistance with eating and oral hygiene. R4 is usually understood but has difficulty communicating some words or finishing thoughts but is able if prompted or given times. R4 has unclear speech, with slurred or mumbled words. R4's care plan stated R4 is at risk for pressure injury related to poor nutrition, immobility, Braden score of 15, and unstageable pressure injury due to a deep tissue injury to right heel. Interventions included: -2/24/26: apply barrier ointment to right heel twice daily and allow to dry, left heel resolved/dry, apply ointment twice daily. Off-load heels when in bed. [NAME] boots on at all times. -1/21/26: apply barrier ointment to buttocks/ coccyx -12/22/25: Repositioning: turn and reposition every 2 hours when in bed (sign posted in room). Off-load heels when in bed. Up in wheelchair during the day repositioning when in chair every 2 hours. [NAME] boots on at all times R4's physician orders identified the following: -monitor right heel area of skin alteration for changes, if area appears larger in size or skin breaks open, notify charge nurse/nurse manager/hospice nurse, monitor and measure area with weekly skin checks until it is healed -apply barrier ointment to right heel twice per day, allow to dry. Left heel resolved/dry, apply barrier ointment twice per day. Off-load heels when in bed. [NAME] boots on at all times. R4 progress notes dated 3/23/26 at 12:47 p.m., right heel (central) unstageable deep tissue injury on the right heel measuring 0.5 cm x 0.5cm, depth unable to be measured. No exudate or odor present. Tissue is closed/resurfaced. Surrounding skin is pink, blanchable, and shows mild scaling. Wound base remains slightly discolored. No undermining, tunneling, or sinus tracts noted. During observation on 3/31/26 at 8:13 a.m., R4 was sitting in his Broda chair in the dining hall, R4 did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have the protective green boots on his lower extremities. During observation on 3/31/26 at 9:09 a.m., R4 was sitting in his Broda chair in his room, R4 did not have the protective green boots on his lower extremities. Protective green boots were sitting on R4's bed. During observation on 3/31/26 at 9:35 a.m., social services (SS)-B asked facility staff to assiste her with repositioning R4. Nursing assistant (NA)-E assisted with repositioning R4, the protective green boots were not applied. During observation on 3/31/26 at 10:18 a.m., R4 put on his call light to ask staff to reposition his lower legs. NA-E responded to R4's call light, R4 told her his legs were uncomfortable and asked to have them moved. NA-E declined to move his legs. NA-E instead brought resident down to activity; did not apply protective green boots. During observation on 3/31/26 at 10:24 a.m., licensed practical nurse (LPN)-A approached R4 to administer medication. LPN-A did not offer and/or apply protective green boots. During observation on 3/31/26 at 11:36 a.m., NA-E took R4 from the activity to the dining room for lunch; did not stop at R4's room to apply protective green boots. During an interview on 3/31/26 at 1:01 p.m., NA-E stated she was unsure if R4 was supposed to wear the protective green boots all the time. NA-E stated she could look at R4's care plans to find out. NA-E stated R4 had pressure ulcers on both heels but thinks they are both healed. During an interview on 3/31/26 at 1:07 p.m., LPN-A stated R4 had an unstageable pressure injury on both heels; stating they are both now healed. LPN-A stated he was supposed to have barrier cream applied twice per day every day and have protective green boots all the time. LPN-A confirmed she did not put his protective green boots on until after lunch today. LPN-A stated it was important for R4 to wear protective green boots all the time because his pressure injuries, while healed, are still very fragile and could worsen very quickly. During an interview on 3/31/26 at 1:20 p.m., registered nurse (RN)-D stated she was unsure what interventions R4 had in place; she would review his care plan if she had questions. RN-D stated R4 was care-planned to wear protective green boots all the time. RN-D stated R4 had provider orders to wear protective green boots all the time. RN-D stated R4 was non-ambulatory so he should have the protective green boots on all the time, regardless of being in the Broda chair or in bed. During an interview on 4/1/26 at 2:10 p.m., physician assistant (PA)-B stated she expected facility staff to implement all care-planned interventions; to include protective green boots. PA-B stated she expected facility staff to follow provider orders; to include protective green boots. PA-B stated R4 is non-ambulatory so he should have the protective green boots on all the time. PA-B stated the importance of protective green boots is to provide cushion to his fragile skin on both his ankles. PA-B stated he would be at risk of re-developing pressure ulcers on both his heels without the protective green boots. R24 R24's quarterly Minimum Data Set, dated [DATE] indicated R24 had moderate cognitive impairment, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long and short-term memory problems, impaired decision making, and disorganized thinking. R24 also had no physical or verbal behaviors, wandering, or rejection of care. The MDS also indicated R24 required set up for eating, substantial assist for oral hygiene and was dependent on staff for other activities of daily living. R24 was at risk for pressure injuries an used pressure reducing devices to bed and chair. R24's care plan updated 3/26/26 indicated R24 was at risk for pressure injury due to impaired bed mobility, and bowel/bladder incontinence. Interventions included: pressure off-loading [NAME] on both feet in bed and no shoes until pressure injury is healed. R24's medication administration record indicated Offload heels while in bed, Use heel boots when they are available every shift starting 3/25/26 with no documentation of refusals. During observation on 3/30/26 at 1:14 p.m. and 4:35 p.m., R24 was seated in the wheelchair with heel boots on both feet. During observation on 3/31/26 at 1:02 p.m., R24 was lying on his right side in bed with a pillow behind his back. Heel boots were observed on the top shelf in R24's closet. During observation and interview at 1:04 p.m., registered nurse (RN)-B stated R24 is very picky and frequently refuses cares. RN-B confirmed R24 had a pressure injury to his left heel that is not open. Staff monitor the area and encourage off-loading of pressure. During observation, R24 was laying on his right side in bed sleeping with a small pillow under his right leg however his foot was touching the bed. R24's left leg was crossed over the right with the outside of his left foot touching the top of his right foot. RN-B stated staff keep R24's feet elevated and R24 refuses to wear the offloading boots. RN-B removed R24's socks. A raised blister-like area containing a tanish fluid was observed on the outside of R24's left heel. The raised area was hardened resembling a callous. RN-B removed and applied R24's socks twice. R24 slept through the procedure. RN-B placed the pillow under R24's right leg and R24's left leg naturally crossed over the right placing area of the blister in close contact to the top of R24's foot. RN-B confirmed it appeared the blistered area was in close contact to the top of R24's foot. RN-B covered R24 with blankets and did not attempt to apply heel boots. Heel boots observed on the top shelf of R24's closet. During an interview on 3/31/26 at 1:25 p.m., nursing assistant (NA)-A stated R24 gets overstimulated easily and prefers to keep to himself. R24 has a habit of refusing cares and staff frequently have to reapproach. NA-A stated R24 wears tubigrips (compression sleeves used to treat swelling) during the day and heel boots at night. NA-A stated R24 just started using the heel boots due to a sore on his foot and has never refused them to her knowledge. When asked if R24 wears the heel boots every time he is in bed or just at night, NA-A read R24's care plan and stated I'll have to go talk to the nurse to see if he needs them on now. During a follow-up interview on 3/31/26 at 2:40 p.m., NA-B stated R24 wears the heel boots all the time now. During an interview on 3/31/26 at 3:41 p.m., the infection preventionist/quality assurance nurse (IPQA) stated on 3/25/26 the charge nurse on duty sent an email informing of the pressure injury to R24's left heel. The next morning, the IPQA assessed the wound and found a surface-level hard calloused area that looked like a deep tissue injury. R24's care plan was updated to include not wearing shoes until area is healed and to wear heel boots every time R24 is laying down. During an interview on 3/31/26 at 3:54 p.m., facility case manager registered nurse (RN)-A stated R24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is not to wear shoes until the pressure injury is healed and should wear heel boots on both feet while in bed. RN-A confirmed NA-A had asked about the boots and confirmed R24 should have had them on when in bed. A facility policy titled Pressure Ulcer/Skin Breakdown dated 02/26, the purpose of this policy is to reduce or prevent the occurrence or worsening of pressure ulcers/skin breakdown and outline the provision of care designed to promote healing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to follow manufacturer's instructions for safe operation of mechanical sit-to-stand lift and/or implement policies to ensure safety and supervision while attached to a sit-to-stand lift for 1 of 1 (R20) resident reviewed for lift safety.Findings include:R20's comprehensive Minimum Data Set (MDS) dated [DATE] indicated R20 had no hearing impairment, speech is clear and intelligible, ability to understand others, and moderate cognitive impairment. Additionally, R20 was dependent on staff for toileting, dressing, and positioning from sitting to standing and chair to bed.R20's care plan dated 2/6/26 stated R20 has limited mobility with interventions including:-assist of 1 staff for transfers using EZ Stand (brand of sit-to-stand mechanical lift) for all transfers, XL harness, do not use leg strap per resident request-informed of risks vs. benefits, resident voiced understanding Additionally, R20's care plan dated 2/6/26 stated R20 was a risk for falling with interventions including:-assure he is in a safe position prior to assisting with EZ lift and that all safety measures regarding equipment are in place as directed-give R20 verbal reminders not to ambulate/transfer without assistanceR20's care plan dated 5/19/25 stated R20 had limited ability to toilet self with interventions included assist of 1 using EZ stand to commodeDuring an observation on 3/30/26 at 1:03 p.m., nursing assistant (NA)-F assisted R20 from his recliner chair to his commode using an EZ stand. NA-F did not disconnect R20's harness from the lift and exited the room. During an observation on 4/1/26 at 9:30 a.m., NA-A assisted R20 from his recliner chair to his commode using an EZ stand. NA-A did not disconnect R20's harness from the lift and exited the room. During an interview on 4/1/26 at 10:55 a.m., NA-A stated she did not think R20 had a safety assessment to remain attached to the EZ stand during toileting. NA-A stated it wasn't really an issue to leave him hooked up because he was probably safe. NA-A stated R20 had slipped out of the EZ stand previously during toileting. NA-A stated R20 was probably still safe to be left alone while still hooked up to the EZ stand. NA-A stated it might be a good idea to complete a safety assessment to make sure R20 would be safe to remain on the EZ stand during toileting.During an interview on 4/2/26 at 1:23 p.m., registered nurse (RN)-C stated generally residents should not be left on the EZ stand while on the commode or toilet. RN-C stated some residents prefer to leave the EZ stand hooked up and in front of them, so they have something to hold on toDuring an interview on 4/2/26 at 12:51 p.m., RN-D stated residents should not be left on the EZ stand unless directly visualized by staff. RN-D stated residents were at risk of injury if left in the EZ stand during toileting. The manual for the Drive EZ Sit to Stand lift indicated:How to transfer the Patient to the desired surface1.Have the wheelchair, bed or commode ready: If transfer the patient to a commode, position the patient over the commode.2. Press the (M1) DOWN button and lower the patient onto the desired surface.3. Lock the rear swivel casters of lift.4. Unhook the sling from all attachment points on the lift.5. Instruct the patient to lift their feet off the footplate.6. Remove the sling from around the patient.7. Pull the lift away from the wheelchair, bed or commode. A facility policy titled Fall Prevention date 10/22, fall assessments will be tailored to the specific risks identified. The risk factors will include fall history, review of medications, evaluation of factors that may predispose resident to falls, medical conditions, functional and psychological factors that may increase fall risk, environmental factors such as lighting and room layout, and modifiable fall risk factors and interventions. Additionally, fall prevention includes securing equipment, and providing a safe environment. curing equipment, and providing a safe environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R4) who was at risk for dehydration had hydration available and within reach.Findings include:Findings include:R4's diagnosis included Parkinson's (progressive neurological disorder leading to movement difficulties), dementia with Lewy bodies (buildup of proteins that lead to a decline in mental abilities, visual hallucinations, language difficulties, and impaired reasoning), pressure ulcer of right heal (injuries to skin and underlying tissue, usually over bony prominences, caused by prolonged pressure, friction, or shear).R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], resident has severe cognitive impairment, is dependent on facility staff for toileting, showering/bathing, dressing, personal hygiene, and position changes and transfers. R4 requires set up/clean up assistance with eating and oral hygiene. R4 is usually understood but has difficulty communicating some words or finishing thoughts but is able if prompted or given times. R4 has unclear speech, with slurred or mumbled words.R4's care plan dated 1/2/25, R4 is at risk for dehydration related to comorbidities, poor coordination, tremors, decreased fluid intake, interventions included:-avoid fluids with diuretic effect (coffee, tea, grapefruit juice)-keep fluids accessible-assist with fluids as needed-encourage fluids to 2000cc per day, offer variety of juices, gelatins, soups, popsicles-assess dehydration (dizziness, change in mental status, decreased urinary output, concentrated urine, poor skin turgor, dry cracked lips, dry mucus membranes, sunken eyes, constipation, fever During an observation on 03/31/26 at 9:09 a.m., R4 was sitting in his room directly in front of the television. R4's water pitcher was sitting on his side table next to the bed, not within his reach. During an observation on 3/31/26 9:35 a.m., social services (SS)-B entered R4's room for her scheduled visit. SS-B spent approximately 4 minutes with R4 and left the room. SS-B did not move R4's water within reach and did not offer him hydration.During an observation on 3/31/26 at 10:18 a.m., R4 put his call light on, nursing assistant (NA)-E answered the call light. NA-E told R4 she was taking him to the activity; she did not offer him any hydration before leaving his room.During an observation on 3/31/26 at 11:35 a.m., activity assistant (AA)-A returned R4 to his room after the activity. AA-A placed R4 in his room directly in front of the television. R4's water pitcher was sitting on his side table next to the bed, not within his reach. AA-A left R4's room as R4 asked her for root beer. AA-A did not address R4's request for hydration.During an observation on 3/31/26 at 11:41 a.m., NA-E entered R4's room and she told him she was taking him to the dining hall for lunch. R4 again asked for root beer; NA-E told him no and took him to the dining hall. During an observation on 3/31/26 at 12:57 p.m., R4 was sitting in his room directly in front of the television. R4's water pitcher was sitting on his side table next to the bed, not within his reach.During an interview on 3/31/26 at 1:07 p.m., licensed practical nurse (LPN)-A stated R4 cannot move within his room. LPN-A stated R4 needed his water within reach of his chair to be able to drink his water without assistance. During an interview on 3/31/26 at 1:20 p.m., registered nurse (RN)-D stated she was not familiar with the hydration care plan interventions in place for R4. RN-D confirmed R4 had a care plan intervention to keep fluids accessible. RN-D stated this means his hydration should be within arm's length regardless of where he is sitting. Additionally, RN-D stated R4 had a care plan intervention that staff should encourage fluids up to 2000cc per day. RN-D stated this means staff should be offering hydration to him anytime they are in his room. RN-D stated it is important to offer R4 hydration whenever interacting with him because he is at high risk of dehydration.A facility hydration policy was requested and not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Tweeten Lutheran Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and records review, the facility failed to ensure that a resident who is a trauma survivor received culturally competent, trauma-informed care by accounting for resident's preference for 1 of 1 resident (R2) reviewed for Trauma informed care.Findings include R2's quarterly Minimum Data Set (MDS) assessment, dated, 2/13/2026 indicated intact cognition, R2 needed substantial assistance with toileting, dressing and personal hygiene.ˆ R2's diagnoses include PTSD, anxiety disorder. R2's [NAME] Trauma Informed Care Assessment was completed on 1/08/2026, indicated yes to history of physical, verbal or sexual abuse. Triggers listed: time of the day, nightmares.ˆ Things that help cope: talk to staff, call someone, and get a hug or hand massage. ˆBased on nursing assistant documentation and facility staffing record review, a male staff member provided personal cares for R2 on 3/20/2026, 3/28/2026 and 3/29/2026. ˆDuring an interview on 03/30/2026 4:19 p.m., R2 stated she had requested no male staff members to provide assistance with activities of daily living due to a history of post-traumatic stress disorder, and that request had not consistently been honored. R2 had communicated her need for no male staff members because of her PTSD to social service designee (SD) and all staff members. ˆR2 stated it is frustrating, they all know about my story, who else do I need to tell?. The other day, one guy walked in here while I was half naked to help me. R2 was teary eye by the end of the interview. During an interview on 3/31/2026 5:46 p.m., nursing assistant, (NA)-D, a male staff member, confirmed he had provided cares to R2 the previous week while he was aware of R2's request for no male staff member to provide personal cares. NA-D stated, when I went in the room, she did not ask me to leave so I did her cares. During an interview an 04/02/2026 3:20 p.m., NA- A, a female staff member, stated wasˆtold by R2 of the requestˆof no male staff memberˆprovided personal care due to history of trauma. During an interview on 3/31/2026 2:07p.m., NA-C, a female staff member stated was aware of R2's request for no male staff member to provide personal cares due to history of trauma. NA- C stated had received the information from a nursing report and was also told by R2 due to the history of trauma. ˆDuring an interview on 3/31/2026 2:09p.m., registered nurse (RN)-B, stated awareness of R2's request for no male staff member to provide personal cares due to history of trauma. RN-B was knowledgeable from communication with other staff members and was unsure if that intervention was identified in the care plan. ˆDuring an interview on 04/02/2026 3:18 p.m., RN-C stated awareness of R2 requestˆfor no male staff member assistance with activities of dailyˆliving, and that intervention was not identified in the care plan. Duringˆˆ an interview on 3/31/2026 2:30 p.m., registered nurse case manager, RN-A stated was aware of R2 ?s request for no male staff member to provide personal cares. RN- A reviewed R2's care plan and confirmed R2 ?s request for no male staff members was not on the care plan. RN-A stated, she had a rough go of things in the past, and I can see why she would request it. During an interview on 3/31/2026 2:39 P.m., SD confirmed, was aware of R2's ˆˆtrauma history since admission and completed the [NAME] TraumaˆInformed Care Assessment dated 1/08/2026. ˆFacility policy titled Trauma Informed Care last revised 10/2022, next review 02/2026 states, in situations where a trauma survivor is reluctant to share their history, we are still responsible to try to identify triggers which may retraumatize the resident and develop a care plan intervention which minimize or eliminate the effect of trigger on the resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain routine dental services and dental services that were requested by 2 of 2 residents (R2, R25) reviewed for routine/emergency dental services.Findingsˆinclude: R25's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated moderate cognitive impairment and diagnoses included, unspecified dementia without behavioral disturbance, Chronic cough, interstitial pulmonary disease (a group of disorder that causes inflammation and scarring of lung tissues). ˆR25's physician orders included: Biotene Moisturizing Mouth (Saliva stimulant), take every hour as needed for dry mouth (dated 5/20/2025), Mechanical soft Diet, ground meat, low sodium (dated 12/1/2025), may crush medications dated (12/13/2023.) R25's oral cavity assessment dated [DATE] indicated R25 was seen 3 years ago by a dental care provider, had an upper partial, denture appliance in good condition, had some missing teeth, no referral necessary and only wanted to be seen if having a problem. ˆR25 ?s Speech therapy treatment note dated 11/5/2025 indicated, R25 had loose fitting partials. ˆR25's oral assessment dated [DATE] indicated, R25 was seen 3 years ago by a dental care provider, had an upper partial, denture appliance in good condition, had some missing teeth, no referral necessary, no referral necessary and only wanted to be seen if having a problem. Oral assessment did not identify loose partial. ˆDuring an interview on 3/30/2026 at 3:13 p.m., R25 stated, had requested dental services due to his upper partial fitting loosely. They said, they will get it set and let my wife know at the last care conference meeting at end of February I think. During an interview registered nurse case manager, RN-(A) on 3/31/2026 11:31 a.m., registered nurse (RN) -A stated, R25 did request a dental appointment during the care conference in February. RN-A reported being in the process of contacting R25 ?s spouse to check on availability to take R25 to a dental appointment.R25 record review showed no documentation regarding dental appointment requests initiated or attempts made by RN-A to make a dental appointment for R25. During an observation on 4/1/2026 at 12:37 p.m., R25 wheeled self from the dining room towardˆhis room, then stopped, turned his wheeled chair around and proceeded back toward the dining room.ˆR25 was asked the reason for returning to the dining room and R25 stated I forgot my upper partial in there, I took it out to eat, it starts to float when you are trying to chew, and it is not comfortable. I think they are trying to set something up. ˆˆ R2 R2's quarterly Minimum Data Set (MDS) assessment dated [DATE],ˆindicated intact cognition, no oral concerns identified and diagnoses, included myotonic muscular dystrophy, chronic diastolic (congestive) heart failure, dry mouth, Gastro-esophageal reflux disease. R2's [NAME] Oral Cavity observation dated completed on 2/10/2026 identified no concerns. ˆ Duringˆan interview on 03/30/2026 12:52 p.m., R2 expressed the desire to be seen by a dentist due to sensitivity with hot, cold food and some missing teeth. ˆR2 stated to have communicated the request to staff a while ago, last fall. During an interviewˆˆ on 03/31/2026 11:40 a.m., registered nurse, case manager RN-(A), confirmed the request made by R2ˆˆ last fall, and stated to be working on getting an appointment/ referral set up for R2.ˆ RN-A stated, social service designee was alsoˆˆ assistingˆˆ with the process of scheduling a dental appointment for R2. ˆ During an interview on 3/31/2026 2:35p.m., SD stated, We were working on getting an appointment /referral set up for her, last fall. ˆThe facility policy titled: ˆDental Services, reviewed on 02/2025, indicates, Routine dental services means an annual inspection of oral cavity for signs of disease, diagnosis, of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 1 of 1 resident (R20) reviewed for enhanced barrier precautions (EBP), additionally the facility failed to ensure shared resident equipment was disinfected between uses, and the facility failed to ensure proper placement of a catheter bag for 1 of 1 resident (R11) reviewed for catheter use.Findings include: R20's comprehensive Minimum Data Set (MDS) dated [DATE] indicated R20 had no hearing impairment, speech is clear and intelligible, ability to understand others, and moderate cognitive impairment. Additionally, R20 was dependent on staff for toileting, dressing, and positioning from sitting to standing and chair to bed.R20's care plan dated 2/6/26 stated R20 has limited mobility with interventions including:-assist of 1 staff for transfers using EZ Stand for all transfers, XL sling, do not use leg strap per resident request-informed of risks vs. benefits, resident voiced understandingAccording to the Center for Disease Control (CDC) R20 required additional personal protective equipment (PPE) requiring Enhanced Barrier Precaution (EBP) isolation. EBP are designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes; they require gown and glove use during high-contact resident care activities. High-contact resident care activities include dressing, bathing, toileting, hygiene, transfers, and bed making.During an observation on 3/30/26 at 1:26 p.m., nursing assistant (NA)-F approached R20's room to answer the light call. NA-F failed to apply the appropriate PPE prior to entering; R20's room door had an Enhanced Barrier Protection isolation sign posted. After entering, NA-F assisted R20 from his recliner chair to the commode via EZ stand; assisting him with removal of lower clothing and handed R20 an empty urinal once he was seated. NA-F left room once R20 was seated.During observation on 3/3026 at 1:28 p.m., NA-F returned to R20's room to assist him with transferring from commode to recliner chair. Prior to entering, NA-F failed to apply the appropriate PPE. Upon exiting NA-F did not disinfect the EZ Stand after use. NA-F placed the EZ stand back in the hall for next use.During observation on 3/30/26 at 1:38 p.m., NA-F came down the hall and grabbed the same EZ stand (that had not been disinfected) and took it to another room to use. The EZ stand was not disinfected prior to using it with second resident.During an interview on 3/30/26 at 1:35 p.m., NA-F stated she was unsure the reason R20 was in EBP. NA-F stated since the EBP sign was posted on the R20's door, she should have put the appropriate PPE on before entering. NA-F stated she should have disinfected the EZ stand after using it with R20. NA-F stated it is important to use the appropriate PPE to prevent the spring of infections from residents to residents. NA-F stated all equipment should be disinfected after use, again, to prevent the spread of infection.During observation on 4/2/26 at 10:43 a.m., NA-G and NA-B entered room [ROOM NUMBER] with a facility lift to assist resident with a transfer from chair to bed. NA-G exited the room with the facility lift, placed in hall outside room, did not disinfect lift after use. NA-B exited room, performed hand hygiene, and grabbed the same facility lift and took it down the hall to 131 to transfer resident from chair to bed, did not disinfect lift before using it with next resident.During observation on 4/2/26 at 11:01 a.m., NA-G and NA-B exited room [ROOM NUMBER], neither had disinfected lift prior to placing it in empty room [ROOM NUMBER].During an interview on 4/2/26 at 11:25 a.m., NA-B stated she should have disinfected the lift equipment after using it with the residents in room [ROOM NUMBER] and 131. NA-B stated all shared equipment should be disinfected after every use before placing it in the hall for re-use. NA-B stated disinfection of equipment is important, so you don't spread infection from resident to resident.During an interview on 4/2/26 at 11:32 a.m., NA-G stated she should have made sure to disinfect the lift equipment after they used it with the residents in room [ROOM NUMBER] and 131. NA-G stated it is important to disinfect lift equipment after every use to prevent the spread of infection. R11R11's comprehensive Minimum Data Set (MDS) dated [DATE] indicated R11 was cognitively intact, dependent on staff for toileting, dressing, and position changes. R11 had a diagnosis of benign prostatic hyperplasia (BPH (enlarged (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prostate that compresses the urethra) with obstructive and reflux uropathy (urine backs up into bladder and kidneys causing damage) requiring a urinary catheter.During an observation and interview on 4/2/26 at 11:43 a.m., NA-G looked inside R11's room, NA-G stated R11's catheter bag should not be laying directly on the facility floor; the catheter bag should be inside a dignity bag or hung on the chair next to him. The catheter bag is not supposed to be on the floor because this could increase the risk of infection for the R11. During an interview on 4/2/25 at 12:51 p.m., registered nurse (RN)-D stated it is an expectation that all staff apply the proper PPE based on the door placard hanging on the resident door. RN-D stated staff must still apply PPE even if they think the resident has been removed from isolation precautions, if the door placard is still in place. The charge nurse or infection preventionist will remove the door placards when they are no longer needed. If the door placard is still in place on resident door, staff are required to continue the appropriate PPE. Additionally, it is a facility expectation that all shared equipment is disinfected after every use. RN-D stated catheter bags are not to be laying directly on the floor; catheter bags should be placed inside a dignity bag or hung on the chair or bed the resident is sitting on. RN-D stated catheter bags left directly on the floor increase the resident risk of infection.During an interview on 4/2/26 at 1:17 p.m., infection preventionist and quality assurance (IPQA) stated it is an expectation that staff apply the correct PPE based on the resident's door placard. IPQA stated the standard of practice is to wear the proper PPE until the placard has been removed by the charge nurse or herself. IPQA further stated, it is an expectation that all facility shared equipment is disinfected after every use before placing the equipment back in the hall for its next use. Additionally, IPQA stated all catheter bags should be placed in a dignity bag and hung on the chair the resident is seated in. IPQA stated the catheter bags should not be directly laying on the floor. IPQA stated the dignity bags are provided by the facility; and are used to prevent the spread of infection. A facility policy titled Enhanced Barrier Precautions (EBP) dated 10/25, EBP precautions are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. EBP signage should be posted on the door or wall outside of the resident room. A facility policy titled Shared Equipment Sanitary Use dated 09/25, lifts and stands that are used must be cleaned with disinfectant before being taken for use outside of that room. A facility policy titled Catheter Care dated 11/25, infection control; be sure the catheter tubing and drainage bag are kept off the floor.