Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2024

Administrator
The Lutheran Home: Belle Plaine
611 West Main Street
Belle Plaine, MN 56011

RE: CCN: 245590
Cycle Start Date: August 6, 2024

Dear Administrator:

On August 6, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 6, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

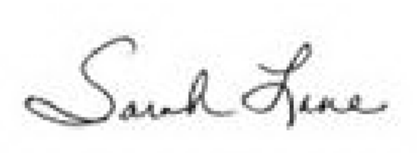
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
August 22, 2024

Administrator
The Lutheran Home: Belle Plaine
611 West Main Street
Belle Plaine, MN 56011

Re: State Nursing Home Licensing Orders
Event ID: 5BWJ11

Dear Administrator:

The above facility was surveyed on August 4, 2024 through August 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

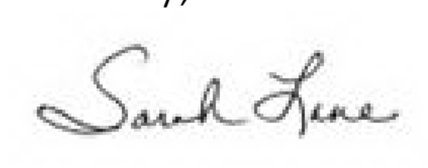
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LUTHERAN HOME: BELLE PLAINE	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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E 000	Initial Comments On 8/4/24, to 8/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include	E 035		9/22/24

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

Electronically Signed | 08/30/2024

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E 035	Continued From page 1 all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure their emergency preparedness plan included a method for sharing information the facility had determined appropriate, with residents and their families or representatives. This had the potential to affect all 50 residents currently residing in the facility and their families/representatives. Findings include: During review of the facility's emergency preparedness plan (EPP), dated 7/11/24, there was no indication the facility had shared any EPP information with clients and their families or representatives. When interviewed on 8/5/24 at 1:10 p.m., housekeeping (H)-A, also identified as emergency preparedness coordinator, indicated the facility has an emergency preparedness manual in the front lobby for anyone to review if they choose. H-A indicated she is unsure who communicates this information with residents and families. During interview on 8/5/24 at 1:50 p.m., the admission coordinator confirmed information related to the EPP is not shared with residents and their families or representatives.	E 035	It is the policy, and intention, of The Lutheran Home: Belle Plaine, to be in full compliance with all regulations and requirements of both the Medicaid and Medicare Programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility's CREDIBLE ALLEGATION OF COMPLIANCE. The written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The facility wishes to preserve its right to dispute these findings in their entirety should any remedies be imposed. It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at E035 LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8). The facility's standard of practice is that our emergency preparedness is complete and current. The facility recognizes that the plan must include a means of communicating information from the plan with residents and their families or representatives.	

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E 035	Continued From page 2 During interview on 8/6/24 at 12:09 p.m., the administrator confirmed the facility was not sharing emergency preparedness information with residents and/or their family members.	E 035	Contributing factors to this finding is that the facility's emergency preparedness committee had been establishing a methodology to meet this requirement at their bi-weekly meetings. This component of the emergency communication plan had not been fully adopted and implemented, at the time of the survey. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. The facility's emergency preparedness committee fully adopted and implemented a Resident and Family Notification of Emergency Plan Policy and Procedure, which includes: -A fact sheet on the emergency plan will be provided to the resident and/or representative in writing during the admission process, upon request, and whenever changes to that information has been made. -Reminders will be provided to residents and/or representativees periodically, but no less than annually. -The facility's public website includes information on the facility's emergency plan. -Instructions for contacting the facility in the event of an emergency is posted to the facility's public website. 2.The emergency plan fact sheet will be distributed to all existing residents and mailed out to their representatives.	

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E 035	Continued From page 3	E 035	3. Ongoing: Quarterly audits of a random sample of residents and resident representatives will be conducted during the resident's care conference, by the Interdisciplinary Team (IDT). Data obtained from the aforementioned audits will be shared with the emergency preparedness committee and incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Analysis of collected data will be conducted, assessing for patterns and contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	
F 000	INITIAL COMMENTS On 8/4/24, to 8/6/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was were reviewed with NO deficiencies cited: H55906574C (MN00105472). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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F 000	Continued From page 4 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		9/22/24

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F 623	Continued From page 5 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623	Continued From page 6 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notice of transfer was provided to the resident and/or resident representative for 1 of 2 residents (R44) reviewed for hospitalization. Findings include: R44's facesheet, included diagnoses of Alzheimer's disease, retention of urine, and urinary tract infection. R44's significant change Minimum Data Set (MDS) assessment dated 5/1/24, indicated R44's impaired cognition R44 was usually understood	F 623	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F623 Notification Requirements Before Transfer/Discharge CFR(s): 483.125(c)(3)-(6)(8). The facility's standard of practice was notification of the ombudsman's office monthly by our social service team. Our care team would notify residents and resident representatives of an upcoming discharge via our bed hold policy and procedure. Contributing factors to this finding is that the bed hold policy and procedure was not all inclusive of the requirements at F623.	

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F 623	Continued From page 7 and could usually understand. R44 did not walk and was dependent on staff for most activities of daily living (ADL). R44's care plan with revised date of 7/30/24, indicated indwelling catheter related to urinary retention; staff were to manage the catheter to prevent UTI and obstruction in drainage. During an interview on 8/4/24 at 1:33 p.m., family member (FM)-E stated R44 had been hospitalized overnight in April 2024 for a urinary tract infection. FM-E did not recall receiving a written notice of transfer. This document was not seen in the scanned documents section of the electronic medical record (EMR). Progress note dated 4/18/24 at 5:00 a.m., indicated R44 was experiencing abdominal distention and discomfort, a fever, and his urinary catheter was not draining well. An okay was received by the hospice provider to send R44 to the emergency room. Progress note dated 4/19/24 at 2:55 p.m., indicated R44 was still in the hospital. Progress note dated 4/21/24 at 6:05 p.m., indicated R44 would be returning to the facility that evening. During an interview on 8/5/24 at 4:34 p.m., registered nurse (RN)-A provided transfer documentation for R44's April hospitalization, but the documentation did not include written notice of transfer to be given to the resident representative and the ombudsman. During an interview on 8/6/24 at 10:31 a.m., RN-A	F 623	Because of this, the resident and resident representative did not receive a written transfer notice for 1 resident in the sample. Resident 44's responsible party has been provided, and has signed, the facility's revised Transfer and Discharge Notice. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. The facility's transfer and discharge policy was reviewed to ensure all the requirements at F623 are included. 2.The facility has implemented a revised Transfer and Discharge Notice form which includes all of the requirements at F623. Facility staff responsible for transferring residents out of the facility have been educated on the new procedure and protocol. A copy of the revised Transfer and Discharge Notice can be found as an attachment to this plan to protect residents in similar situations. 3. Ongoing: In response to identifying, and reviewing, how other residents potentially impacted, the facility will implement quarterly audits of a random sample of resident transfers will be conducted to ensure that residents and resident representatives have received written transfer notices at the time of transfer. Data obtained from the aforementioned audits will be incorporated into the	

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F 623	Continued From page 8 stated she did not know who in the facility completed a written notice of transfer when a resident was transferred to the hospital, adding nursing did not. During an interview on 8/06/24 at 10:50 a.m., the director of nursing stated nursing did not complete a written notice of transfer when a resident was transferred to the hospital and thought social services might do that. During an interview on 8/06/24 at 11:04 a.m., resident and family liaison (RFL)-B stated social services did not complete a written notification of transfer form of any kind and thought nursing might do that. RFL-B stated she did inform the ombudsman each month of residents who were transferred. During an interview on 8/6/24, at 11:45 a.m., the DON stated they facility did not have a policy on written notice of transfer.	F 623	facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		9/22/24

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F 688	Continued From page 9 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement therapy recommendations in a timely manner to maintain strength and mobility for 1 of 1 resident (R41) reviewed for range of motion (ROM). Findings include: R41's face sheet, indicated diagnoses of Parkinson's disease, age-related physical debility, and weakness. R41's admission Minimum Data Set (MDS) assessment dated 6/13/2024, identified no cognitive impairment, the ability to understand and be understood, no rejection of care, limited range of motion on both sides of upper and lower extremities, and physical assist with personal hygiene, bed mobility, dressing, toilet use, and transfers. R41's care plan dated 6/26/2024 and revised 8/5/2024, indicated staff were to assist resident with ROM (range of motion) to bilateral upper and lower extremities as resident tolerates and resident totally dependent on staff for all transfers and mobility. R41's PT (physical therapy) Therapist Evaluation Summary dated 6/11/2024, indicated staff were to assist R41 with upper and lower body passive range of motion programs daily and to see	F 688	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3). The facility's standard of practice is that our care team follow through with all therapy & medical providers recommendations and orders. Additionally, all staff follow individualized resident care plans. Contributing factors to this finding is that the physical therapist's Evaluation Summary indicating that staff were to assist the resident with upper and lower body passive range of motion programs was not documented in the resident's care plan and/or on the care team's care cards. Upper and lower bilateral PROM orders were obained and Resident 41's Kardex, care plan, and care cards were immediately updated to include upper and lower extremities PROM, once the survey team brought this finding to the attention of the facility's care team. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. Rehabilitation Therapy written and	

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F 688	Continued From page 10 attachments for passive stretches recommended. Also instructed to provide slow and gentle stretches during range of motion and to ensure R41's tolerance with verbal and visual pain assessments. R41's OT (occupational therapy) Therapist Evaluation Summary dated 6/12/2024, indicated a recommendation of bilateral upper extremity PROM (passive range of motion) for staff to perform daily to prevent worsening muscle contractures. R41's Kardex (used by nursing assistance's) dated 8/5/2024, failed to include any reference to PROM exercises. R41's orders dated 8/5/2024, failed to include any reference to PROM exercises. On 8/5/2024 at 10:26 a.m., R41 was observed in his wheelchair with arms bent up towards his chest. R41 stated staff had not completed exercises with him and he would have liked them to do exercises and stretching with him. On 8/5/2024 at 3:33 p.m., registered nurse (RN)-C stated the PROM exercises were missed when therapy recommended them and the recommendations for R41 had not been started. RN-C further stated that going forward the recommendations will be implemented right away. On 8/6/2024 at 8:40 a.m., occupational therapist (OT)-F stated the therapy department gave the recommendation to nursing on 6/12/2024. OT-F further stated the lack of PROM did not cause change in functional ability for R41 due to already	F 688	verbal recommendations will be communicated to the IDT during morning report. The facility's Director of Nursing/Clinical Coordinators will review any new therapy instructed ROM recommendations weekly, to ensure that the nursing order has been implemented and communicated to staff. The residents involved will also have their care plan and Kardex reviewed to ensure that the order has been transcribed. 2. Licensed nursing staff responsible for care coordination and order transcribing will receive re-education on processing rehabilitation therapy orders and review communication processes with the therapy department. 3. Ongoing: Quarterly audits of a random sample of residents will be conducted by the Interdisciplinary Team (IDT) to ensure compliance. Data obtained from the aforementioned audits will be shared with the care team and rehabilitation therapy department, and incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Analysis of collected data will be implemented to ensure compliance and if a variation is identified, a root cause analysis will be implemented to identify contributing factors so that they may be mitigated. Audits will be continued for not less than one year.	

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F 688	Continued From page 11 severely impaired active movement and functional control of extremities. OT-F also stated R41 would still benefit from implementation of the PROM recommendations. On 8/6/2024 at 10:45 a.m., director of nursing (DON) stated she would expect PROM recommendations to be implemented timely to prevent decline in functional abilities. A policy titled Prevention of Decline in Range of Motion revised 1/2024, stated the following: a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: assistance as needed (active assisted, passive, and supervision).	F 688		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		9/22/24

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F 732	Continued From page 12 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nurse staff postings were accurate and up-to-date on a daily basis. This had the potential to affect all 50 residents who resided in the facility and/or any visitors who may have wished to view the information. Findings include: During interview on 8/4/24 at 12:00 p.m., trained medication assistant indicated he was called in to work this morning to assist, as a nurse on the unit had called in for the shift.	F 732	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F732 Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4). The facility's standard of practice is that our nursing personnel staffing is posted at the front desk, with the posting being by shift, position and hours worked. The expectation is that as staffing levels change after the posting is placed, that it will be updated to reflect those changes. Contributing factors to this finding was the nursing staffing coordinator's practice of posting the entire weekend's staffing, at	

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F 732	Continued From page 13 During observation on 8/4/24, at 7:06 p.m., staff posting dated Friday 8/2/24 was posted on a back wall by the reception desk. The form included date, census, registered nurse (RN), licensed practice nurse (LPN's), trained medication assistant (TMA) and nursing assistant (NA) for each scheduled shift with total hours all listed at 8 hours. Total hours was present for each shift. During observation and interview on 8/5/24 at 8:33 a.m., the receptionist indicated she is not responsible for changing the posted staffing for the day. The staff posting remained dated as Friday 8/2/24. During interview on 8/5/24 at 8:36 a.m., the scheduler (S)-D indicated on Friday she will post the Saturday and Sunday postings behind Friday. S-D indicated she frequently comes in on Monday and Friday remains the posted staff hours. S-D stated she will review the working schedules staff use to make any corrections that occurred over the weekends to staffing such as call ins. S-D confirmed a licensed practical nurse (LPN) called in for Sunday 8/5/24 and a trained medication assistant (TMA) replaced the LPN position. S-D stated she will make the necessary changes to the posted hours usually after the nursing posted hours are taken down as that is when she discovers the call ins which sometimes requires changes. S-D is unsure who is responsible for ensuring the correct date posting is posted but thought it would be the charge nurse who is working over the weekend. S-D added sometimes the charge nurse is on-call versus being in the building though. During observation and interview on 8/5/24 at 8:45 a.m., the director of nursing (DON)	F 732	the end of the day on Friday. There wasn't a designee charged with keeping the posting current in the absence of the nursing staffing coordinator. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. The facility has provided education and training to evening and night shift nurses and weekend nurses to make appropriate updates to the staffing document/posting, and rotating the appropriate days worksheet forward. The nursing staffing coordinator will continue to make appropriate changes and updates to the staffing worksheet/posting Mondays through Fridays during business hours. 2. Ongoing: Quarterly audits of a random sample of nursing staffing postings will be conducted during various times of the day and days of the week, to ensure ongoing compliance with the requirements at F732. The nursing leadership team will conduct said audits. Data obtained from the aforementioned audits will be shared with the staffing coordinator and facility floor licensed nursing staff and will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Analysis of collected data will be conducted and compared for patterns and contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	

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F 732	Continued From page 14 confirmed the posted hours remained on Friday 8/2/24. The DON indicated there is always a charge nurse in the building on weekends. A policy and procedure on nursing staffing posts was requested but none received.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure doses of a	F 761	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the	9/22/24

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F 761	Continued From page 15 controlled substance were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerators observed for medication storage. Findings include: During an observation on 8/6/24 at 7:52 a.m., observed two nurses, licensed practical nurse (LPN)-A and registered nurse (RN)-B perform shift change narcotic reconciliation in a medication cart at the "Mainstreet" nurses station. At the end of the narcotic count, LPN-A stated they also needed to count the narcotics in the refrigerator. During an observation of the small dorm-size refrigerator in the locked medication room, an opened, multi-dose bottle of lorazepam (a medication to relieve anxiety) concentrate, 2 mg/ml (milligrams per milliliter) was observed on a shelf on the door of the refrigerator - not in a separately locked, permanently affixed compartment in the refrigerator. During an interview on 8/6/24 at 12:38 p.m., the director of nursing (DON) was informed of the observation and stated she was unaware lorazepam, a schedule IV medication, needed to be in a separately locked, permanently affixed compartment in the refrigerator. Facility Medication Storage policy dated 7/24, indicated if a medication was supplied in a unit-dose system, schedule III-IV medications could be stored in trays with other medications.	F 761	requirements at F761 CFR(s): 483.45(g)(h)(1)(2) Labeling of Drugs and Biologicals. The facility's standard of practice is to ensure each medication is properly labeled with name and direction for use for each resident, including monitoring for expired medications. Medications and biologicals are stored in locked compartments under proper temperature controls, and permits only authorized personnel to have access to the keys. Contributing factors to this finding is that the facility was of the understanding that since the refrigerator was locked and the medication room door, where the locked refrigerator was stored, was also locked, that the facility was compliant with the requirement to store the schedule IV medication in a compartment with double locks. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. Facility Staff responsible for medication administration will be educated regarding the proper storage of controlled medications. 2. The facility installed locked medication boxes, which are secured to the locked medication refrigerators, in each locked medication room. 3. Ongoing: Appropriate storage of controlled medications will occur by the	

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F 761	Continued From page 16	F 761	nurses reconciling controlled medications at each shift change. Quarterly audits of accurate medication storage will be conducted by the contracted pharmacy consultant. Data obtained from the aforementioned audits (both daily and quarterly) will be shared with the medical director and incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Analysis of collected data will be analyzed for patterns and contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner	F 847		9/22/24

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F 847	Continued From page 17 that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to inform the resident or representative of the right to not sign the arbitration agreement as a condition of admission or as a requirement to continue to receive care at the facility. Findings include:	F 847	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F847 Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5). The facility's standard of practice was to include the Arbitration Agreement at the end of the Admission Agreement. New admissions were told verbally that	

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F 847	Continued From page 18 An Admission Agreement, undated, included a portion titled Arbitration Agreement Clause that included subsections including contractual and/or property damage disputes, personal injury, wrongful death or medical malpractice, exclusion from arbitration, right to legal counsel, location of arbitration, time limitation for arbitration, limitation on damages and allocation of costs and limited resident right to rescind this binding agreement clause. The next page of the admission agreement included Signatures of Parties to Agreement for the entire document. Two pages behind the signature page is a Notice of Right to Rescind Binding Arbitration Clause informing they have a right to rescind the agreement regarding binding arbitration within 30 days and must send the notice certified mail or hand deliver no later than 30 days from admission agreement signature. The Admission Agreement and Arbitration Agreement Clause did not include a section to inform the resident or representative of the right to not sign the arbitration agreement. During interview on 8/5/24 at 12:38 p.m., the director of nursing stated no residents or representatives have signed the arbitration agreement at the facility and no residents have filed a dispute. During interview on 8/5/24 at 1:59 p.m., admissions coordinator (AC)-A indicated all the residents in the facility have signed the arbitration agreement which is part of the admission agreement. They do not require separate signatures. AC-A stated none of the residents or families have submitted the Notice of Right to Rescind. AC-A indicated she gives a verbal explanation of arbitration prior to the resident or representative signing the admission agreement	F 847	they were not required to agree to the Arbitration Agreement and the facility explained the process to rescind an Arbitration Agreement. Prior to the survey, the facility had been working with legal counsel to retract the Arbitration Agreement from the Admission Agreement. Those revisions were in process at the time that the survey occurred. During the survey, the Arbitration Agreement was updated and retracted from the Admissions Agreement, in order to avoid the possible presumption that admission was contingent upon signing the Admission Agreement which included the Arbitration Agreement. Contributing factors to this finding was based on the timeliness of implementing legal counsel's recommendation that the Arbitration Agreement language be removed from the Admission Agreement and made it's own, stand alone, agreement. The Lutheran Home: Belle Plaine, will consult with all residents/resident representatives that entered into the old admission contract with the included arbitration provision and inform residents/resident representatives of current arbitration agreement and the resident□s choice to enter into the same which is not a condition of admission and that this consult included informing residents/resident representatives: " Signing the Arbitration Agreement is completely voluntary and is not a condition of Resident□s admission or continued	

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	245590	A. BUILDING _____ B. WING _____	C 08/06/2024

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F 847	Continued From page 19 but does not inform them of the right to not sign the Arbitration Agreement section. During interview on 8/5/24 at 2:00 p.m., the administrator stated only one signature is required for admission which includes the arbitration agreement also and if the resident doesn't want to agree to arbitration, they are required to submit the Notice of Right to Rescind Binding Arbitration Clause. The administrator indicated there is an assumption that could be made since the admission agreement is required for admission. During interview on 8/5/24 at 4:14 p.m., the administrator confirmed the current agreement does not include written documentation that arbitration is not a requirement of admission to the facility or continuation of care.	F 847	admission to the facility. " All the parties have a say in choosing the arbitrator. " When choosing an arbitrator, the facility will share the extent of any previous relationship with an arbitrator or arbitration service they have used in the past, including how often the facility has used them, and in whose favor the arbitrator has ruled. " Arbitration takes place at an agreed upon location at or near the facility, but not in a court room. " The decision is final for the parties entering the arbitration agreement. " Signing the Arbitration Agreement does not prevent them from speaking to any federal, state, or local officials and facility shall not discourage them from doing so. " They have the right to rescind your decision to arbitrate within the next 30 days and if they later decide not to agree to arbitration, they just fill out and mail or hand deliver and signed and dated written notice of rescission as described on page 3 of the Arbitration Agreement. These consults will occur with all residents/resident representatives that entered into the old admission contract with the included arbitration provision, at the time of the resident's quarterly care conference. Facility Wide Response Addressing Protection of Residents in Similar Situations: 1. The facility's Admission Agreement and	

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F 847	Continued From page 20	F 847	Arbitration Agreement were made into two seperate stand alone agreements. This was completed and implemented during the actual survey. 2. Legal counsel provided orientation and training on the revised Arbitration Agreement on August 7, 2024. The facility's two Social Service representatives, the Admissions Coordinator, and Administrator received said orientation and training. 3. Ongoing: Quarterly audits of new admissions to ensure that the Admission Agreement and the Arbitration Agreement are separate, will occur. Data obtained from these audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. The QAPI Committee will ensure that the following are included in the admission process: " Signing the Arbitration Agreement is completely voluntary and is not a condition of Resident□s admission or continued admission to the facility. " All the parties have a say in choosing the arbitrator. " When choosing an arbitrator, the facility will share the extent of any previous relationship with an arbitrator or arbitration service they have used in the past, including how often the facility has used them, and in whose favor the arbitrator has ruled. " Arbitration takes place at an agreed upon location at or near the facility, but not in a court room.	

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F 847	Continued From page 21	F 847	" The decision is final for the parties entering the arbitration agreement. " Signing the Arbitration Agreement does not prevent them from speaking to any federal, state, or local officials and facility shall not discourage them from doing so. " They have the right to rescind your decision to arbitrate within the next 30 days and if they later decide not to agree to arbitration, they just fill out and mail or hand deliver and signed and dated written notice of rescission as described on page 3 of the Arbitration Agreement. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		9/22/24

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F 880	Continued From page 22 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 23 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow proper procedures to prevent the spread of infection when emptying a urinary drainage bag for 1 of 1 resident (R44) observed for infection control practices. Findings include: R44's facesheet, included diagnoses of Alzheimer's disease, retention of urine, and urinary tract infection (UTI). R44's significant change Minimum Data Set (MDS) assessment dated 5/1/24, indicated R44's was cognitively impaired. R44 was usually understood and could usually understand. R44 did not walk and was dependent on staff for most activities of daily living (ADL). Physician orders dated 11/14/23, included monitoring Foley (a type of indwelling catheter) output each shift. R44's care plan with revised date of 7/30/24, indicated indwelling catheter related to urinary	F 880	It is the intention of The Lutheran Home: Belle Plaine, to be compliant with the requirements at F880 Infection Prevention and Control CFR(s) 483.80(a)(1)(2)(4)(e)(f). The facility's standard of practice is to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Contributing factors to this finding includes Nursing Assistant A & B, not following the facility's Catheter Care Policy which ensures residents with indwelling catheters receive appropriate catheter care when an indwelling catheter is in use, which includes ensuring the drainage bag does not touch the floor unless a barrier was provided. The nursing assistants involved with Resident 44's catheter care were provided just-in-time education on the facility's	

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F 880	Continued From page 24 retention; staff were to manage the catheter to prevent UTI. The drainage bag was to be emptied every shift. During an interview on 8/4/24 at 1:28 p.m., family member (FM)-E stated R44 had a urinary catheter in place because, "His urine doesn't come out." FM-E stated R44 had a bad UTI in April 2024 and was hospitalized. During an observation on 8/5/24 at 1:24 p.m., in R44's room, nursing assistants (NA)-A and NA-B moved R44 from his wheelchair to the toilet via an EZ-stand (a device that helps someone stand up from a chair). While R44 sat on the toilet, NA-A set the urinary drainage bag directly on the floor next to the toilet and emptied the urine from the urinary drainage bag into a urinal. During an interview on 8/5/24 at 1:36 p.m., NA-A was informed of the observation of the urinary drainage bag on the floor. NA-A stated she had to do that to get the clamp open on the port to drain out the urine. NA-A indicated it could cause bacteria to enter R44's urinary drainage system and stated, "He's had infections." During an interview on 8/5/24 at 2:47 p.m., registered nurse (RN)-A indicated, "That's a big infection control issue" and stated she would have expected the urinary drainage bag to be hooked onto something when emptying it. During an interview on 8/6/24 at 10:50 a.m., the director of nursing (DON) was informed of the observation of a NA setting a urinary drainage bag on the floor of the bathroom to empty it and acknowledged that was not the proper way to empty the bag and could contribute to a UTI.	F 880	Catheter Care Policy, including ensuring the drainage bag does not touch the floor unless a barrier is provided. Additionally, Resident 44's urinary status was reassesed and it was determiined that he is appropriate for, and would benefit from, a urinary leg bag for his catheter. An additional benefit is that it mitigates this event from happening again to Resident 44. The leg bag will be off the floor. Facility Wide Response Addressing how Other Residents Potentially Impacted will be Identified and Reviewed: 1. Facility nursing staff will receive a refresher education module on the facilty's Catheter Care Policy. The emphasis of the training will be on emptying indwelling catheter bags. 2. Residents potentially impacted will be identified using the MDS 3.0 Resident-Level Quality Measure (QM) Report. 3. Ongoing random audits will be conducted on nursing personnel emptying catheter bags and catheter bag cares. These audits will be conducted by the infection preventionist, director of nursing, and clinicaL coordinators, for not less than one year with a 100% compliance rating as our goal. Data obtained from the aforementioned audits will be incorporated into the facilty's Quality Assurance and Performance	

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F 880	Continued From page 25 Facility Catheter Care policy dated 7/3/23, indicated it was the policy of the facility to ensure residents with indwelling catheters received appropriate catheter care when an indwelling catheter was in use; to ensure the drainage bag was not touching floor surfaces unless barrier was provided.	F 880	Improvement (QAPI) program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process. Said audits will continue for a period not less than one year.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/4/24, to 8/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was were reviewed with NO deficiencies cited: H55906574C (MN00105472). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state	2 000		

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2 000	Continued From page 2 form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with	2 302		9/22/24

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2 302	Continued From page 3 this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in written or electronic format, a description of the their Alzheimer's training program, the categories of staff trained, the basic topics covered and the frequency of the training. Findings include: During interview on 8/6/24 at 12:09 p.m., the administrator confirmed the facility had not provided to consumers in written or electronic form, a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. SUGGESTED METHOD OF CORRECTION: The administrator or designee could update written materials, facility postings or website materials, to include the required information related to their Alzheimer's training program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected	
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director	2 895		9/22/24

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2 895	Continued From page 4 of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement therapy recommendations in a timely manner to maintain strength and mobility for 1 of 1 resident (R41) reviewed for range of motion (ROM). Findings include: R41's face sheet, indicated diagnoses of Parkinson's disease, age-related physical debility, and weakness. R41's admission Minimum Data Set (MDS) assessment dated 6/13/2024, identified no cognitive impairment, the ability to understand and be understood, no rejection of care, limited range of motion on both sides of upper and lower extremities, and physical assist with personal hygiene, bed mobility, dressing, toilet use, and transfers. R41's care plan dated 6/26/2024 and revised 8/5/2024, indicated staff were to assist resident with ROM (range of motion) to bilateral upper and lower extremities as resident tolerates and resident totally dependent on staff for all transfers and mobility.	2 895	Corrected	

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2 895	Continued From page 5 R41's PT (physical therapy) Therapist Evaluation Summary dated 6/11/2024, indicated staff were to assist R41 with upper and lower body passive range of motion programs daily and to see attachments for passive stretches recommended. Also instructed to provide slow and gentle stretches during range of motion and to ensure R41's tolerance with verbal and visual pain assessments. R41's OT (occupational therapy) Therapist Evaluation Summary dated 6/12/2024, indicated a recommendation of bilateral upper extremity PROM (passive range of motion) for staff to perform daily to prevent worsening muscle contractures. R41's Kardex (used by nursing assistance's) dated 8/5/2024, failed to include any reference to PROM exercises. R41's orders dated 8/5/2024, failed to include any reference to PROM exercises. On 8/5/2024 at 10:26 a.m., R41 was observed in his wheelchair with arms bent up towards his chest. R41 stated staff had not completed exercises with him and he would have liked them to do exercises and stretching with him. On 8/5/2024 at 3:33 p.m., registered nurse (RN)-C stated the PROM exercises were missed when therapy recommended them and the recommendations for R41 had not been started. RN-C further stated that going forward the recommendations will be implemented right away. On 8/6/2024 at 8:40 a.m., occupational therapist (OT)-F stated the therapy department gave the	2 895		

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	00605	A. BUILDING: _____ B. WING _____	C 08/06/2024

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2 895	Continued From page 6 recommendation to nursing on 6/12/2024. OT-F further stated the lack of PROM did not cause change in functional ability for R41 due to already severely impaired active movement and functional control of extremities. OT-F also stated R41 would still benefit from implementation of the PROM recommendations. On 8/6/2024 at 10:45 a.m., director of nursing (DON) stated she would expect PROM recommendations to be implemented timely to prevent decline in functional abilities. A policy titled Prevention of Decline in Range of Motion revised 1/2024, stated the following: a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: assistance as needed (active assisted, passive, and supervision). SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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21390	Continued From page 7	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to follow proper procedures to prevent the spread of infection when emptying a urinary drainage bag for 1 of 1 resident (R44) observed for infection control practices.	21390	Corrected	9/22/24

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21390	Continued From page 8 Findings include: R44's facesheet, included diagnoses of Alzheimer's disease, retention of urine, and urinary tract infection (UTI). R44's significant change Minimum Data Set (MDS) assessment dated 5/1/24, indicated R44's was cognitively impaired. R44 was usually understood and could usually understand. R44 did not walk and was dependent on staff for most activities of daily living (ADL). Physician orders dated 11/14/23, included monitoring Foley (a type of indwelling catheter) output each shift. R44's care plan with revised date of 7/30/24, indicated indwelling catheter related to urinary retention; staff were to manage the catheter to prevent UTI. The drainage bag was to be emptied every shift. During an interview on 8/4/24 at 1:28 p.m., family member (FM)-E stated R44 had a urinary catheter in place because, "His urine doesn't come out." FM-E stated R44 had a bad UTI in April 2024 and was hospitalized. During an observation on 8/5/24 at 1:24 p.m., in R44's room, nursing assistants (NA)-A and NA-B moved R44 from his wheelchair to the toilet via an EZ-stand (a device that helps someone stand up from a chair). While R44 sat on the toilet, NA-A set the urinary drainage bag directly on the floor next to the toilet and emptied the urine from the urinary drainage bag into a urinal. During an interview on 8/5/24 at 1:36 p.m., NA-A	21390		

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21390	Continued From page 9 was informed of the observation of the urinary drainage bag on the floor. NA-A stated she had to do that to get the clamp open on the port to drain out the urine. NA-A indicated it could cause bacteria to enter R44's urinary drainage system and stated, "He's had infections." During an interview on 8/5/24 at 2:47 p.m., registered nurse (RN)-A indicated, "That's a big infection control issue" and stated she would have expected the urinary drainage bag to be hooked onto something when emptying it. During an interview on 8/6/24 at 10:50 a.m., the director of nursing (DON) was informed of the observation of a NA setting a urinary drainage bag on the floor of the bathroom to empty it and acknowledged that was not the proper way to empty the bag and could contribute to a UTI. Facility Catheter Care policy dated 7/3/23, indicated it was the policy of the facility to ensure residents with indwelling catheters received appropriate catheter care when an indwelling catheter was in use; to ensure the drainage bag was not touching floor surfaces unless barrier was provided. SUGGESTED METHOD OF CORRECTION: The DON (director of nursing) or designee could re-educate staff on proper infection control practices related to emptying a urinary drainage bag. The DON or designee could perform periodic audits to ensure staff adherence and results of those audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committee to determine compliance and need for further monitoring. Time Period for Correction: Twenty-one (21)	21390		

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21390	Continued From page 10 days.	21390		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure doses of a controlled substance were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerators observed for medication storage. Findings include: During an observation on 8/6/24 at 7:52 a.m., observed two nurses, licensed practical nurse (LPN)-A and registered nurse (RN)-B perform shift change narcotic reconciliation in a medication cart at the "Mainstreet" nurses station. At the end of the narcotic count, LPN-A stated they also needed to count the narcotics in the refrigerator. During an observation of the small dorm-size refrigerator in the locked medication room, an opened, multi-dose bottle of lorazepam (a medication to relieve anxiety) concentrate, 2 mg/ml (milligrams per milliliter) was observed on a shelf on the door of the refrigerator - not in a separately locked, permanently affixed compartment in the refrigerator.	21615	Corrected	9/22/24

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21615	Continued From page 11 During an interview on 8/6/24 at 12:38 p.m., the director of nursing (DON) was informed of the observation and stated she was unaware lorazepam, a schedule IV medication, needed to be in a separately locked, permanently affixed compartment in the refrigerator. Facility Medication Storage policy dated 7/24, indicated if a medication was supplied in a unit-dose system, schedule III-IV medications could be stored in trays with other medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review medication storage policies and re-educate nursing staff on proper storage of controlled medications. The DON or designee could conduct periodic audits to ensure controlled medications are securely stored with the appropriate locking devices. The DON or designee, could conduct random audits to ensure controlled medications are stored properly. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21615		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the	21915		9/22/24

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21915	Continued From page 12 responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 50 residents who reside in the facility and families. Findings include: During interview on 8/5/24, at 2:24 p.m., social services (SS)-B confirmed the facility did not have an existing family council nor has a letter been sent to families related to interest in forming a family council since March 6, 2023. During interview on 8/5/24, at 3:05 p.m., the director of nursing indicated she was not aware no attempts were made over the past year to form a family council. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure attempts are made annually to develop a family council. The administrator or her designee could develop monitoring systems for auditing to ensure attempts are made to initiate the family council. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915	Corrected	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/06/2024. At the time of this survey, THE LUTHERAN HOME BELLE PLAINE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 08/30/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THE LUTHERAN HOME BELLE PLAINE is a two-story building with a partial basement. The building was constructed at (5) different times. The original building was built in 1954, is one-story, has no basement, and was determined to be of Type V(111) construction. The 1st	K 000		

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K 000	Continued From page 2 Addition was built in 1967, is one-story, has no basement, and was determined to be of Type II(111) construction. The 2nd Addition was built in 1971, is two-stories, has no basement, and was determined to be of Type II(111) construction. The 3rd Addition was built in 1998, is one-story, has no basement, and was determined to be of Type II(111) construction. The 4th Addition was built in 2008, is one-story, has no basement, and was determined to be of Type II(111) construction. Because the original building and all subsequent additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.	K 271		8/30/24

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K 271	Continued From page 3 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide approved discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/06/2024 between 9:30 AM and 2:00 PM, it was revealed by observation that the exit located adjacent to U144, the sidewalk exhibited vertical slab-to-slab displacement greater than ½ inch presenting a trip and fall hazard. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 271	It is the policy, and intention, of The Lutheran Home: Belle Plaine, to be in full compliance with all regulations and requirements of both the Medicaid and Medicare Programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility's CREDIBLE ALLEGATION OF COMPLIANCE. The written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The facility wishes to preserve its right to dispute these findings in their entirety should any remedies be imposed. It is the intention of The Lutheran Home: Belle Plaine, to be in compliance with K271 - NFPA 101 Discharge from Exits (LSC 2012 Health Existing) The facility's standard of practice is to be compliant with NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6. It is the facility's intention to keep all walking surfaces as approved per NFPA 101 (2012 edition). ADS concreate lifting fixed one of the sidewalks outside of 144, on August 29, 2024. They will be back on August 30, 2024, with the correct equipment to get the other sidewalk lifted.	

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K 271	Continued From page 4	K 271	Facility Wide Response Addressing measures put into place to ensure the deficiency does not reoccur and monitoring measures to ensure solutions are sustained includes monthly inspections of all egresses. Monthly inspection prompts will be established in our TELS System. Our maintenance team will be responsible for conducting the inspections. Inspection data will be reviewed and acted upon by the environmental services director or her designee. Data obtained from the aforementioned inspections will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.	K 374		8/30/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LUTHERAN HOME: BELLE PLAINE	**611 WEST MAIN STREET BELLE PLAINE, MN 56011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 5 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire / smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/06/2024 between 9:30 AM and 2:00 PM, it was revealed by observation that the following fire / smoke barrier door assemblies exhibited and air-gap greater that 1/8 inch, allowing the movement and passage of smoke: Assembly adjacent to U119, Assembly adjacent to RM U115, Assembly adjacent to RM 313, Assembly adjacent to RM 315, Assembly adjacent to RM 301, Assembly adjacent to RM 213, Assembly adjacent to the Dining Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	The intention of The Lutheran Home: Belle Plaine, is to be compliant with the requirements at K374 as it relates to Subdivision of Building Spaces-Smoke Barrier Doors. The facility's intention is to maintain its smoke barrier doors per NFPA 101 (2012 edition), Life Safety Codes, sections 19.3.7.6, 19.3.7.8, 19.3.7.9 and 8.5.4.1 Several fire/smoke barrier door assemblies exhibited an air-gap greater than 1/8 inch. Fire doors were all fixed by in-house maintenance team between 8/7/24 □ 8/12/24. The maintenance supervisor verified on 8/29/24, that the doors in the tag are all in working order. Ongoing monitoring of smoke barrier doors for compliance at K374 will be conducted monthly by the maintenance team. Data obtained from the smoke barrier audits will be reviewed and analyzed as part of the facility's ongoing Quality Assurance and Performance Improvement (QAPI) process, to ensure ongoing compliance with the requirements at K374.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 1, 2024

Administrator
The Lutheran Home: Belle Plaine
611 West Main Street
Belle Plaine, MN 56011

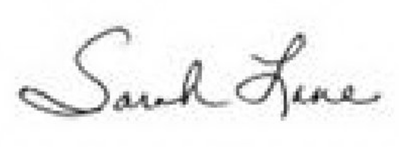
RE: CCN: 245590
Cycle Start Date: August 6, 2024

Dear Administrator:

On September 30, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Electronically delivered

October 1, 2024

Administrator
The Lutheran Home: Belle Plaine
611 West Main Street
Belle Plaine, MN 56011

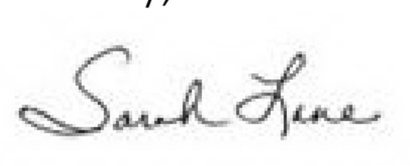
Re: Reinspection Results
Event ID: 5BWJ12

Dear Administrator:

On September 30, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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