Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2023

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

RE: CCN: 245590
Cycle Start Date: September 21, 2023

Dear Administrator:

On September 21, 2023, 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:

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

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 December 21, 2023 (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 March 21, 2024 (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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

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 09/21/2023

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
E 000	Initial Comments On 9/18/23 - 9/21/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/18/23 - 9/21/23, 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 complaints were reviewed with NO deficiencies cited: H55905538C (MN91658) H55905644C (MN89546) H55905645C (MN83928) H55905646C (MN83634) H55905647C (MN83673) H55905648C (MN83579) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/06/2023

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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F 000	Continued From page 1 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 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 document review, the facility failed to ensure medications were labeled with current, accurate physician orders and in accordance with the standard of	F 761	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	10/27/23

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F 761	Continued From page 2 care to reduce the risk of adverse events (i.e., errors) for 1 of 7 residents (R40) observed to receive medication during the survey. Findings include: During observation on 9/20/23 at 11:55 a.m., licensed practical nurse (LPN)-A prepared an Insulin Aspart pen 100 unit/mL for R40 from a mobile medication cart. The label instructed to subcutaneously inject 6 units of Insulin Aspart 100 units/mL twice daily before breakfast and lunch and to hold if blood sugar was less than 150. LPN-A administered the Insulin Aspart to the resident and returned the insulin pen to the cart. Review of the electronic medical record had an order dated 6/3/23 which directed staff to inject Insulin Aspart 100 unit/mL solution injection subcutaneously (0.06 mL/6 unit) twice a day at breakfast and lunch and to hold if blood sugar less than 120. The electronic medical record also had an order dated 6/2/23 which directed staff to inject Insulin Aspart 100 unit/mL solution injection subcutaneously (0.04 mL/4 unit) daily at supper and to hold insulin if blood sugar less than 120. During interview on 9/21/23 at 12:42 p.m., LPN-B stated they would verify the order and put a sticker on the medication label to indicate the order changed or remove medication from the cart and ask pharmacy for a new label if they discovered a medication label did not match current orders. LPN-B stated they would report the discrepancy to the next shift. LPN-B verified the label on R40's Insulin Aspart pen instructed to hold the insulin if R40's blood sugars was less than 150 and R40's MAR instructed to hold the insulin if blood sugar was less than 120. LPN-B	F 761	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 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. Contributing factors to this finding is that the label on the insulin Aspart pen had not been updated to reflect the administration parameters change made on 6/3/23. The label on the insulin Aspart pen has been updated to reflect the correct parameters for medication administration. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. Faciliy Staff responsible for medication	

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F 761	Continued From page 3 stated the label did not describe R40's order to receive 4 units of Insulin Aspart 100 unit/mL at supper time either. During observation and interview of medication cart on 9/21/23 at 4:12 p.m., TMA-A verified the medication cart held expired Tylenol suppositories 650 mg for R40 with expiration date of 6/21/23. TMA-A verified Tylenol suppositories were supposed to be stored in a refrigerator as indicated on its label. During interview on 9/21/23 at 5:11 p.m., the director of nursing (DON) stated if a medication order changed, staff should put a "change of direction" sticker on the medication label. The DON stated they expected staff to have placed a sticker on the insulin pen and follow the order in the MAR or clarify the order. The DON stated the risk of the insulin pen label and MAR not matching depended on the dosing of the insulin given or held. The DON stated they expected medications to be discarded immediately if expired and stored according to appropriate guidelines. The facility's policy "Medication Labels" dated 9/2023, indicated if the physician's direction for use changed or the label was inaccurate, the nurse may place a "direction change-refer to chart" label on the container indicating there was a change in directions for use. The policy directed the medication nurse to check the resident's MAR or the physician's order for current information and staff to inform the pharmacy prior to the next refill of the prescription so the new container shows an accurate label. The medication storage policy was requested but	F 761	administration will complete a medication administration review module. 2.Weekly medication pass observations (medication pass observation tracking form included with this POC) will be conducted by the clinical coordinators and/or the director of nursing. These observations will include checkiing for accurate labeling and expiration of medications. All concerns identified during the medication reviews will be brought to the attention of the director of nursing immediately. 3. Ongoing: Quarterly audits of accurate medication labeling will be conducted by the contracted pharmacy consultant. Data obtained from the aforementioned audits (both weekly 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. The facility's goal is a medication error rate less than 3% of both weekly audits and cumulative data over the course of one year.	

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F 761	Continued From page 4 not provided.	F 761		
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: §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	F 880		10/27/23

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F 880	Continued From page 5 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed for 1 of 1 resident (R40) observed for incontinence cares. Findings include: R40's quarterly Minimum Data Set (MDS) dated	F 880	It is the intention of The Lutheran Home: Belle Plaine, to be compliant with the requirements at F880 CFR(s) 483.80(a)(1)(2)(4)(e)(f) Infection Control.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	

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F 880	Continued From page 6 6/28/23, included R40 was moderately cognitively impaired, required extensive assistance of one staff for toileting and personal hygiene, had a urinary catheter and was always incontinent of bowel. R40's care plan dated 7/12/23, included R40 required staff assistance with perineal hygiene and wiping, oral care, and dressing, used an incontinence brief, and instructed staff to keep his skin clean and dry and his linens dry and wrinkle free. During observation of morning cares on 9/21/23 at 8:55 a.m., nursing assistant (NA)-A washed her hands, filled a wash basin with warm soapy water, put gloves on, placed a clean washcloth in the soapy water, and handed it to R40 so he could wash his face. NA-A used the washcloth to wash R40's body, set the wash basin to the side, removed her gloves, completed hand hygiene, and then donned gloves to apply a cream to a red area at the tip of R40's penis. She removed the gloves, washed her hands, put on new gloves, and assisted R40 to roll to his left side. A cloth pad was under R40 covering the bottom sheet. NA-A removed R40's soiled incontinence brief placed it in the garbage can by the bed and reached for a package of wipes on the top of the night stand next to the bed. She used several wipes from the container to remove feces from R40 and placed them directly into the garbage can, then removed several more and stacked them up on top of the container of wipes. She used those one by one, and placed them in a pile, soiled with fecal matter, on the cloth under pad next to the package of clean wipes. When she was finished wiping R40 she grabbed the pile of soiled wipes from the under pad with her soiled	F 880	development and transmission of communicable diseases and infections. Contributing factors to this finding includes Nursing Assistant A's being distracted by the survey process and being directly observed by a surveyor. The nursing assistant was aware of not following appropriate infection control policy and procedure immediately following the observation. In response, the nursing assistant completed a hand hygiene educational module and completed a hand hygiene policy/presentation review test. The nursing assistant also did a return demonstration of technique with the infection preventionist. Facility Wide Response Addressing Other Residents with the Potential to be Affected: 1. Facility staff receive ongoing infection control education. All direct care staff will successfully complete a hand hygiene learning module via the facility's electronic learning system, by the date certain for this POC. 2. The facility's infection preventionist, will conduct weekly random direct observation audits of staff performing hand hygiene practices and procedures to ensure compliance. The audit tool accompanies this POC. 3. Ongoing weekly Audits of appropriate glove usage and hand hygienme will be conducted by the infection preventionist,	

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F 880	Continued From page 7 gloved hands and placed them in the garbage can. NA-A picked up the package of clean wipes and moved it to the nightstand, grabbed a clean incontinence brief, tucked it under R40, rolled him over to his back, affixed the brief, and adjusted his legs. She removed her gloves, and without performing hand hygiene, brought the wash basin to the bathroom, came out and took a sweatshirt from the closet, moved the wipes from the top of the nightstand into a drawer, removed R40's deodorant and helped him apply it, assisted R40 with his sweatshirt, and adjusted his pillows. NA-A went to the bathroom and picked up R40's toothbrush, added toothpaste, and brought it out to R40 along with a small basin, a towel, and a cup of water so he could brush his teeth. NA-A went into the bathroom and put one glove on her right hand to clean the large wash basin, removed the glove and washed her hands. While R40 brushed his teeth NA-A donned gloves, picked up a urinal from the bathroom and emptied R40's catheter bag. She dumped the contents into the toilet and set the urinal on the back of the toilet, removed her gloves, and without washing her hands, picked up the cup of water and gave it to R40 to rinse his mouth. She brought the cup, toothbrush, and basin back to the bathroom and put the oral care products into the wall cabinet. NA-A brought R40's electric razor to the bathroom to plug it in per his request, flushed the toilet containing the previously dumped urine, turned the bathroom light off, closed the door, and picked up the bag of soiled linen and garbage bag containing the soiled brief and wipes, tied them closed, replaced the bags, organized papers on top of R40 night stand, moved his overbed table closer to the bed, and then grabbed both bags with no gloves, opened the door to the hallway, touched a code into the	F 880	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 Improvement (QAPI) program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process.	

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F 880	Continued From page 8 keypad to open the soiled utility room, dropped off the bags, and then performed hand hygiene. During interview on 9/21/23 at 9:20 a.m. NA-A confirmed she did not complete hand hygiene as she should have, set the soiled wipes on R40's under pad without replacing it, and stated it was important to do these things to prevent the spread of germs. During interview on 9/21/23 at 11:32 a.m. registered nurse (RN)-A stated she expected staff to perform hand hygiene before and after cares, when helping residents to the bathroom, before donning gloves, and after removing them. During interview on 9/21/23 at 1:08 p.m. director of Nursing (DON) stated hand hygiene should be completed before, during, and after cares, and before donning and after removing gloves for infection control purposes. The facility Hand Hygiene policy dated 7/3/23, included all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy indicated if a task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.	F 880		

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	245590	A. BUILDING **01 - MAIN BUILDING 01 1951 ADDITION** B. WING _____	**09/19/2023**

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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 09/19/2023. 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 IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/12/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 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	K 000		

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K 000	Continued From page 2 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 97 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 211	It is the policy, and intention, of The	10/27/23

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K 211	Continued From page 3 facility failed to maintain facility means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6.1.1, 7.1.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that the concrete slab outside of the Chapel Exit exhibited a 2-inch gap between the threshold and the slab, creating a potential trip or fall hazard. 2. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that the concrete slab outside of the Sun Porch Exit (Door #7) exhibited a 1-inch gap vertical drop between threshold and the slab, creating a potential trip or fall hazard. 3. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that the concrete slab outside of the Main Street North Exit exhibited an uneven walking surface and degrading of concrete walkway, creating a potential trip or fall hazard. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211	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 K0211, Means of Egress, as described in NFPA 101. The facility's standard of practice is to keep all aisles, passageways, corridors, exit discharges, exit locations, and accesses in compliance with Chapter 7, and the means of egress continuously maintained free of all obstructions to full use in the case of an emergency. The concrete slabs in were corrected by mud jacking on September 28, 2023. 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	

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K 211	Continued From page 4	K 211	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 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain, test and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9, 7.9.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed during documentation review	K 291	It is the intent of The Lutheran Home: Belle Plaine, to be in compliance with K291. Emergency lighting of at least 1-1 1/2 hours duration is provided automatically in accordance with NFPA 101 7.9, 18.2.9.1 and 19.2.9.1. The emergency lighting testing requirement has been added to the facility's TELS System to ensure that it is being completed and documented. The environmental services director, or her	10/27/23

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K 291	Continued From page 5 that no documentation was present for review to confirm that emergency light testing in occurring. 2. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed during observation that the emergency light fixture located in the area of the Basement Parts Room was found disconnected from wall outlet power. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 291	designee, will monitor and assure that the testing is being completed and documented. The referenced light fixture in the basement parts room is not an emergency lighting fixture and was left there after the last remodel of the boiler room. The light fixture did not work and was removed. All of the light fixtures in the basement parts and boiler rooms are tied into the generator for emergency lighting in these rooms. Emergency lighting testing data 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. Audits will continue for not less than one year.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324		10/7/23

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K 324	Continued From page 6 or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5, 19.3.2.5.3(9). These deficient findings could have an isolated impact on the residents within the facility. Findings Include: On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that in the following locations cooking device did not have the proper lock-out, timeout, and disconnect hardware connected to the device: Facility Serving Kitchens; Physical Therapy / Occupational Therapy Area. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	It is the intention of The Lutheran Home: Belle Plaine, to be in compliance with the requirements at K324 of NFPA 101 as it applies to Cooking Facilities. Furthermore, it is the facility's intention to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5, 19.3.2.5.3(9). All 3 cooking devices referenced in this finding, have been disconnected from their power source until the proper lock-out, timeout, and disconnect hardware arrives. Proper lock-out, timeout, and disconnect hardware has been ordered for all 3 cooking devices referenced in this finding. UPS has sent confirmation of an October 18, 2023, delivery confirmation. Once the	

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K 324	Continued From page 7	K 324	safety features have been added to the 3 cooking devices, the maintenance department will monitor their continued working order during monthly safety inspections. Observations and data obtained will be shared at the facility's Quality Assurance and Performance Improvement (QAPI) Meetings and incorporated into the QAPI process to ensnsure ongoing compliance.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to conduct visual inspection of manual fire alarm boxes (pull-stations) per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.14.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that manual fire	K 345	It is the intention of The Lutheran Home: Belle Plaine to be in compliance with K345, the testing and maintenance of the Fire Alarm System in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and signaling Code, section 17.14.5. A small stainless steel cart with wheels was parked in front of the pull station in the LTC kitchenette. dietary staff will monitor the pull station on a daily basis, to	10/27/23

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K 345	Continued From page 8 alarm pull-station located in the LTC Kitchenette was access obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	ensure that access to the pull station is not obstructed. The environmental services director will be responsible for documenting monthly compliance observations. The information gathered will be presented to the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Recommendations. including recommendations based upon observed data, will be integrated into the QAPI process.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in	K 353	It is the intention of The Lutheran Home: Belle Plaine, to be in compliance at K353	10/27/23

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K 353	Continued From page 9 accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2(5)(6), 5.2.1.2, 5.2.2.2, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section 8.5.6. These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation in the Activities Room Closet the sprinkler head exhibited signs of paint splatter. 2. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation in the Kitchen and Dishwashing Area of the facility exhibited signs of debris loading and oxidation. 3. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that throughout the facility that sprinkler heads located in close proximity to HVAC corridor positive pressure venting exhibited signs of debris loading. 4. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation in the Basement Parts Room that a water capture tarped assembly was attached too and being load-supported by the sprinkler piping system. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	for the Maintenance and Testing of the Sprinkler System. Maintenance and Testing of the Fire Alarm System requires inspection and testing in accordance with NFPA 25. The facility acknowledges that the records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. All sprinkler heads in the findings will be replaced and/or corrected by Summit Fire Protection and the maintenance department. All sprinkler heads will be inspected, for compliance with the aforementioned requirements, on a semi-annual basis. The plastic water tarped assembly was removed from the sprinkler piping system, in the basement parts room. The outcome, of said inspections, will be maintained in a secure location and will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) Program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process to ensure ongoing compliance with all rules and regulations which apply.	

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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. 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 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 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that the Dementia Care Unit fire / smoke barrier door exhibited and air-gap greater that 1/8 inch, allowing the movement and passage of smoke. An interview with the Maintenance Director verified this deficient finding 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. The facility's intention is to maintain its smoke barrier doors per NFPA 101 (2012 edition), Life Safety Codes, sections 19.3.7.8 and 8.5.4.1. The dementia care unit fire/smoke barrier door exhibited an air-gap greater than 1/8 inch. Parts for the door, to correct the finding, have been ordered and are expected to arrive on October 6, 2023. Upon receipt, the equipment will be installed to correct the gap. Ongoing monitoring of smoke barrier doors for compliance at K374 will be conducted monthly by the maintenance	10/27/23

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	245590	A. BUILDING **01 - MAIN BUILDING 01 1951 ADDITION** B. WING _____	**09/19/2023**

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THE LUTHERAN HOME: BELLE PLAINE	**611 WEST MAIN STREET BELLE PLAINE, MN 56011**

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K 374	Continued From page 11	K 374	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.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		10/27/23

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K 918	Continued From page 12 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that 36-month - 4-hour load bank testing is occurring for the emergency generator serving the Dementia Care Unit of the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	The Lutheran Home: Belle Plaine, maintains compliance at K918, as it relates to Electrical Systems-Essential Electric System Maintenance and Testing. Findings stated that it was revealed by a review of available documentation that no documentation was presented for review to confirm that a 36-month 4-hour load bank test had occurred in the facility's dementia care unit. Upon speaking with the environmental services director, documentation exists demonstrating the required load bank testing of the dementia unit's generator on July 25, 2023. Pioneer Critical Power conducted the testing. In order to maintain compliance with the load bank testing requirement, Pioneer Critical Power tracks when the testing has occurred and when it is due. The facility also does this by tracking the requirement on our TELS System. Load bank testing documentation and outcomes are presented to the facility's Quality Assurance and Performance Improvement (QAPI) Committee on a	

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K 918	Continued From page 13	K 918	quarterly basis.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a widespread impact on the	K 920	It is the intention of The Lutheran Home: Belle Plaine to be in compliance with the requirements at K920, relating to Electrical Equipment-Power Cords and Extension Cords. During the survey, there were findings involving managing the usage of relocatable power taps in accordance with NFPA 99 (2012 edition)	10/27/23

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K 920	Continued From page 14 residents within the facility. Findings include: 1. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that in RM 128 that relocatable power taps were daisy chained together. 2. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that in Main Kitchen Office that and appliance was connected to a relocatable power tap. 3. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that in RM 139 a relocatable power tap was connected to 1-to-3 wall plug adapter. 4. On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that in Physical Therapy that relocatable power taps were connected to wall mounted power strips. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	and NFPA 70 (2011 edition). 1. The relocatable power taps that were daisy chained in room 128 has been removed. 2. According to the dietary director, the appliance referenced in the Main Kitchen Office was a refrigerator and is plugged directly in the wall, and has never been plugged into a relocatable power tap. 3. The relocatable power tap that was connected to a 3 wall plug adapter in room 139, has been removed. 4. The facility's information technology director reconfigured the computer equipment which had been plugged into relocatable power taps that were plugged into wall mounted power strips in the physical therapy department. The power strips have been removed from the room. All facility staff will be re-educated on electrical equipment, power cords, and extension cords. In order to maintain compliance, all staff will monitor electrical outlets and electrical equipment during the work responsibilities. Any variation of what is allowed at K920, will be immediately brought to the attention of the environmental services or the individual who is in charge of the building. Monthly audits will be conducted by the maintenance team and the data obtained from the audits will be presented to the Quality Assurrance and Performance	

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K 920	Continued From page 15	K 920	Improvement (QAPI) Committee's attention for review, analysis and recommendation. This formal reporting will continue for not less than one year.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with	K 923		10/27/23

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K 923	Continued From page 16 integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5, 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by observation in the Med Gas (O2) Storage Room there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	It is the intent of The Lutheran Home: Belle Plaine, to be in compliance with all of the requirements of K923, Gas Equipment-Cylinder and Container Storage. The facility intends to maintain proper medical gas storage and management according to NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. Empty oxygen cylinders have been separated from full cylinders and properly marked. The oxygen cylinders are stored secured in an oxygen cylinder holding rack provided by the facility's oxygen provider. Weekly audits by the maintenance team will ensure proper storage. The data obtained from the weekly checks will be presented at the quarterly Quality Assurance and Performance Improvement Meetings. Recommendations based upon observed data, will be incorporated into the QAPI process. Audits will continue for not less than one year.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of	K 926		10/27/23

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K 926	Continued From page 17 Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2023 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm confirming that staff in the facility have been trained on the risks associated with their handling and use of medical gases and cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926	It is the intention of The Lutheran Home: Belle Plaine, to be in compliance with Medical Gas Equipment Qualifications and Training of Personnel at K926. All personnel concerned with the application, maintenance and handling of medical gases and cylinders will be trained on the risks. The facility will provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of the equipment. To ensure ongoing compliance with the requirements at K926, random audits of training records of personnel responsible for medical gas equipment usage, maintenance and storage will be conducted. The facility's human resource department will conduct the audits. Audit outcome data will become part of the facility's Quality Assurance and Performance Improvement process.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 29, 2023

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

RE: CCN: 245590
Cycle Start Date: September 21, 2023

Dear Administrator:

On November 6, 2023, the Minnesota Departments of Health and Public Safety 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.

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