Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 26, 2022

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

RE: CCN: 245590
Cycle Start Date: May 12, 2022

Dear Administrator:

On June 27, 2022, we notified you a remedy was imposed. On July 18, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 7, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 12, 2022 be discontinued as of August 7, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 25, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 12, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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August 26, 2022

CMS Certification Number (CCN): 245590

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 7, 2022 the above facility is certified for:

97 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 97 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any 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 05/12/2022

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 5/9/22, through 5/12/22, 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 5/9/22, through 5/12/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5590122C (MN00082842). 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. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/07/2022

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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of potential neglect and/or abuse to the State Agency (SA) for 3 of 3 residents (R2, R37, R6) reviewed for abuse. Findings include:	F 609	Plan of Corrections: F609 SS= D Reporting of Alleged Violations Based on interview and document review, the facility failed to ensure that State agency (SA)was notified within two hours	7/12/22

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F 609 Continued From page 2

R2's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/25/22 indicated the resident had a "Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed R2 was cognitively intact. Review of the functional status indicated R2 required extensive assistance of one staff member for bed mobility and transfers. R2 did not have any behaviors during the look back period. This MDS indicated R2 required the assistance of one staff member to walk in her room and required the assistance of one staff member for toilet use.

Review of a document provided by the facility titled "Concern/Grievance Investigation Report," dated 4/28/22 indicated R2 reported to a family member that she had been assisted by nursing assistant (NA)-A to the bathroom after supper and R2 claimed NA-A refused to assist her back to her recliner. Per report, R2 told her family member she was still in her wheelchair and NA-A commented "No wonder no one wants to work with you." Per report, the family member instructed R2 to set the phone down and leave him on the phone to hear the conversation. Per report, the family member stated another voice, NA-B, was overheard to say, "Good luck, you have her and I don't." Per the report, the family member then asked R2 about the comment and R2 reported NA-A was present during this exchange.

During an interview on 5/9/22 at 8:53 a.m, R2 stated not all staff treated her well. R2 stated there were two staff members who worked the evening shift from 3:00 p.m. to 11:00 p.m.. R2 stated she had reported an incident to Social Services Designee (SSD)-B. During a

F 609

of reported allegations, following reported allegations and incidents reported by (R2, R37, & R6) Corrective Action: Clinical Coordinators, Social Services Department, & DON were immediately educated on reporting requirements for Alleged Violations.

Clinical Leadership, Social Services were reeducated on June 10th, 2022, on the Reporting Requirements of all Alleged Violations. On June 06, 2022, all facility staff were enrolled in a Relias Course for Recognizing, Reporting, and Preventing Abuse. Policy and Procedure Reviewed. Auditing Tool created.

Corrective Action: Clinical Leadership were re-educated on June 10th, 2022, on the Reporting Requirements of all Alleged Violations.
Audits will be completed 1 time for 4 weeks; results will be reviewed by the Administrator and/or DON. Any concerns will be addressed as discovered and education will be provided. Any pattern identified will be immediately addressed. If necessary, an action plan will be written by Interdisciplinary Team. Any written action plan will be monitored and tracked by Administrator weekly until resolution. All audits, results, concerns, patterns will review at quarterly QA committee. If QA determines through reviewing audits and results that deem concerns, random audits will continue to take place until QAA deems necessary, and concerns are resolved.

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F 609	Continued From page 3 subsequent interview at 9:43 a.m., R2 stated the two staff members were no longer working at the facility. R2 stated she felt abused by the two staff members. R2 stated NA-B had made a snide remark to her, while NA-B was out in the hallway to NA-A. R2 stated NA-A did not want to take her to the bathroom before bed and made a face at her. R2 stated this made her feel terrible. R2 stated facility staff never asked her if she felt abused. R2 stated she reported this to incident to the SSD-B and the Resident and Family Liaison (RFL)-A. During an interview on 5/11/22 at 2:37 p.m., family member (FM)-F confirmed he was the one who R2 reported an incident to. The FM-F confirmed he asked R2 to place the phone down and to keep it on so he could hear any interaction. FM-F stated R2 reported to him NA-A was physically and verbally rough. FM-F confirmed there was a "smart comment" made to R2 and stated NA-B made the comment "you got her and good luck." The family FM-F stated the facility implemented that two staff members were present, while providing care to R2, after this incident. FM-F stated he reported the incident the next day. The family member did not remember the dates of these incidents. During an interview on 5/11/22 at 4:51 p.m., the administrator stated she was unsure when R2's allegation was brought to her attention. The administrator stated RFL-A (clinical coordinator) conducted the initial investigation regarding R2's allegations. The administrator stated the facility sought information for the SA before reporting an allegation of abuse/neglect. The administrator stated the facility gathered information and identified if abuse occurred or not. The	F 609	On May 18th, 2022, Education provided to all QAA members regarding F609 S=D Reporting of Alleged Violations Director of Nurses and/or Clinical Coordinators of neighborhoods will be responsible for the completion of the audits. Audits will be provided to the Administrator and kept in folder. Logs of audit results will be maintained and tracked by DON and/or Administrator.	

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administrator stated the facility identified if the information gathered matched the criteria for repotting to the SA or not. The administrator stated R2 received the services she requested and therefore no report was made to the SA.

R37's annual "MDS" with an "ARD of 12/29/21 indicated the resident had a "BIMS" score of 15 out of 15 which revealed R37 was cognitively intact. Review of the functional status indicated R37 required extensive assistance of two staff members for bed mobility and transfers. The resident did not have any behaviors during the look back period.

R37's care plan dated 8/16/21 indicated there were to be two staff present in R37's room since the resident had a history of making accusations of mistreatment.

Review of a document provided by the facility titled "Nurses Notes," dated 11/21/21 at 3:35 a.m. indicated R37 became angry and aggressive to nursing aid (NA-C) during cares and would not allow NA-C to help put lotion on his back until much later. The nurses notes indicated R37 had a history of blaming staff and making up stories. R37 claimed NA-C threw the lotion bottle on him and made fists. The nurse then documented he spoke with NA-C; and advised her to avoid talking back to the resident when resident became aggressive or angry.

Review of a document provided by the facility titled "Concern/Grievance Investigation Report," dated 11/23/21 indicated R37 reported on 11/21/21 he had asked NA-C to place lotion on his neck. R37 stated NA-C threw the lotion bottle at him hitting his face. R37 stated he did not feel

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safe with NA-C with him.

During an interview on 5/9/22 at 9:30 a.m., R37 stated he turned a staff member in and believed the staff member still worked at the facility.

During an interview on 5/10/22 at 8:26 a.m., the administrator was asked who makes the determination of whether an allegation was considered an abuse allegation or a grievance and when would an allegation of abuse be reported to the SA. The administrator stated the facility had two hours to investigate to decide if the allegation was reportable or not to the SA. RFL-A was present during this interview and stated R37's allegation came to her attention on 11/23/21 and the allegation happened over the weekend (11/21/21 was a Sunday). RFL-A stated her part of the grievance report was dated 11/23/21 and this was when she received the initial allegation. The administrator stated registered nurse (RN)-A received the initial report from R37.

During an interview on 5/10/22 at 9:32 a.m., RN-A stated R37's allegations were made on the night shift on 11/21/21 and she came into work that morning in which she was alerted to R37's allegations. RN-A, who was the clinical coordinator for R37, stated she may had been alerted to R37's allegations at approximately 9:00 a.m. on 11/21/21.

During a subsequent interview on 5/10/22 at 10:15 a.m., R37 stated he was afraid of NA-C and stated she was by herself when he had asked NA-C to apply lotion to his back. R37 pointed to a bottle of lotion. R37 stated NA-C wanted to apply another lotion product instead of

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F 609	Continued From page 6 the that lotion, and he said "no." R37 said NA-C then threw the bottle at him hitting him in the face. R37 stated there were typically two staff present, but not during this incident. During an interview on 5/10/22 at 9:44 a.m., the director of nursing (DON) stated there was not a pattern of abuse with R37. The DON stated there was no need to contact the SA since the facility investigated the allegation and made the determination that no abuse happened. The DON stated her expectation was not to report the allegation made by R37 to the SA. During an interview on 05/10/22 at 10:24 a.m., RFL-A stated her responsibility, when an allegation of abuse was made was to ensure the resident was safe. RFL-A stated she would notify the clinical coordinators, DON, and the administrator of allegations. RFL-A stated by the time she received an allegation of abuse much of the leg work had been completed by the clinical coordinator. RFL-A stated it was the clinical coordinator who would notify the SA of an allegation of abuse and this should be done within a two-hour period. During an interview on 5/11/22 at 1:01 p.m., the medical director stated any time the facility was able to substantiate an allegation of abuse, the SA would then be notified. During an interview on 5/11/22 at 5:16 p.m., RN-A stated all facility staff were mandated reporters and RN-A confirmed she did not notify the SSA regarding R37's allegation of abuse. R6's quarterly Minimum Data Set (MDS) dated 2/9/22, indicated R6 had intact cognition and no	F 609		

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F 609	Continued From page 7 rejection of care. The MDS further indicated R6 required one personal physical assist with transfers, bed mobility, dressing, toilet use, personal hygiene, and bathing R6' s care plan printed 5/12/22, indicated R6's diagnoses included dementia with behavioral disturbance, obsessive compulsive disorder, and cognitive impairment. Documented titled Concern/Grievance Investigation Report dated 4/15/22, indicated on 4/15/22, at approximately 1 p.m. R6 complained that she was forced to take a bath. On 5/10/22, at 8:12 a.m. during an interview dietary aide (DA)-A indicated approximately a month ago she observed registered nurse (RN)-A, in a very loud voice, direct R6 to take a bath or R6 could not live at the facility anymore. DA-A stated she reported the incident within two hours to the assistant cook and human resources. On 5/11/22, at 11:24 a.m. the administrator indicated when she received an allegation of abuse she would determine the timeframe of the allegation, ensured resident safety, and immediately started the investigation. The administrator stated the facility would first investigate the incident prior to notification to the SA. The administrator indicated the SA would be notified if the incident was determined substantiated by the facility or not completed within two hours. The administrator stated the incident with R6 occurred 4/15/22, approximately at 12:45 p.m. and confirmed the incident was not reported to the SA and indicated the facility completed a comprehensive investigation and	F 609		

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determined the incident was not reportable. The administrator further indicated the investigation verified R6 felt safe, did not feel abused and had no other concerns. The administrator discussed she was following the facilities policy about investigation first and then reporting to the SA.

On 5/12/22, at 9:03 a.m. during an interview the human resource director indicated DA-A contacted her regarding an incident with R6 and stated she immediately notified the administrator of the incident.

Review of a document provided by the facility titled "Abuse, Neglect, & Exploitation," dated 09/23/21, indicated ". . .Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. . . Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injures of unknown source, and misappropriation of resident property. . . Deprivation by staff of goods or services includes those goods or services that are necessary to attain or maintain physical,

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F 609	Continued From page 9 mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s). . . Immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than 2 hours after the allegation is made, if the events (Potential crime) that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. . . Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. . ."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 610		7/12/22

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F 610	Continued From page 10 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a thorough investigation for two 2 of 2 residents (R2, R37) who were reviewed for abuse. Findings include: R2 Review of a document provided by the facility titled "Concern/Grievance Investigation Report," dated 4/28/22, indicated R2 reported to a family member that she had been assisted by nursing assistant (NA)-A to the bathroom after supper and R2 claimed NA-A refused to assist her back to her recliner. Per the report, NA-B and NA-A allegedly made negative comments referring to the resident. Per the report as part of the investigation, the facility pulled the call light report and noted R2 waited for a staff member for 44 minutes before assisting her. The grievance report revealed NA-A and NA-B were contracted from a staffing agency and their contracts were not extended. There was no information to show other staff and residents were interviewed as part of the facility's investigation to rule out potential abuse/neglect. There were no interviews identified with NA-A and NA-B. During an interview on 5/9/22 at 8:53 a.m., R2 stated not all staff treated her well and she had reported an incident to Social Services Designee (SSD)-B. During a subsequent interview at 9:43 a.m., R2 stated the two staff members were no longer working at the facility. R2 stated she felt	F 610	F610 SS= D Investigate/Prevent/Correct Alleged Violations Based on interview and document review, the facility failed to to complete a thorough investigation for 2 of 2 residents (R2, R37) who were reviewed for abuse. Corrective Action: Clinical Coordinators, Social Services Department, & DON were immediately educated on completing and documenting a thorough investigation to include addition interviews if applicable. Clinical Leadership, Social Services were reeducated on June 10th, 2022, on the completing and documenting a thorough investigation. On June 06, 2022, all facility Directors, Licensed Staff, and Clinical Coordinators were enrolled in a Relias Course for Conducting Abuse Investigation. Policy and Procedure Reviewed. Auditing Tool created. Corrective Action: Clinical Leadership and Social Services were re-educated on June 10th, 2022, on the conducting and documenting a thorough investigation for alleged violations. Audits will be completed 1 time for 4 weeks; results will be reviewed by the Administrator and/or DON. Any concerns will be addressed as discovered and education will be provided. Any pattern identified will be immediately addressed. If	

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 05/12/2022

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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F 610	Continued From page 11	F 610		

abused by the two staff members. R2 stated NA-B had made a snide remark to her, while NA-B was out in the hallway to NA-A. R2 stated NA-A did not want to take her to the bathroom before bed and made a face at her. R2 stated this made her feel terrible. R2 stated facility staff never asked her if she felt abused.

During an interview on 5/10/22 at 11:43 a.m., NA-A confirmed he worked with R2. NA-A stated he was an agency NA for the facility. NA-A stated no one from the facility contacted him regarding an allegation of neglect that involved R2.

During an interview on 5/10/22 at 12:07 p.m., NA-B confirmed she worked with R2. NA-B stated no one from the facility contacted her regarding an allegation of abuse that involved R2.

During an interview on 5/11/22 at 4:51 p.m., the administrator stated she was unsure when R2's allegation was brought to her attention. The administrator stated the Resident and Family Liaison (RFL)-A conducted the initial investigation regarding R2's allegations. RFL-A was present during this interview and stated she did not interview NA-A and NA-B as part of the facility's investigation. RFL-A stated she did not contact the staffing agency to obtain written statements from NA-A and NA-B regarding abuse/neglect allegation made by R2.

R37

Review of a document provided by the facility titled "Concern/Grievance Investigation Report," dated 11/23/21, indicated the allegation made by R37 happened on 11/21/21. The report indicated R37 claimed NA-C was not fast enough to apply

necessary, an action plan will be written by Interdisciplinary Team. Any written action plan will be monitored and tracked by Administrator weekly until resolution. All audits, results, concerns, patterns will review at quarterly QA committee. If QA determines through reviewing audits and results that deem concerns, random audits will continue to take place until QAA deems necessary, and concerns are resolved.

On May 18th, 2022, Education provided to all QAA members regarding F610 S=D Investigate/Prevent/Correct Alleged Violations
Director of Nurses and/or Clinical Coordinators of neighborhoods will be responsible for the completion of the audits. Audits will be provided to the Administrator and kept in folder. Logs of audit results will be maintained and tracked by DON and/or Administrator.

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F 610	Continued From page 12	F 610		

lotion to his back and then claimed NA-C threw the bottle of lotion hitting him in the face when he asked told her "Never mind." The report indicated both the nurse on duty (no name was present) and NA-C were present. The report indicated R37 stated he did not feel safe with NA-C present. The report failed to include specific statements collected from the staff involved. There was no information to show other staff and residents were interviewed as part of the facility's investigation to rule out potential abuse/neglect.

During an interview on 5/9/22 at 9:30 a.m., R37, when questioned about abuse, stated he turned a staff member in and believed the staff member still worked here.

During an interview on 5/10/22 at 9:13 a.m., registered nurse (RN)-A, the clinical coordinator for R37, confirmed she interviewed R37 as part of her investigation. RN-A stated there were to be two staff members present during cares of R37. RN-A stated when there was an allegation of abuse/neglect she made a referral to the social services department. RN-A stated NA-C worked for a staffing agency. RN-A stated she placed a call to NA-C and left a message to have NA-C speak with her. RN-A stated she did not interview other residents as part of her investigation.

On 5/10/22 at 11:14 a.m., the administrator presented documents and stated these documents were part of the facility's investigation of R37 that alleged NA-C threw a bottle of lotion at him. Review of the undated handwritten documents failed to identify a resident name, date, or time of when the notes were taken. Included with these documents was a typed document, again without a name of the resident

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F 610	Continued From page 13	F 610		

who was involved, full names of staff members who were interviewed, and failed to identify specifically when the RN-A was notified of an allegation of abuse. The typed note indicated there was a witness, who stood at the door of the resident's room to observe the interaction between a staff member and a resident. This typed document failed to identify who the witness was.

During an interview on 5/11/22 at 11:24 a.m., the administrator stated when she received an allegation of abuse/neglect, they attempt to identify the time frame when the incident may have occurred. The administrator stated she then pulled in the appropriate team members to ensure the resident was safe. The administrator stated the facility would call the staff member who was involved and attempt to locate other witnesses and stated the facility completed all their investigation within two hours after receiving the allegation of abuse/neglect. The administrator stated the facility completed a thorough investigation.

Review of a policy provided by the facility titled "Abuse, Neglect, & Exploitation," dated 09/23/21, indicated ". . .It is the policy of the Lutheran Home Association that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation of property) are promptly and thoroughly investigated. . . The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately upon identification of alleged abuse. A root cause investigation and analysis will be completed. The information gathered is given to administration. All staff must cooperate during the investigation

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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**

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F 610	Continued From page 14 to assure the resident is fully protected. . . The investigation will include . . . who was involved . . . resident's statements . . . involved staff and witness statements of events. . ."	F 610		

Electronically delivered
May 25, 2022

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

RE: CCN: 245590
Cycle Start Date: May 12, 2022

Dear Administrator:

On May 12, 2022, 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:

Sarah Grebenc, Unit Supervisor
Metro A 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: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 August 12, 2022 (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 November 12, 2022 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 25, 2022

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

Re: Event ID: 7GHR11

Dear Administrator:

The above facility survey was completed on May 12, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00605	A. BUILDING: ______ B. WING ______	C 05/12/2022

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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2 000	Initial Comments	2 000		

*****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 5/9/22 through 5/12/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.

The following complaints were found to be

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00605	A. BUILDING: ______ B. WING ______	C 05/12/2022

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

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2 000	Continued From page 1 UNSUBSTANTIATED: H5590122C (MN00082842). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		