DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NE1C
Facility ID: 00605

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245590**

2.STATE VENDOR OR MEDICAID NO.
(L2) **751243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHERAN HOME**
(L4) **611 WEST MAIN STREET**
(L5) **BELLE PLAINE, MN** (L6) **56011**

4. TYPE OF ACTION: 7 (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/12/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 10/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/20/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/20/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245590

October 20, 2015

Ms.. Ann Robinson, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, Minnesota 56011

Dear Ms.. Robinson:

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 October 1, 2015 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 bed.

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 Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118   Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 20, 2015

Ms.. Ann Robinson, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, Minnesota 56011

RE: Project Number S5590026

Dear Ms.. Robinson:

On September 15, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 28, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 3, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 28, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 28, 2015, effective October 1, 2015 and therefore remedies outlined in our letter to you dated September 15, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245590	A. Building B. Wing	10/12/2015

Name of Facility	Street Address, City, State, Zip Code
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	10/01/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	10/01/2015	ID Prefix F0257 Reg. # 483.15(h)(6) LSC	10/01/2015
ID Prefix F0356 Reg. # 483.30(e) LSC	10/01/2015	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	10/01/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GL/mm	Date: 10/20/2015	Signature of Surveyor: 15507	Date: 10/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/28/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245590	A. Building B. Wing 02 - 1961, 1970, 1998 ADDITIONS	10/3/2015

Name of Facility	Street Address, City, State, Zip Code
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0076	Correction Completed **10/01/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	10/20/2015	25822	10/03/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/26/2015				

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NE1C
Facility ID: 00605

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245590**

2. STATE VENDOR OR MEDICAID NO. (L2) **751243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHERAN HOME**
(L4) **611 WEST MAIN STREET**
(L5) **BELLE PLAINE, MN** (L6) **56011**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/28/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sandro Tatro, HFE NEII 09/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/19/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **01/01/1992** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 15, 2015

Ms. Ann Robinson, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, Minnesota 56011

RE: Project Number S5590026

Dear Ms. Robinson:

On August 28, 2015, a standard 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> **- your right to request an informal reconsideration to dispute the attached deficiencies.**

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 24, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 28, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by February 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 ______	08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	**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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		10/1/15

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

Electronically Signed — 09/25/2015

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.

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 ______	08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	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
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 injuries of unknown origin to the designated State agency (SA) for 1 of 1 resident (R116) who experienced an unwitnessed fall with hip fracture and hospitalization. In addition, facility failed to report resident to resident altercation immediately to the designated SA for 1 of 3 residents (R34) who were reviewed for abuse prohibition. Findings include: R116's incident/accident report dated 5/8/15, at 9:45 p.m. revealed the resident had a fall and sustained a right hip fracture in the hallway and no one witnessed the fall. The fall summary indicated that R116 was found on the floor lying on his back in the south hallway. His shoes were intact on his feet and no items were on the floor that he may have caused him to trip. Due to his level of dementia, he was unable to recall how or	F 225	The following plans of correction are being submitted in good faith to comply with Federal & State law. The plan of correction is not an admission of wrong doing or failure to meet a standard of a breach of any statute, rule, regulation, or standard. It is the policy and intention of The Lutheran Home to be in compliance with all regulations and requirements of the Medicaid and Medicare programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101 (2000) F225 It is the policy of the Lutheran Home to ensure that all alleged violations involving injuries of unknown origin are reported immediately to the state agency. 1. An internal investigation was	

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F 225

Continued From page 2

why he ended up on the floor. R116's incident report revealed that resident complained of pain to right lower extremity, winced when right hip/groin area was palpated and was unable to completely straighten.

R116's fall investigation report (FIR) dated 5/8/15, identified medical status/illness dementia and weakness as the contributing factors. FIR identified root cause of the fall as being "Resident has a dx [diagnosis] of dementia and wanders frequently. Is unaware of safety measures". Portable X-ray was obtained later that evening which identified a fracture. R116 was sent to the hospital the following morning and underwent surgery. Although the incident was unwitnessed and the resident was unable to state what had happened, the incident was never reported to the SA.

A review of R116's medical history and care plan identified diagnoses including dementia with behaviors, Alzheimer's disease, paranoid state and anxiety. The care plan also identified R116 has having impaired decision making skills, being unaware of safety needs and being at risk for falls due to history of falls/injury. R116's annual Minimum Data Sat (MDS) dated 6/1/15, identified resident with severe cognitive impairment and needed extensive assistance of two plus person physical assist with bed mobility, transfer, dressing, toilet use and personal hygiene.

During an interview on 8/27/15, at 1:20 p.m. with the vice president of operations, administrator, and the director of nursing (DON) the staff explained they had reviewed the incident during the interdisciplinary team (IDT) meeting but they did not report it because they deemed it to be

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conducted on resident R116 on 5/8/2015 and for resident 34 on 5/4/2015. Staff involved have been reeducated on abuse reporting.
2. Corrective action as it applies to others: The policy and procedure for abuse prevention have been reviewed. All staff will be reeducated on abuse prevention and reporting on September 30 and October 1, 2015.
3. Recurrence will be prevented by systematic changes:
¿ Review and revise vulnerable adult reporting policies as necessary.
¿ Reeducate all staff regarding reporting of alleged violations involving abuse allegations and injuries of unknown origin.
¿ Provide NHA designee(s) education regarding investigation and determination of reportability to the Administrator and to other officials in accordance with State and Federal law.
4. Facility will monitor performance by :
¿ Interdisciplinary team to review incident reports at interdisciplinary team meeting for compliance with decision making and provide reeducation as necessary.
¿ Summary report will be provided to QAA/QAPI committee which meets quarterly.
5. Correction will be monitored by: NHA or designee.

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F 225	Continued From page 3 non-reportable. The DON verified the fall was unwitnessed and R116 could not accurately report what had actually happened. The administrator noted that there was no violation of care plan and that "If it was care planned and the care plan was violated, that's when we report". The DON stated that "We update the care plan after every fall". R34's vulnerable adult reporting tool dated 5/4/15, revealed that R34 was assaulted by another resident resulting in bruising to the left forearm and scrape to the right elbow. The incident details report indicate that the incident took place on 5/4/15. The perpetrator was sent to the hospital on 5/4/15, at 10:30 p.m. The incident was reported to the office of healthcare facility complaints (OHFC) on 5/6/15, two days after the occurrence of the incident. This incident was not reported immediately to the SA. During an interview on 8/28/15, at 11:19 a.m. the DON verified that the reportable incident was reported to OHFC two days later and not immediately. The DON stated that she did not know why the report was submitted to OHFC two days later. During an interview on 8/28/15, at 11:29 a.m. the administrator also confirmed that the report was submitted to OHFC two days later. The administrator stated that her expectations was the reports would be submitted "on time" but was not sure why the the social service staff had been late in submission. Later that afternoon at 12:00 p.m. the administrator reported that she had tried to locate the social worker who submitted the report, but had been unable to reach her.	F 225		

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F 225	Continued From page 4 The Lutheran Home Vulnerable Adult Reporting policy dated 7/1/15, identified the reportable incidents to include, "Unexplained injury (incident causing injury was not observed, and can not be reasonably explained, and the injury is suspicious in nature due to extent, location of number of injuries". The policy further stated that, "Reportable incidents must also be electronically sent to the Minnesota Department of Health Office of Health Facility Complaints within 24 hours of the incidents discovery as required at 42 CFR 483.13(c) (2). Within 5 working days after the incident the facility investigative report must be entered and submitted to MDH. The administrator, director of nursing, social worker, or designee will complete and submit report".	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to operationalize policies for abuse prohibition as required for 2 of 4 residents (R34, R116) reviewed for allegations of abuse and/or injuries of unknown origin. In addition, the facility's policy failed to direct staff to immediately report any potential allegations of abuse or neglect to the designated State agency (SA). Findings include:	F 226	The following plans of correction are being submitted in good faith to comply with Federal & State law. The plan of correction is not an admission of wrong doing or failure to meet a standard of a breach of any statute, rule, regulation, or standard. It is the policy and intention of The Lutheran Home to be in compliance with all regulations and requirements of the Medicaid and Medicare programs as	10/1/15

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F 226	Continued From page 5 The Lutheran Home Vulnerable Adult Reporting policy dated 7/1/15, identified the reportable incidents to include, "Unexplained injury (incident causing injury was not observed, and can not be reasonably explained, and the injury is suspicious in nature due to extent, location of number of injuries". The policy further stated that, "Reportable incidents must also be electronically sent to the Minnesota Department of Health Office of Health Facility Complaints within 24 hours of the incidents discovery as required at 42 CFR 483.13(c) (2). Within 5 working days after the incident the facility investigative report must be entered and submitted to MDH. The administrator, director of nursing, social worker, or designee will complete and submit report". R116's incident/accident report dated 5/8/15, at 9:45 p.m. revealed the resident had a fall and sustained a right hip fracture in the hallway and no one witnessed the fall. The fall summary indicated that R116 was found on the floor lying on his back in the south hallway. His shoes were intact on his feet and no items were on the floor that he may have caused him to trip. Due to his level of dementia, he was unable to recall how or why he ended up on the floor. R116's incident report revealed that resident complained of pain to right lower extremity, winced when right hip/groin area was palpated and was unable to completely straighten. R116's fall investigation report (FIR) dated 5/8/15, identified medical status/illness dementia and weakness as the contributing factors. FIR identified root cause of the fall as being "Resident has a dx [diagnosis] of dementia and wanders frequently. Is unaware of safety measures".	F 226	well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101 (2000) It is the policy of the Lutheran Home to operationalize vulnerable adult policies and to direct staff to immediately report any potential allegations of abuse or neglect to the designated State agency. 1. An internal investigation was conducted on resident R116 on 5/8/2015 and for resident 34 on 5/4/2015. Staff involved have been reeducated on abuse reporting. 2. Corrective action as it applies to others: The policy and procedure for abuse prevention were reviewed and are being revised to direct staff to immediately report any potential allegations of abuse or neglect to the designated State agency. 3. Recurrence will be prevented by systematic changes: ¿ Vulnerable adult and abuse prohibition policies and procedures will be reviewed and revised to ensure compliance with F226. ¿ All staff will be reeducated to the updated policies and procedures on September 30 and October 1, 2015. 4. Facility will monitor performance by: ¿ QAA/QAPI committee to review and approve revision of vulnerable adult and abuse prohibition policies and procedures. ¿ HR Director to review all training records to ensure completion. ¿ Incident reports will be reviewed at Interdisciplinary team meeting for	

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F 226	Continued From page 6 Portable X-ray was obtained later that evening which identified a fracture. R116 was sent to the hospital the following morning and underwent surgery. Although the incident was unwitnessed and the resident was unable to state what had happened, the incident was never reported to the SA. A review of R116's medical history and care plan identified diagnoses including dementia with behaviors, Alzheimer's disease, paranoid state and anxiety. The care plan also identified R116 has having impaired decision making skills, being unaware of safety needs and being at risk for falls due to history of falls/injury. R116's annual Minimum Data Sat (MDS) dated 6/1/15, identified resident with severe cognitive impairment and needed extensive assistance of two plus person physical assist with bed mobility, transfer, dressing, toilet use and personal hygiene. During an interview on 8/27/15, at 1:20 p.m. with the vice president of operations, administrator, and the director of nursing (DON) the staff explained they had reviewed the incident during the interdisciplinary team (IDT) meeting but they did not report it because they deemed it to be non-reportable. The DON verified the fall was unwitnessed and R116 could not accurately report what had actually happened. The administrator noted that there was no violation of care plan and that "If it was care planned and the care plan was violated, that's when we report". The DON stated that "We update the care plan after every fall". R34's vulnerable adult reporting tool dated 5/4/15, revealed that R34 was assaulted by another resident resulting in bruising to the left forearm	F 226	compliance with policy and reporting decision making and recommend reeducation as needed. ¿ QAA/QAPI committee to review summary report of all incidents to evaluate for compliance and make any additional recommendations or changes to policy and procedure. 5. Correction will be monitored by NHA or designee.	

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F 226	Continued From page 7 and scrape to the right elbow. The incident details report indicate that the incident took place on 5/4/15. The perpetrator was sent to the hospital on 5/4/15, at 10:30 p.m. The incident was reported to the office of healthcare facility complaints (OHFC) on 5/6/15, two days after the occurrence of the incident. This incident was not reported immediately to the SA. During an interview on 8/28/15, at 11:19 a.m. the DON verified that the reportable incident was reported to OHFC two days later and not immediately. The DON stated that she did not know why the report was submitted to OHFC two days later. During an interview on 8/28/15, at 11:29 a.m. the administrator also confirmed that the report was submitted to OHFC two days later. The administrator stated that her expectations was the reports would be submitted "on time" but was not sure why the the social service staff had been late in submission. Later that afternoon at 12:00 p.m. the administrator reported that she had tried to locate the social worker who submitted the report, but had been unable to reach her.	F 226		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 257	The following plans of correction are	10/1/15

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Continued From page 8

review the facility flied to ensure comfortable temperatures were maintained for 3 of 5 (R11, R53, R2) residents reviewed for environmental concerns.

Findings include:

R11 reported on 8/24/15, at 4:25 p.m. it was too cold in the building, and she was "freezing" all the time. R11 reported she had informed staff, but was told they could do nothing about the problem, because the air conditioning was on because the "staff" needed it. R11's Minimum Data Set (MDS) 8/12/15, indicated the resident had intact cognition.

R53 reported the temperature in her room was "too cold" all the time in her room, and she had to wear a sweater and use a heating pad to help her stay warm. R53's MDS 8/5/15, indicated her cognition was intact cognition was intact.

R2 reported on 8/26/15, at approximately 1:45 p.m. the temperatures were kept too cold in the building and all of the residents had to wear sweaters. R2 added that it "didn't do any good" to complain about it to staff. A registered nurse then stated, "All the residents are complaining their rooms are too cold. I think they have the thermostat turned down." The administrator then reported, "I just put into the TELS [communication system] for maintenance to be checking air temperatures in all the neighborhoods which they need to be doing."

The director of facility services (DFS) stated on 8/26/15, at 9:07 a.m. the computer in the maintenance office showed the temperature of the common areas in the facility. He also stated

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being submitted in good faith to comply with Federal & State law. The plan of correction is not an admission of wrong doing or failure to meet a standard of a breach of any statute, rule, regulation, or standard. It is the policy and intention of The Lutheran Home to be in compliance with all regulations and requirements of the Medicaid and Medicare programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101 (2000)

It is the policy of the Lutheran Home to maintain a safe and comfortable temperature

1. The air temperature on the second floor was adjusted during the survey and continues to be adjusted to accommodate the requests of those residents cited in the deficiency.

2. Corrective action as it applies to others:

¿ All residents in the facility have the potential to be affected based on their individual temperature preferences.

¿ Staff will be reeducated to put a request through Tels, our automated work order request system, if residents have temperature concerns in the facility.

¿ Maintenance staff will be reeducated to the building temperature requirements and the need to ensure responsiveness to individual resident concerns.

3. Recurrence will be prevented by systematic changes:

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F 257	Continued From page 9 that every other resident room had a thermostat and that two resident rooms were connected to one thermostat. The DFS stated staff were allowed to adjust thermostats in residents' rooms or common areas and that only therapy and laundry thermostats were locked because too many people adjusted them. When a complaint came to the maintenance staff, they just adjusted the temperatures, but did not track the complaints. Building temperatures were not routinely measured. The DFS also explained building temperatures had been dropped due to increased humidity, and temperatures were set at around 72 degrees, but not lower than 70 degrees. Residents were provided blankets, and resident vents could be shut in individual rooms, and/or thermostats which controlled the two rooms could be adjusted. The DFS said it could be challenging when residents did not agree on a comfortable temperature. The facility had added electric heat to the hallway during the past spring. The DFS stated he thought they could not set temperatures below 68 degrees. A maintenance staff (M)-B then entered the DFS's office and explained he reviewed temperatures on the computer, and set them at 72 degrees. If residents complained, he adjusted their thermostat. If residents complained of being cold in the summer, he checked the air handles and exhaust fans for proper function. Residents could open the windows in their rooms, as well. He had never tracked concerns voiced by residents about temperatures, rather they were verbal exchanges. Later that morning the DFS stated he relied on housekeeping and nursing staff to inform the maintenance staff if residents were too cold.	F 257	¿ A task has been put into our preventive maintenance and automated work order software called Tels to require weekly temperature monitoring of select common areas and resident rooms and interview of residents to ensure compliance. 4. Facility will monitor performance by: ¿ Resident reported satisfaction during monthly resident council meetings. ¿ Facility Services Director will review temperature logs for compliance monthly. ¿ Facility Services Director will provide a summary report to QAA/QAPI committee quarterly, which will recommend any additional changes. 5. Correction will be monitored by the Facility Services Director and NHA.	

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F 257	Continued From page 10 On 8/26/15, at approximately 1:30 p.m. a nursing assistant (NA)-A stated if a resident was too cold they provided them with a blanket. NA-A also stated it was hard to regulate the resident room temperatures with the air conditioning. NA-A said a lot of the residents wanted the air conditioning on, and staff did assist those who were cold to sit in the dining room where it was warmer. During an environmental tour on 8/26/15, at 10:20 a.m. temperatures were measured in various rooms as follows: 1) Room 200 the thermostat was set at 71 degrees and temperatures on the wall above the bed measured 73 degrees. A quilt was observed on the bed as well as three blankets and a sweatshirt jacket on the chair. Room 216 the room measured 70 degrees on several walls, however the diffuser in the ceiling was wide open, and a temperature reading measured 67 degrees. The hallway outside of room 216 measured 70 degrees. Room 223 measured 69 degrees when measured in several places, and 67 degrees at the diffuser bent in the veiling. The DFS explained that shutting the diffuser vent would definitely help in warming up the room. An Air & Water Temps: Test and Log Air Temperatures policy indicated, Instructions due by August 31, 2015 indicated Steps: This task has no steps. Perform task for building: SNF & Hope."	F 257		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		10/1/15

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F 356	Continued From page 11 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the nursing hours were accurately posted for public viewing. This had the potential to affect all residents and visitors to the facility. Findings include: Nursing staffing hours posted near the front door	F 356	The following plans of correction are being submitted in good faith to comply with Federal & State law. The plan of correction is not an admission of wrong doing or failure to meet a standard of a breach of any statute, rule, regulation, or standard. It is the policy and intention of The Lutheran Home to be in compliance with all regulations and requirements of	

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 ______	08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	**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
F 356	Continued From page 12 on 8/24/15, at approximately 1:30 p.m. revealed inaccuracies in hours worked for various shift designations within categories of registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants (NAs). Inaccuracies were also noted for some of the shift totals for all the workers within some employee categories. When staff hours postings were reviewed from the previous seven days, additional inaccuracies were noted, ranging from the total hours within a an employee category for a given shift, to total numbers of employees for different shifts, to total hours for different shifts. During an interview about the staff hours posting on 8/28/15, the director of nursing (DON) it was indicated may different shift combinations of shift start and end times were grouped within the traditional (day, evening and night shifts) to give them flexibility to maintain adequate staff coverage on the units. For example 12 shifts were noted to be worked by 16 NAs according to the 8/24/15 posting. Each of the various shifts had either different start times or different shift lengths, though all were grouped under the general category of "Day" on the posting. There were 14 different NA shifts grouped under "Evening" on the posting. According to clerical worker (CW)-B, who was present at the time and who was the person who created the postings, they utilized a spread sheet to keep track of employee hours and produce the hours posting. The DON and CW-B indicated the start and end times of the shifts on the posting were accurate as to what hours were being worked by employees on the various shifts. However, they said, the totals, or span of hours for start and end times were wrong in a few cases. The shift totals also indicated the times the employee was in the	F 356	the Medicaid and Medicare programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101 (2000) It is the policy of the Lutheran Home to post the daily nursing staffing information. 1. The facility corrected the formula in the nursing staffing posting during the time of the Minnesota Department of Health survey. The posting form will be amended to include all required information including Facility name, current date, total number and the actual hours worked by the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, licensed practical nurse, certified nurses aides and census. 2. Corrective action as it applies to others: Staff coordinator and house charge nurses will be reeducated as to the accurate completion of the form and posting requirements. 3. Recurrence will be prevented by systematic changes: ¿ The posting form will be revised to ensure compliance with the requirements of F356. ¿ Formulas will be protected in the document to ensure changes cannot accidentally be made when the form is updated. 4. The facility will monitor for performance by: ¿ The Director of Nursing or designee will audit for compliance weekly. ¿ Findings of audit will be reported to the QAA/QAPI committee quarterly who	

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 ______	08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	**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
F 356	Continued From page 13 building and did not account for any break times in the total. The policy for posting nursing staffing hours, dated 9/1/11 indicated up to date nursing hours would be posted on paper at the front entrance. It further indicated the posting was to include the total numbers of RNs, LPNs, and NA by shift. The responsibility for changing the posting was assigned to the overnight nurses, and was to be changed at the beginning of each day. On 8/28/15, at 11:28 a.m. CW-B stated regarding Monday's posting of the 6:30 a.m. to 11:00 a.m. LPN shift, with one LPN scheduled to work, "It says the total hours for that shift are 8.25 hours--that's wrong. It should say 4.5 hours." After further examining the posting she added, "And the total daytime amount of [NA] staff says 15. It should be 18. We need to change the formulas in the master of the spreadsheet." The DON, at 11:38 a.m. stated, "We would like [the time span between the start and end times indicated for the various shifts] to reflect the hours worked by the employee in the building," and reiterated that changes would need to be made to some of the hours spreadsheet formulas.	F 356	will recommend any additional change in practices. 5. Responsible Person: Director of Nursing	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		10/1/15

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 ______	08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	**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
F 431	Continued From page 14 controlled drugs is maintained and periodically reconciled. 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. 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. 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 narcotic medication was disposed of according to facility policy, and in a manner to minimize the least likelihood of narcotic diversion for 1 of 26 residents (R36) reviewed during medication administration observation. Findings include:	F 431	The following plans of correction are being submitted in good faith to comply with Federal & State law. The plan of correction is not an admission of wrong doing or failure to meet a standard of a breach of any statute, rule, regulation, or standard. It is the policy and intention of The Lutheran Home to be in compliance with all regulations and requirements of	

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 ______	08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	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

F 431

Continued From page 15

R36 was administered a Fentanyl (pain medication) patch on 8/27/15 at 8:18 a.m. by a licensed practical nurse (LPN)-B. LPN-B removed the used patch and placed the sticky side of the removed patch onto the envelope packaging of the new patch and stated, "That's how we dispose of them. I could flush it, but this is safer." Without the presence of a witness, she then disposed of the old patch in a sharps container (used to dispose of used needles) on the medication cart.

On 8/27/15 at 8:25 a.m. LPN-C was asked about the facility policy related to disposing of narcotic medication patches. LPN-C replied, "I've never come across that. I'll have to look into that--get the policy." LPN-C then sated she had to call the director of nursing and get back to the surveyor. At 8:54 a.m. LPN-C reported that the Fentanyl patch "should not have been disposed of that way. We should have folded it in half and flushed it down the sewer system. Going forward starting today we will do it that way." She then presented a policy from the pharmacy used by the facility and stated, "I talked to the DON and the nurse about it and we will inform all nurses about it, and will follow this from this time forward. We definitely need to do some education on that. The DON is working on an inservice for this today."

The Thrifty White Pharmacy Services Disposal of Fentanyl (Duragesic) Patches Policy noted proper disposal included the following: "The Fentanyl patch should be folded (so that the adhesive side adheres to itself) or placed onto a tissue paper (so that the adhesive side adheres to the disposable tissue paper)...Immediately flushed into the sewer system in the presence of a

F 431 (Plan of Correction)

the Medicaid and Medicare programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101 (2000)
It is the policy of the Lutheran Home to provide for safe and secure storage (including proper temperature controls, limited access, and mechanisms to minimize loss or diversion) and safe handling (including disposition) of all medication.

1. Staff member LPN-B was reeducated during the survey as to the policy on destruction of Fentanyl patches.
2. Corrective action as it applies to others:
¿ All licensed nursing staff were reeducated at the time of the survey as to proper destruction of Fentanyl patches.
3. Recurrence will be prevented by systematic changes
¿ Pharmacy policies and procedures have been made available online to improve accessibility for nursing staff.
¿ Medication destruction and diversion policies have been reviewed and revised and licensed staff reeducated on September 30 and October 1, 2015.
4. The facility will monitor performance by:
¿ The Director of Nursing or designee will audit for compliance by observing medication destruction practices once weekly on different neighborhoods for a month and then monthly going forward.
¿ Summary report to be provided to QAA/QAPI committee who meets quarterly and will evaluate for compliance

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 ______	08/28/2015

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

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F 431	Continued From page 16 licensed nurse and a witness...Placing the patches in sharps containers or other biohazard disposal containers is not acceptable...Destruction and witness of destruction must be documented on the medication administration record (MAR) or other appropriate documentation record in order to provide the facility with appropriate tracking of patch destruction in patient records." The DON was interviewed about the proper procedure for disposal of Fentanyl patches on 8/28/15 at 11:05 a.m. She indicated she did expect staff to follow facility policies, adding, "Per Thrifty policy, we're supposed to fold and flush them."	F 431	and make any additional recommendations or changes. 5. Responsible Person: Director of Nursing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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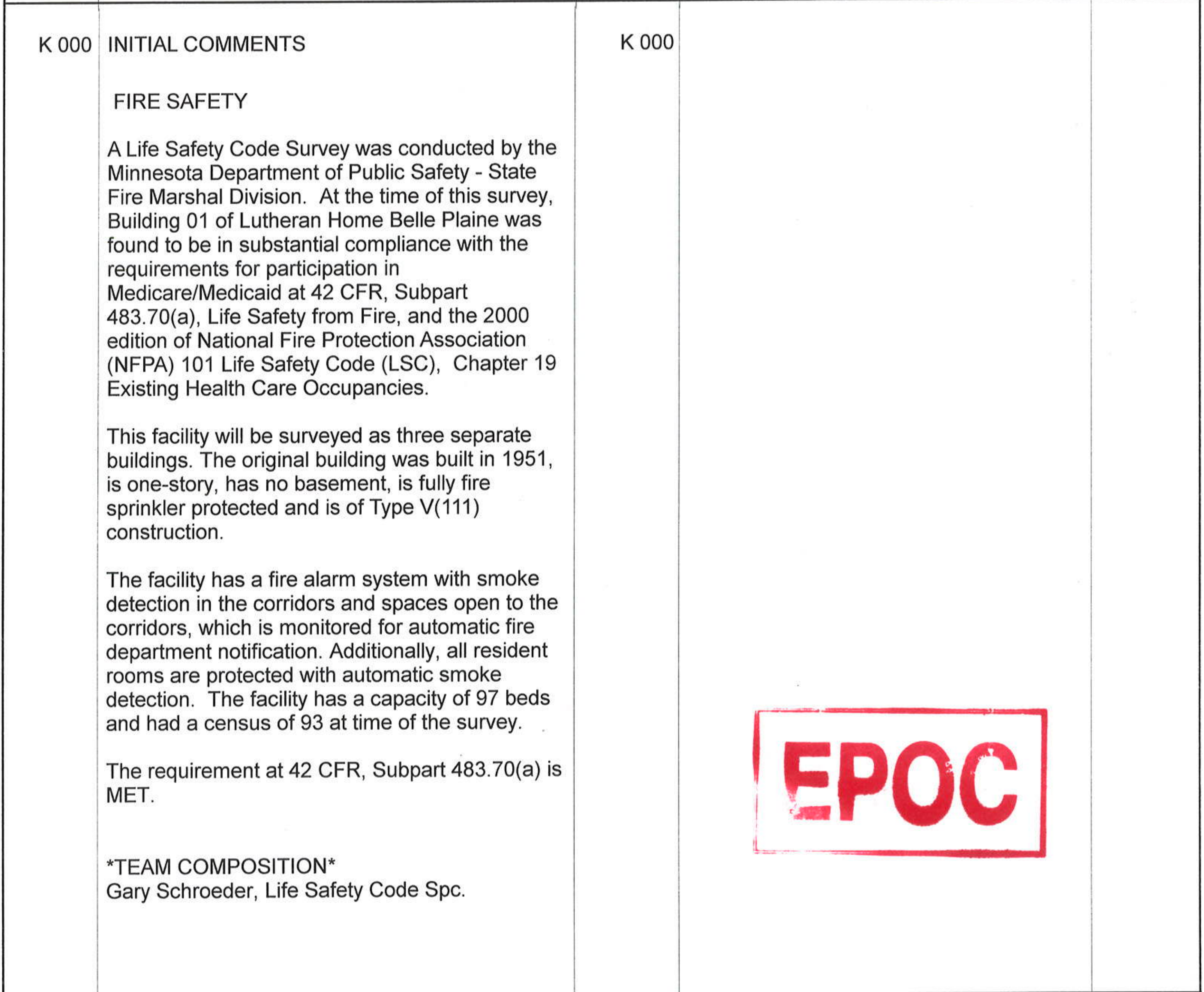
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING **01 - MAIN BUILDING 01 1951 ADDITION** B. WING ______	**08/26/2015**

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



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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Building 01 of Lutheran Home Belle Plaine was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. This facility will be surveyed as three separate buildings. The original building was built in 1951, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Additionally, all resident rooms are protected with automatic smoke detection. The facility has a capacity of 97 beds and had a census of 93 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2015

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5590023

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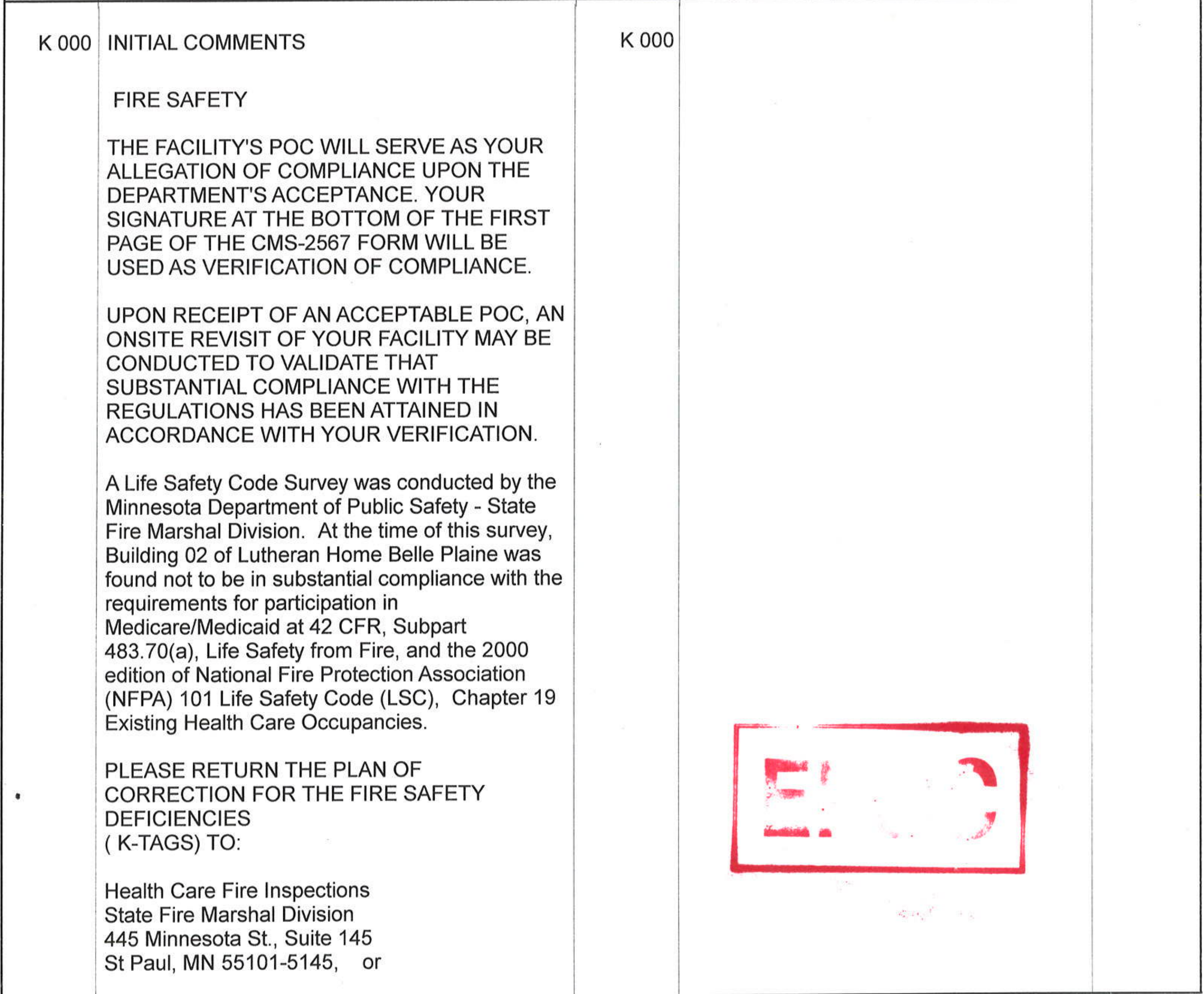
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING **02 - 1961, 1970, 1998 ADDITIONS** B. WING ____________	**08/26/2015**

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



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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Building 02 of Lutheran Home Belle Plaine was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING 02 - 1961, 1970, 1998 ADDITIONS B. WING	08/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

This facility will be surveyed as three separate buildings. The 1st Addition was built in 1961, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The 2nd Addition was built in 1970, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The 3rd Addition was built in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Additionally, all resident rooms are protected with automatic smoke detection. The facility has a capacity of 97 beds and had a census of 93 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING **02 - 1961, 1970, 1998 ADDITIONS** B. WING ______	**08/26/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has oxygen cylinders not properly stored in compliance with the requirements of 1999 NFPA 99, Sections 4-3.1.1.2. This deficient practice could affect 20 out of 93 residents. Findings include: On facility tour between 10:00 AM and 2:30 PM 08/26/2015, observation revealed that in the oxygen store room / transfill rooms over 3000 cubic feet, that the following was found: 1. Both rooms the light switches are located less than 5 feet off of the floor 2. Mechanical vent was not working on 2nd floor These deficient practices were confirmed by the Director of Maintenance (JS) at the time of discovery.	K 076	The following plans of correction are being submitted in good faith to comply with Federal & State law. The plan of correction is not an admission of wrong doing or failure to meet a standard of a breach of any statute, rule, regulation, or standard. It is the policy and intention of The Lutheran Home to be in compliance with all regulations and requirements of the Medicaid and Medicare programs as well as all Life Safety Code requirements for health care occupancies. It is the policy of the Lutheran Home to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99 1. The light switches in both oxygen rooms will be moved to less than 5 feet off	10/1/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245590	A. BUILDING 02 - 1961, 1970, 1998 ADDITIONS B. WING	08/26/2015

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

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K 076	Continued From page 3 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 076	the floor on 9/28/2015. 2. Repair of the mechanical vent in the 2nd floor oxygen storage room was completed on 9/4/2015. 3. Facility Services Director was responsible for the correction and the ongoing monitoring to prevent a reoccurrence of the deficiency	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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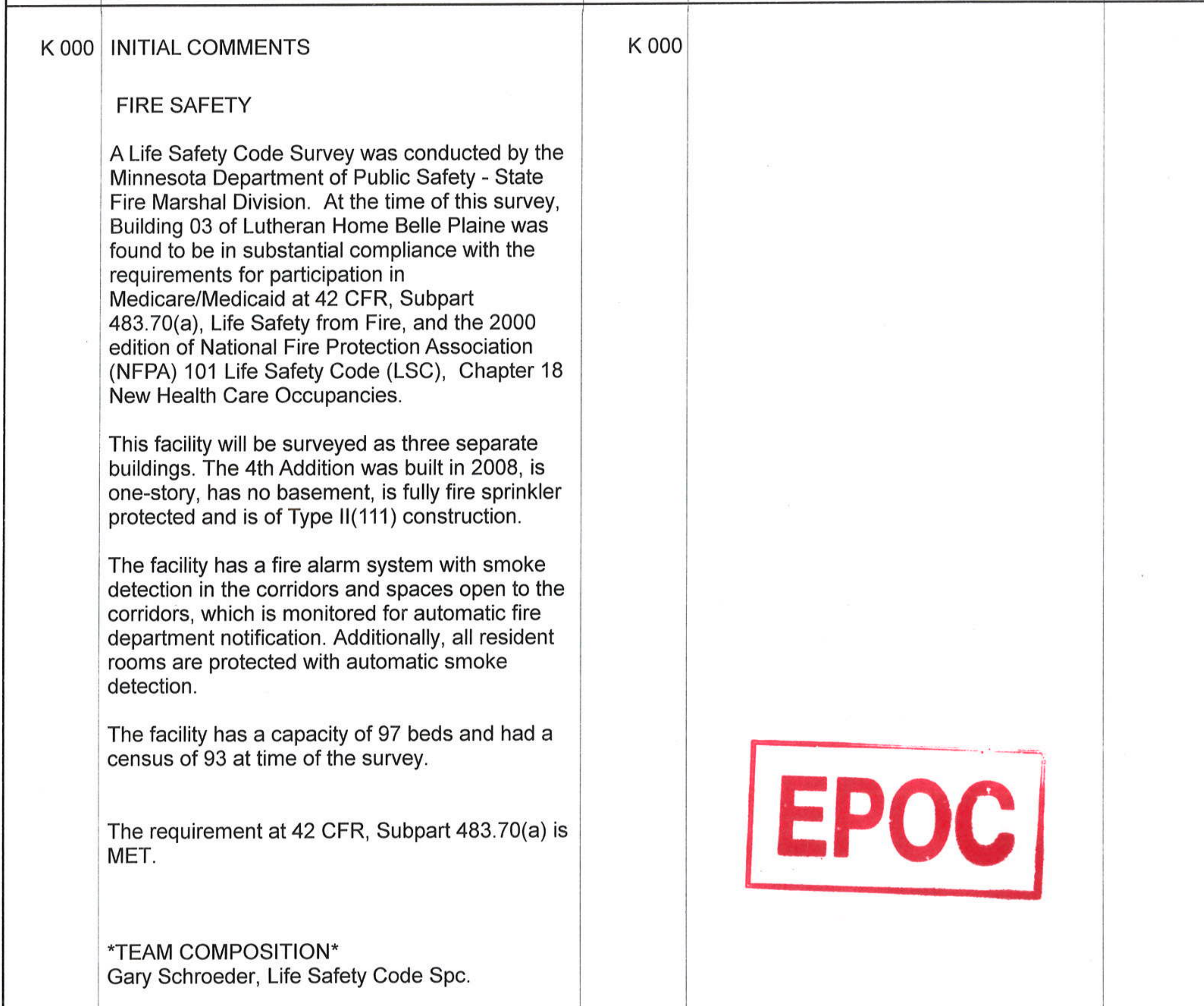

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING **03 - 2008 KITCHEN/LAUNDRY/OFFICE** B. WING ______	**08/26/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Building 03 of Lutheran Home Belle Plaine was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. This facility will be surveyed as three separate buildings. The 4th Addition was built in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Additionally, all resident rooms are protected with automatic smoke detection. The facility has a capacity of 97 beds and had a census of 93 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2015

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING 03 - 2008 KITCHEN/LAUNDRY/OFFICE B. WING	08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	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