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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QUB2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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) **THE LUTHERAN HOME: BELLE PLAINE**
(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 **09/18/2017** (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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 :
Susie Haben, Unit Supervisor 10/02/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/03/2017 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245590 October 3, 2017

Mr. Spencer Beard, Administrator
The Lutheran Home: Belle Plaine
611 West Main Street
Belle Plaine, MN 56011

Dear Mr. Beard:

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 25, 2017 the above facility is recommended 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 3, 2017

Mr. Spencer Beard, Administrator
The Lutheran Home: Belle Plaine
611 West Main Street
Belle Plaine, MN 56011

RE: Project Number S5590028

Dear Mr. Beard:

On August 8, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 27, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 25, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 27, 2017, effective August 25, 2017 and therefore remedies outlined in our letter to you dated August 8, 2017, 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QUB2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00605

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(L2) **751243100**

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(L3) **THE LUTHERAN HOME: BELLE PLAINE**
(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 **07/27/2017** (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:

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

* Code: **B*** (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 :
Dawn Chiabotti, HFE NEII 09/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/02/2017 (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:

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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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 8, 2017

Mr. Spencer Beard, Administrator
The Lutheran Home: Belle Plaine
611 West Main Street
Belle Plaine, MN 56011

RE: Project Number S5590028

Dear Mr. Beard:

On July 27, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

Informal Dispute Resolution - 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:

Susie Haben, Unit Supervisor
Metro D Survey Team
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: susie.haben@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 15, 2017, 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 October 27, 2017 (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 January 27, 2018 (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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

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

cc: Licensing and Certification File

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/24 through 7/27/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable 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 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based off observation, interview, and document review, the facility failed to implement care plan interventions as directed for 1 of 3 residents (R121) reviewed for nutrition who had significant weight loss. Findings include:	F 282	NA-A educated that all residents must be offered meals regardless of time of day. Meal times and procedures educated to nursing staff. Residents indicating significant weight loss reviewed in accordance with care plans by dietician. Appropriate adjustments made to care plan and intakes if indicated. Electronic	8/25/17

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

Electronically Signed | 08/18/2017

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 R121's care plan dated 7/5/17, identified R121 was at moderate nutritional risk and to provide diet as ordered and offer choices in food and beverages. The care plan directed staff to monitor for diet compliance, offer encouragement, monitor for signs and symptoms of choking/aspiration, offer a bedtime snack, and record R121's intake. During observation on 7/27/17, at 8:39 a.m. R121 was observed in his reclined wheel chair sleeping in his room. On the same day at 10:33 a.m. nursing assistant (NA)-A and NA-B entered R121's room and performed cares. NA-B stated R121 was assigned to her for the day and that was the first time she "had gotten to him and [R121] had not eaten breakfast yet." NA-B took R121 to the dining room at 10:55 a.m. During interview on 7/27/17, at 10:55 a.m. NA-A stated R121 was gotten up by the night shift prior to 6:30 a.m. NA-A confirmed R121 was not offered or had eaten breakfast and stated R121 would just eat lunch today since it is so late. On 7/27/17, at 11:01 a.m. NA-B stated R121 was up in his wheel chair when she came on shift at approximately 7:00 a.m. NA-B confirmed R121 was not offered or did not receive breakfast. On the same day at 11:18 a.m. Clinical Coordinator (CC)-A, stated R121 had a significant change due to weight loss. CC-A was unaware when R121 had gotten up or if he had eaten breakfast. CC-A expected that all residents were offered meals. On 7/27/17, at 11:34 a.m. R121 was observed at a dining room table with a can of nutritional	F 282	medical record system updated to offer two separate charting options which are: offered and consumed 0% or refused. Resident intake sheets will be changed to include how and why a resident refuses to obtain their meal. Resident intake sheets will be observed by the Dietician or designee on a weekly base for 4 months. The findings of the audits will be presented to the quality assurance committee.	

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2	F 282		

supplement and a glass of cranberry juice in front of him. At 11:43 a.m. R121 had a puree meal in front of him with staff feeding him. R121 was holding his nutritional supplement can and drank it independently. R121 was awake, alert, and willingly ate with staff assist. At 12:01 p.m. R121 had eaten 100% of his lunch meal and liquids and stated "it was good."

On 7/27/17, at 11:33 a.m. registered dietician (RD) stated R121 had significant weight loss which initiated hospice services. RD stated R121 had varied meal intakes but breakfast had always been his better meal eating approximately 50%. RD stated R121 usually ate 25% for lunch, and 25-50% for dinner. RD stated she was aware documentation had reflected R121 had refused his breakfast several times in the month of July. RD stated R121's weights were stable until 7/10/17, when he dropped approximately 10 pounds.

On 7/21/17, a nutritional assessment was completed which identified R121 had varied intakes of 25-75% and 0-360 milliliters (ML) of fluid and was at high nutritional risk. The assessment identified R121 will be continued to be offered foods and beverages for quality of life.

Review of R121's weights in pounds was documented as follows:
6/17/17: 177
6/18/17: 178.4
6/19/17: 179
6/26/17: 184
6/30/17: 179
7/3/17: 177
7/10/17: 165
7/11/17: 166

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 _____	07/27/2017

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 282	Continued From page 3 In review of the NA paper intake log R121's breakfast meal for 7/27/17, was charted as zero for breakfast food % and zero for breakfast fluid. However, on the same day at 2:00 p.m. R121's breakfast meal was charted as 0% "Ref" (refused) and 0 ML for fluid in the facility's electronic health record system. R121's plan of care was not followed as staff had not offered R121 breakfast. On 7/27/17, at 12:50 p.m. the director of nursing (DON) expected R121 to be checked on and offered breakfast. The DON expected the NA paper intake log to be completed and utilized as a double check to see if all residents were fed. The DON then expected the paper intake documentation to be entered into the electronic health records. The facility policy titled "Intake and Output Measurement" dated 9/1/11, identified the purpose to maintain an accurate measurement of the resident's intake and output to assess fluid balance. Further the policy directed licensed nurses to evaluate intake and output on a 24-hour basis and weekly basis to determine adequacy. The facility policy titled "Activities of Daily Living" dated 9/23/16, identified the purpose to assist residents as necessary to improve their quality of life. The facility policy titled "A.M. Cares (Early Morning Care)" dated 5/24/17, identified the purpose to prepare resident for breakfast.	F 282		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	F 322		8/25/17

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	245590	A. BUILDING _____ B. WING _____	07/27/2017

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F 322	Continued From page 4 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to check placement of a percutaneous endoscopic gastrostomy tube (PEG) prior to administration of nutritional supplement and medications for 1 of 1 resident (R149) reviewed for medication/nutritional supplement administration via tube. This had the potential to affect 2 of 2 residents who received medications and nutritional supplement via feeding tube. Findings include: R149's Diagnoses List dated 7/24/17, identified R149 had diagnoses of: small cell B-cell	F 322	R149's tube placement was checked in accordance to updated policy. LPN-B educated on appropriate procedure of testing enteral tube placement. Enteral tube orders reviewed facility wide. Policy created by DON and Medical Director on procedure to check placement of enteral tubes. All nurses educated on policy and procedure before they work on the floor. Placement procedure will be audited monthly for 6 months if enteral tubes present in the facility. Audit findings will be presented to the quality assurance committee.	

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	245590	A. BUILDING _____ B. WING _____	07/27/2017

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F 322	Continued From page 5	F 322		

lymphoma, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, facial weakness following cerebral infarction, dysphagia, aphasia, depression, gastrostomy status, esophagitis, Barrett's esophagus, and anemia.

R149's current Physician Orders dated 7/24/17, identified R149 was nothing by mouth (NPO) and received tube feeding four times per day. The orders also indicated to perform oral cares with aspiration precautions.

During observation on 7/26/17, at 9:18 a.m. licensed practical nurse (LPN)-B entered R149's room to administer 1.5 bottles of Isosource 1.5 calorie nutritional supplement. With gloved hands LPN-B exposed the PEG tube and placed a syringe into the tube, LPN-B then flushed the tube with approximately 30 milliliters (ML) of water via push with the syringe. LPN-B stated during that process she was checking the tube for patency. LPN-B then proceeded to administer 1.5 bottles of Isosource 1.5 calorie nutritional supplement.

On the same day at 10:07 a.m. LPN-B re-entered R149's room to administer medication. With gloved hands LPN-B exposed the PEG tube and placed a syringe into the tube, LPN-B then flushed the tube with approximately 30 ML of water via push with the syringe and administered medication.

On 7/27/17, at 12:45 p.m. the director of nursing (DON) stated her expectation was to administer tube feed per physician order and facility policy. The DON stated checking placement of the tube needed to be completed prior to administration of supplement and/or medication administration.

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F 322	Continued From page 6 The DON confirmed pushing 30 ml of water through the tube to check placement/patency was not correct technique. The facility policy titled Enteral Feeding, Tube dated 5/23/17, directed staff to assess for tube migration prior to administration. The facility policy titled Medication Administration through Tube Feeding dated 9/1/11, directed staff to check tube placement and patency by gently trying to aspirate gastric fluid. The policy further indicated if gastric fluid is not evident to place a stethoscope on the resident's upper portion of the stomach and insert a small amount of air and listen for air movement.	F 322		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 325		8/25/17

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F 325	Continued From page 7 by: Based off observation, interview, and document review the facility failed to ensure the breakfast meal was served to 1 of 3 (R121) residents reviewed for nutrition who had significant weight loss. Findings include: R121 was admitted to the facility on 6/16/17, and the admission Minimum Data Set (MDS) identified R121 as being severely cognitive impaired. The MDS identified R121 needed supervision and cueing for eating and extensive assist of two for all other ADLS. The MDS identified R121 was on a mechanically altered diet and had diagnoses of: anemia, atrial fibrillation, hypertension, diabetes mellitus, dementia, and anxiety. R121's care plan dated 7/5/17, identified R121 was at moderate nutritional risk and to provide diet as ordered and offer choices in food and beverages. The care plan directed staff to monitor for diet compliance, offer encouragement, monitor for signs and symptoms of choking/aspiration, offer a bedtime snack, and record R121's intake. The care plan identified the registered dietician (RD) was to be notified if there were changes in nutritional status. The nutritional Care Area Assessment (CAA) with reference date of 7/20/17, identified R121 to have a recent significant weight loss of greater than 5% in one month. The CAA identified resident to be on a pureed diet with nectar thickened liquids. During observation on 7/27/17, at 8:39 a.m. R121 was observed in his reclined wheel chair sleeping	F 325	NA-A educated that all residents must be offered meals regardless of time of day. Meal times and procedures educated to nursing staff. Residents indicating significant weight loss reviewed in accordance with care plans by dietician. Appropriate adjustments made to care plan and intakes if indicated. Electronic medical record system updated to offer two separate charting options which are: offered and consumed 0% or refused. Resident intake sheets will be changed to include how and why a resident refuses to obtain their meal. Resident intake sheets will be observed by the Dietician or designee on a weekly base for 4 months. The findings of the audits will be presented to the quality assurance committee.	

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F 325	Continued From page 8	F 325		

in his room. On the same day at 10:33 a.m. nursing assistant (NA)-A and NA-B entered R121's room and performed cares. NA-B stated R121 was assigned to her for the day and that was the first time she "had gotten to him and [R121] had not eaten breakfast yet." NA-B took R121 to the dining room at 10:55 a.m.

During interview on 7/27/17, at 10:55 a.m. NA-A stated R121 was gotten up by the night shift prior to 6:30 a.m. NA-A confirmed R121 was not offered or had eaten breakfast and stated R121 would just eat lunch today since it was so late.

On 7/27/17, at 11:01 a.m. NA-B stated R121 was up in his wheel chair when she came on shift at approximately 7:00 a.m. NA-B confirmed R121 was not offered or did not receive breakfast.

On the same day at 11:18 a.m. Clinical Coordinator (CC)-A, stated R121 had a significant change due to weight loss. CC-A was unaware when R121 had gotten up or if he had eaten breakfast. CC-A expected that all residents were offered meals.

On 7/27/17, at 11:34 a.m. R121 was observed at a dining room table with a can of nutritional supplement and a glass of cranberry juice in front of him. At 11:43 a.m. R121 had a puree meal in front of him with staff feeding him. R121 was holding his nutritional supplement can and drank it independently. R121 was awake, alert, and willingly ate with staff assist. At 12:01 p.m. R121 had eaten 100% of his lunch meal and liquids and stated "it was good."

On 7/27/17, at 11:33 a.m. registered dietician (RD) stated R121 had significant weight loss

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F 325	Continued From page 9	F 325		

which initiated hospice services. RD stated R121 had varied meal intakes but breakfast had always been his better meal eating approximately 50%. RD stated R121 usually ate 25% for lunch, and 25-50% for dinner. RD stated she was aware documentation had reflected R121 had refused his breakfast several times in the month of July. RD stated R121's weights were stable until 7/10/17, when he dropped approximately 10 pounds.

On 7/21/17, a nutritional assessment was completed which identified R121 had varied intakes of 25-75% and 0-360 milliliters (ML) of fluid and was at high nutritional risk. The assessment identified R121 will be continued to be offered foods and beverages for quality of life.

Review of R121's weights in pounds was documented as follows:
6/17/17: 177
6/18/17: 178.4
6/19/17: 179
6/26/17: 184
6/30/17: 179
7/3/17: 177
7/10/17: 165
7/11/17: 166

In review of the NA paper intake log R121's breakfast meal for 7/27/17, was charted as zero for breakfast food % and zero for breakfast fluid. However, on the same day at 2:00 p.m. R121's breakfast meal was charted as 0% "Ref" (refused) and 0 ML for fluid in the facility's electronic health record system.

On 7/27/17, at 12:50 p.m. the director of nursing (DON) expected R121 to be checked on and

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F 325	Continued From page 10 offered breakfast. The DON expected the NA paper intake log to be completed and utilized as a double check to see if all residents were fed. The DON then expected the paper intake documentation to be entered into the electronic health records. The facility policy titled "Intake and Output Measurement" dated 9/1/11, identified the purpose to maintain an accurate measurement of the resident's intake and output to assess fluid balance. Further the policy directed licensed nurses to evaluate intake and output on a 24-hour basis and weekly basis to determine adequacy. The facility policy titled "Activities of Daily Living" dated 9/23/16, identified the purpose to assist residents as necessary to improve their quality of life. The facility policy titled "A.M. Cares (Early Morning Care)" dated 5/24/17, identified the purpose to prepare resident for breakfast.	F 325		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334		8/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 334	Continued From page 11 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 334		

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F 334	Continued From page 12 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R83) reviewed for immunizations was offered and provided the pneumococcal conjugate vaccine (PCV13). Findings include: The current guidelines by the Center for Disease Control and Prevention (CDC) recommended PCV13 and pneumococcal polysaccharide vaccine (PPSV23) for all adults 65 years or older. It further recommended "If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23." R83's Admission Face Sheet indicated R83 was 84 years old. Review of the facility supplied Immunization Report ran 7/28/17, identified R83's most recent dose of PPSV23 was given on 11/21/00, however the medical record lacked evidence of the PCV13 had been offered, refused or administered.	F 334	Resident R83 offered Pneumococcal immunization and charted. Resident Pneumococcal immunization records reviewed. Residents offered Pneumococcal immunizations if records did not indicate administered, refused, or offered. Process added to review Pneumococcal immunization status on 14 day assessment & quarterly assessment. Monthly pneumococcal immunization audit will occur for 4 months. The findings of the audits will be presented to the quality assurance committee.	

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	245590	A. BUILDING _____ B. WING _____	07/27/2017

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F 334	Continued From page 13 During interview on 7/27/17, at 10:30 a.m. the director of nursing (DON) stated upon admission a resident's pneumococcal vaccination status was reviewed by the medical records department. If a resident was not current with their vaccinations, a memo would be sent to the clinical coordinator. The clinical coordinator would then initiate the standing orders for pneumococcal vaccination. Later that day at 1:31 p.m., the DON stated R83 should have gotten the PCV13 but could not find any documentation that indicated it was offered to her. The facility's "Standing Orders for Administering Pneumococcal Vaccines [PCV13 & PPSV23]" policy updated 8/1/2016 indicated "...PCV13 should be administered routinely to all previously unvaccinated adults age 65 years and older."	F 334		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food temperatures were consistently monitored to ensure proper palatability. This had the potential to affect 93 of 95 residents who ate out of the	F 364	Kitchen staff educated on appropriate food temperature ranges. Education on food temp ranges listed on food temp log sheets. Education occurring to all kitchen employees. The systematic change of	8/25/17

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	245590	A. BUILDING _____ B. WING _____	07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 364	Continued From page 14 kitchen. Findings include: On 7/27/17, at 11:01 a.m. Cook-C placed the temperature probe in the prepared lettuce salads with dressing on them in the cart in the walk in cooler and the probe read 44.1 degrees Fahrenheit (F). Cook-C placed the probe in a couple applesauce bowls and the probe read 47 degrees F and 48 degrees F. Cook-C stated herself and Cook-B had made up the lettuce salads and applesauce up at approximately 9:15 a.m. and placed in walk in cooler at approximately 9:45 a.m. Cook-C stated the applesauce should be maintained cooler, "35 to 42 degrees." Cook-C stated the salads should be maintained 40 to 45 degrees F. Cook-C stated because the dressing was not necessarily cold when put on the lettuce salads and the applesauce was at room temperature before scooping up into the individual bowls. Cook-C stated it would be an easy fix to push the cart of bowls back further into the walk in cooler closer to the fan and motor. Cook-C stated that would help keep them cooler because of the door to the cooler being opened frequently. Cook-C stated the cooks are trained to test the cold entrees and salads before taking out to the units and document. Cook-C verified the fruit cocktails and the lettuce salads made up for yesterday had not been documented on the food temperature log and also other cold foods not documented on the July 2017 food temperature log in the kitchen. On 7/27/17, at 11:20 a.m. cook-B was observed removing the cart of trays of bowls of lettuce salads with dressing and applesauce out of the walk in cooler and placing on the LTC unit food	F 364	prepping salad dressing, vegetables, and canned fruit will occur first in meal prepping to have longer cooling time before serving. Daily temperature logs to be reviewed daily for 3 months and findings reported to the quality assurance committee.	

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F 364	Continued From page 15 cart. The cart was brought the LTC kitchenette. On 7/27/17, at 11:25 a.m. DA-B placed the tray of sald and applesauce on the surface counter of the dishwasher which had just shut off from cleaning the dishes. DA-B put a temperature testing probe into a bowl of lettuce with salad dressing and read in the 60's degrees F. DA-B moved the tray of individual salads from off the top of the dishwasher which she stated was hot and moved over and rechecked the temperature of the lettuce salads at 58 degrees F. DA-B tested the applesauce bowls and the probe read 51 degrees F and stated should be colder. DA-B stated 16 of 18 residents were to receive the lettuce salads and/or applesauces. On 7/27/17, at 11:36 a.m. surveyor requested food temperature logs and policies on Food Storage and Food Temperatures. The logs revealed the following: The LTC unit food temperature log, dated 7/1 through 7/26/17, revealed 12 meals where hot and cold food temperatures were not documented. The same log also indicated cold foods out of acceptable temperature range (ATR): 7-6 bread pudding 43 degrees F 7-11 fruit 47 degrees F 7-12 pears 48 degrees F 7-15 jello 49 degrees F 7-24 jello-chilled (no temperature reading) The 2nd floor unit food temperature log, dated 7/1 through 7/26/17, revealed 16 meals where hot and cold food temperatures were not documented. The same log also indicated cold foods out of ATR: 7-1 lettuce 48 degrees F	F 364		

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 16 7-2 carrot salad 49 degrees F 7-2 applesauces (no temperature reading) 7-6 peaches (no temperature reading) 7-15 jello (no temperature reading) 7-21 potato salad 39 degrees F 7-25 potato salad 47 degrees F 7-26 cheese cake 49 degrees F The TCU food temperature log, dated Review of 7/1 through 7/26/17, revealed eight meals where hot and cold food temperatures were not documented. The same log also indicated cold foods out of ATR: 7-1 salad 49 degrees F 7-2 apple sauce 46 degrees F 7-3 pears 48 degrees F 7-4 dessert 51 degrees F 7-4 dessert 43 degrees F 7-5 bread pudding 48 degrees F 7-5 bread pudding 53 degrees F 7-8 salad 38 degrees F 7-11 dessert 47 degrees F 7-11 pears 45 degrees F 7-12 dessert 43 degrees F 7-12 pears 58 degrees F 7-12 carrots 47 degrees F 7-13 fruit 43 degrees F 7-15 jello 58 degrees F 7-16 oranges 45 degrees F 7-17 dessert 48 degrees F 7-18 dessert 46 degrees F 7-19 salad 54 degrees F 7-21 peaches 46 degrees F 7-22 cole slaw 38 degrees F 7-23 tomato 48 degrees F 7-24 peaches 52 degrees F 7-25 dessert 46 degrees F 7-25 potato salad 38 degrees F 7-26 cheesecake 58 degrees F	F 364		

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 17 The Neighborhood Food Temperatures and Main Kitchen Food Temperatures for Hot and Cold Foods directed the staff to take food temperatures of every meal daily. In addition, the log indicated to the staff what the temperatures should be at for the type of food(s) served,"... Acceptable Temperature Ranges (Fahrenheit)... Salad 40-45 [degrees] Refrigerated Dessert 35 [degrees] Cold Entree 35-42 [degrees] ..." On 7/27/17, at 10:46 a.m. RD stated she was responsible for reviewing temperature logs in the kitchen and kitchenettes. RD stated she had noticed empty spaces on the logs and would figure out which staff worked that day and talk to them. A policy for safe food temperatures and handling was requested and not provided.	F 364		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		8/25/17

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 18 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to dispose of expired foods and properly label and date stored foods. In addition, the facility failed to properly store foods off the floor in the walk in freezer. This had the potential to affect 93 of 95 residents who ate out of the kitchen. Findings include: Main kitchen Expired/Undated food: During an initial tour of the kitchen on 7/24/17, at 1:21 p.m. with director of facility services (DFS) an opened and retied plastic bag of hard boiled eggs was observed undated in the walk in cooler. Also observed were two cartons of milk opened and not dated. DFS stated foods once opened should be re-bagged and dated and kept for three days and then discarded. DFS stated milk would just go by the expiration date when to discard. A box of bread sticks was observed in an opened, unsealed and undated plastic bag. DFS stated staff would take the bread sticks they needed out of the bag and staff then should have twisted and closed up the bag after taking some out. Also observed were five plastic containers of pudding dated 7/17. Sign posted on the walk in door was observed to state "throw out food after three days."	F 371	Kitchen staff educated on appropriate food storage methods and procedures. Education occurring to all kitchen employees. Daily labeling sheet audits. Weekly review of the main kitchen and kitchenettes food/beverage items to assure proper labeling and storage. Daily labeling logs and weekly food/beverage storage audits to be reviewed for 3 months and findings reported to the quality assurance committee.	

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 19 On 7/27/17, at 10:09 a.m. registered dietician (RD) verified an opened, unsealed bag of mixed cauliflower and broccoli undated in the freezer. RD stated staff should have sealed and dated foods after opening. RD stated staff were trained to fold over the bag and with masking tape and date. RD verified in the walk in cooler a rack of lettuce salads with dressing over it and applesauce in individual bowls on a rack uncovered. RD verified six jellos dated 7/20 and stated jello could be kept 7 to10 days after preparing due to the higher sugar content. RD stated staff were trained to discard foods prepared and opened after three days. RD handed the opened, unsealed bag of cauliflower and broccoli to Cook-B and asked her to seal the broccoli and cauliflower bag with masking tape and date it. Kitchenettes Expired/Undated food: During a tour of the transition care unit (TCU) kitchenette refrigerator on 7/24/17, at 1:45 p.m. noted five bowls of jello uncovered and undated and a bag of three hamburgers in a plastic bag undated. DFS stated the jello should have been covered and dated and the hamburger patties should have been dated when brought out of the freezer and put in the refrigerator. Also observed, were bags of macaroni cheese undated and a bag of hotdogs dated 4-21. The long term care unit (LTC) kitchenette refrigerator noted two bowls of jello uncovered and undated. DFS stated the staff should have covered the jello with saran wrap and dated. The 2nd floor kitchenette refrigerator noted a bowl of pudding dated 7/15, a bowl of jello dated	F 371		

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 _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 20 7/17, and a bag of hamburgers undated. On 7/26/17, at 8:11 a.m. Cook-A verified two cartons of plus two protein shakes in the 2nd floor kitchenette refrigerator expired March 8th and stated he did not know why they were in the refrigerator and tossed the shakes into the garbage. On 7/26/17, at 9:32 a.m. was observed in the LTC refrigerator a bag of bacon slices opened and unsealed with the date 9/19 handwritten on it. Dietary aide (DA)-A verified the opened, unsealed bag of bacon strips with 9/19 written on top of it and stated did not know when the bacon had been opened. DA-A stated food after opening should be thrown out after three days. DA-A stated 23 residents were served food from the LTC kitchenette. An hour later at 10:28 a.m. DFS stated the bacon in the LTC kitchenette refrigerator was precooked and was made available in case the residents wanted some. DFS stated the bacon should have been sealed and dated and did not know what 9/19 could have meant on top of the bacon and should have been discarded. DFS stated staff were trained to throw out food three days after opened. DFS stated there had been a lot of new dietary staff trained recently with turnover. On 7/26/17, at 10:07 a.m. homemaker (HM)-A verified one opened container of applesauce one-fifth full in the memory unit kitchenette refrigerator dated 7/11. Shortly later on 7/26/17, at 2:19 p.m. in the LTC kitchenette refrigerator were observed two uncovered, undated bowls of fruit cocktail and a	F 371		

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	245590	A. BUILDING _____ B. WING _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 21	F 371		

bag of bag opened, unsealed bacon strips with 9/19 written on top of the package. Nursing assistant (NA)-G verified the uncovered, undated fruit cocktail and the opened, unsealed bacon with 9/19 written on it. The bacon had not been thrown away per morning observation 7/26/17.

On 7/27/17, at 9:58 a.m. in the LTC kitchenette refrigerator were observed two little plastic cups of jello covered, dated 7/20, two cartons of milk, one undated and one dated 7/24 and an opened, bag of bacon strips with the end of package bent over, not sealed with date of 9/19 handwritten on top. HM-B stated food was good for five days after opening and tossed the jello cups into the garbage. The bacon remained in the kitchenette after the staff indicated it should have been thrown away.

On 7/27/17, at 10:46 a.m. RD stated foods should be resealed and dated after opening.

Guidelines provided by the facility undated REFRIGERATOR GUIDELINES indicated, "ALL FOODS MUST BE LABELED WITH DATE OPENED and TYPE OF FOOD ... ALL FOODS FOR RESIDENTS MUST BE LABELED WITH RESIDENT'S NAME AND DATE FOOD WAS MADE/OPENED ... FOOD MUST BE THROWN OUT BEFORE THE EXPIRATION DATE ON THE PACKAGE OR AFTER 3 DAYS FOR FOOD MADE IN THE FACILITY. WHEN IN DOUBT ... JUST THROW IT AWAY!"

The policy provided by the facility dated 7/2/16, Floor Stock indicated, "... POLICY: Limited supplies of food and drink items will be available ... from the refrigerator, kitchenette and/or food storage areas... Rotate stock and remove

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	245590	A. BUILDING _____ B. WING _____	07/27/2017

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

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F 371	Continued From page 22 outdated items..." Food stored on the floor: During a tour of the walk in freezer on 7/24/17, at 1:24 p.m. with DFS noted boxes stacked on the floor. DFS stated food inventory had been delivered to the facility that day and not yet put away; but would be stored up off the floor on the shelves. On 7/27/17, at 10:09 a.m. were observed 10 boxes of food stacked on the floor in the walk in freezer. The RD stated food inventory was delivered to the facilities three times a week and that was part of the problem with two larger deliveries on Mondays and Wednesdays and one smaller delivery on Wednesday. Food had been stored on the floor for one day. On 7/27/17, at 11:01 a.m. Cook-C was interviewed about the boxes on the floor. Cook-A stated "Honestly, we don't have enough shelf space." Cook-C stated Mondays' and Fridays' orders were larger than Wednesdays' orders. A policy for food storage was requested of the RD and was not provided.	F 371		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with	F 465		8/25/17

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 _____	07/27/2017

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 465	Continued From page 23 applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure wheel chair equipment was in good repair for 2 of 9 residents (R34, R150) reviewed for safe and comfortable equipment. Findings include: On 7/25/17, at 2:45 p.m. an environmental tour was completed with the administrator and director of nursing (DON) who confirmed the following finding: R34's arm rests on her wheel chair were not in good repair, there were cracks observed on both arm rests. The surface area of the right arm rest was cracked over approximately 1/2 of the area. The left arm rest was approximately ¾ cracked over the surface. R34's quarterly Minimum Data Set dated 6/21/17, identified her to be dependent on her wheel chair. On the same day at 3:09 p.m. the DON stated the condition of the wheel chair was not her expectation and she needed to put a work order in immediately to get R34's arm rests replaced which the facility did have in house. On 7/26/17, at 10:37 a.m. the DON stated when equipment needed to be repaired a work order would be completed through the online maintenance system called TELS. The DON stated all nursing personnel are able to complete	F 465	R34 and R150's arm rest replaced immediately upon Administrator and DON's observation of cracks on the environmental tour. Resident wheel chairs assessed on each unit for repair needs. Wheel chair policy & procedure created in connection to Broken/Damaged Equipment policy and dispersed to each unit for review. Resident wheel chairs to be audited weekly for 4 months by unit coordinators or designee. The findings of the audits will be presented to the quality assurance committee.	

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F 465	Continued From page 24	F 465		

work orders. The DON stated she was unaware how R34's wheel chair became in that condition without being replaced and reported.

On the same day at 12:31 p.m. the administrator stated the TELS system did not have preventive maintenance checks on wheel chair equipment. The administrator stated his expectation was for nursing staff to report equipment that needed repair using the TELS system or to call the maintenance department. The administrator stated the night shift are responsible to clean wheel chairs on a regular basis and R34's should have been seen and reported.

During observation on the unit on 7/26/17, at 1:51 p.m. R150's wheel chair was observed with cracks and open areas along the entire length of both arm rests which had yellow cushion exposed.

On 7/26/17, at 1:57 p.m. during interview with nursing assistant (NA)-C she explained there was a TELS system to report broken equipment. NA-C stated she would report cushions or arm rests that have cracks on a wheel chair.

NA-C observed R150's arm rests and stated they should be reported and replaced and was unaware how long they had been in that condition.

On the same day at 2:03 p.m. NA-D stated she would report cracked cushions and arm rests to be repaired as it was a hazard and a potential to cause skin tears. NA-D stated nursing assistants are busy with cares and these equipment reports could fall through the cracks and be missed.

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	245590	A. BUILDING _____ B. WING _____	07/27/2017

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F 465	Continued From page 25 At 2:09 p.m. NA-D informed surveyor that she observed R150's wheel chair arm rests and needed to report his cracked arm rests immediately to be replaced as they are cracked on both sides. The facility's policy titled "Broken/Damaged Equipment" dated 3/18/16, directed staff to call maintenance or fill out a TELS work order for damaged equipment.	F 465		

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

F5590025

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 _____	**07/25/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (The Lutheran Home) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility was surveyed as two separate buildings. The original building was built in 1954, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

F3590025

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 _____	**07/25/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 **02 - 1961, 1970, 1998 ADDITIONS** B. WING _____	**07/25/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		