Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 16, 2025

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

RE: CCN: 245590
Cycle Start Date: April 30, 2025

Dear Administrator:

On April 30, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 30, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 30, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 04/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/28/25-4/30/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/28/25-4/30/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55903527C (MN00105905). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		6/8/25

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

Electronically Signed | 05/23/2025

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

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F 561	Continued From page 1 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure preferences for bedtime were honored and implemented for 1 of 1 resident (R26) reviewed for choices. Additionally, the facility failed to ensure food preferences were honored for 1 of 2 residents (R45) reviewed for choices related to food.	F 561	It is the policy, and intention, of The Lutheran Home: Belle Plaine, to be in full compliance with all regulations and requirements of both the Medicaid and Medicare Programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as	

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F 561	Continued From page 2 Findings include: R26's quarterly Minimum Data Set (MDS) assessment dated 1/29/25, indicated R26 had severe cognitive impairment, no behaviors or rejection of care, utilized a wheelchair, dependent on staff for chair/bed to chair transfer, lower body dressing, toileting hygiene, and required substantial/maximal assistance with personal hygiene, diagnoses included seizure disorder and repeated falls. R26's annual MDS dated 8/14/24, indicated R26 bedtime was very important to choose. R26's care plan dated 2/11/25, indicated encourage to engage in daily and activity preferences and interventions included offer individualized care based on customary routine, R26 has indicated for his daily preferences that it is very important, to choose his own bedtime (likes to go to bed between 6-7pm and get up in the morning around 6am or earlier), impaired mobility R/T (related to) weakness and failure to thrive, left sided weakness from previous stroke, bed mobility: extensive assistance from 1-2 staff with turning and repositioning resident in bed. On 4/28/25 at 5:24 p.m., R26 was seated in his wheelchair in his room with his call light activated. Nursing assistant (NA)-A entered R26's room and R26 stated he would like to go to bed now. NA-A stated R26 can't be put to bed until 7:00 p.m., R26 again asked to go to bed, and NA-A stated, "I legally can't put you to bed until 7:00 p.m., you've only been up for about ten minutes since eating supper, you wait a little bit". NA-A exited R26's room and R26 remained seated in his wheelchair.	F 561	required, are submitted as the facility's CREDIBLE ALLEGATION OF COMPLIANCE. The written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The facility wishes to preserve its right to dispute these findings in their entirety should any remedies be imposed. It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F561 Self-Determination CFR(s): 483.10(f)(1) through (11). The facility's standard of practice is to allow self-determination, including bed times and food choices, as stated in the facility's policy. Contributing factors to this finding is NA-A's misunderstanding that residents are allowed to go to bed before 7 pm and that they have the right to choose whatever time they wish to go to bed. Resident 45's nutritional assessment did not identify him as not liking corn and hence it was not noted in his dietary card. NA-A received 'Just in Time' education on resident self-determination and resident 45's diet card was corrected by the dietary manager immediately after it was brought to her attention. *Facility Wide Response Addressing Other Residents with the potential to be	

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F 561	Continued From page 3 On 4/28/25 at 5:26 p.m., R26 was seated in a wheelchair in his room, and stated he would like to go to bed now, but was told by staff he couldn't' and had to wait. R26 stated there was a time frame of 7:00 p.m., before they will allow me to go to bed. On 4/28/25 at 5:37 p.m., NA-A stated R26 "enjoyed" going to bed early, and she doesn't want to put him to bed and then get him up in an hour again. NA-A stated staff encouraged R26 to stay up until 7:00 p.m., and 6:30 p.m., was the earliest she would assist R26 to bed. NA-A stated in her schooling she learned residents were not allowed to go to bed until 7:00 p.m., and the nursing staff at the facility stated he wasn't allowed to go to bed until 6:30 p.m. On 4/28/25 at 5:46 p.m., R26 continued to sit in his wheelchair and shook his head side to side and stated he was mad he can't go to bed. On 4/28/25 at 5:47 p.m., NA-B stated residents can go to bed when requested and stated R26 was expected to be put to bed when he requested his bedtime. NA-B stated she was going to his room now to assist R26 to bed per his request. NA-B was observed to enter R26's room. On 4/28/25 at 5:49 p.m., licensed practical nurse (LPN)-A stated if a resident requested to go to bed staff were expected to assist the resident to bed and were not expected to make R26 wait a certain time before he could go to bed. LPN-A stated R26 liked to go to bed after the evening meal and that was his routine. On 4/29/25 at 11:54 a.m., registered nurse	F 561	Affected: 1. Nursing assistants received renewal education on resident rights including resident self-determination as it relates to bed times. 2. The charge nurse on each unit will be responsible for ensuring that every residents' choice of bed time is observed and respected. 3. Social Services will assess residents, by asking, if they are provided the opportunity to choose their bed time and what time they get up from bed during resident care conferences. 4. A new nutritional observation, including food preferences and dislikes, will be implemented by the dietary director. Identified food preferences and dislikes will be added to the residents' diet cards. 5. The dietary director will assess residents' food preferences during residents' care conferences. 6. Ongoing: In response to identifying, and reviewing, how other residents potentially impacted, the facility will implement quarterly audits of a random sample of residents regarding satisfaction of their bedtime requests. Additionally, audits of resident food preferences and dislikes identified and carried through to the resident diet cards will occur at residents' quarterly care conferences.	

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F 561	Continued From page 4 (RN)-A stated R26 preferred to go to bed early and was very routine after his evening meal and stated if staff were able to accommodate R26's early request for bedtime, they should not make him wait. On 4/29/25 at 3:52 p.m., the director of nursing (DON) stated residents were allowed to go to bed upon their request and stated there was no timeframe residents needed to wait for to be placed into bed. The DON stated staff were expected to assist R26 to bed when he requested if staff were available and expected staff to honor R26's bedtime preference. Facility Resident Rights policy dated 10/10/22, indicated : Policy: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing. The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents. Training topics will be appropriate to the individual's role. FOOD PREFERENCES R45's quarterly MDS assessment dated 4/9/25,	F 561	Data obtained from the aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	

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F 561	Continued From page 5 indicated R45 had severe cognitive impairment, behaviors not directed toward others and wandering which occurred one to three days during the MDS look back period, and no rejection of cares. The MDS indicated R45 used a walker, required setup or clean-up assistance for eating, and diagnoses included diabetes mellitus, Alzheimer's disease, and anxiety. R45's care plan dated 4/28/25, lacked preference to not have corn with meals. R45's progress note dated 9/2/24, indicated R45 stated he did not eat his soup because corn gave him loose stools. The dietary aid and unit manager were informed to add information to R45's diet card. R45's Admission Nutritional Assessment dated 7/29/24, lacked information under the section "Describe R45's food preferences, likes/dislikes, religious/cultural/ethnic food needs." R45's Quarterly Nutritional Assessments dated 10/21/24, 1/13/25 and 4/7/25, also lacked information under the section described above. On 4/28/25 at 1:58 p.m., R45 stated he asked for a different vegetable when served corn, since corn gave him diarrhea. On 4/29/25 at 1:11 p.m., nursing assistant (NA)-F stated diet cards located in the kitchen listed residents' food preferences. NA-F had not heard R45 would not want corn. On 4/29/25 at 1:25 p.m., dietary aid (DA)-A stated they served residents based on their diet cards. R45's diet card listed his diet and instructed to	F 561		

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F 561	Continued From page 6 give large portions. DA-A stated resident preferences were printed on the bottom of diet cards and verified R45's diet card did not list preferences. On 4/29/25 at 1:51 p.m., licensed practical nurse (LPN)-B stated most residents did not complain about their food and found alternatives for those who did. LPN-B stated R45 told staff what he wanted or did not want and did not know anything specific he did not like. On 4/29/25 at 3:23 p.m., NA-D stated each resident had a diet card which listed allergies and preferences. NA-D stated R45 did not eat "regular" corn but ate cream of corn. On 4/29/25 at 3:37 p.m., NA-E stated they would reference R45's diet card to know whether to serve him corn or not. On 4/30/25 at 1:28 p.m., registered nurse (RN)-B stated R45 indicated Tylenol gave him diarrhea but was not aware of corn. RN-B expected R45 to have no corn on his diet card if he requested. On 4/30/25 at 2:13 p.m., the dietician stated they asked residents about their food preference during the admission assessment if the assistant culinary services manager (ACM) and director of culinary services (DCS) had not asked already. The dietician did not have access to R45's medical record at the time of interview and stated they were not as familiar with R45. On 4/30/25 at 2:45 p.m., ACM stated the dietician, DCS, or themselves asked residents about their food preferences, and they or DCS updated diet cards and a book in the kitchen.	F 561		

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F 561	Continued From page 7 ACM stated R45's diet card was updated today to include no corn. On 4/30/25 at 2:59 p.m., the director of nursing (DON) stated residents' food preferences were on their diet cards and important to list related to residents' health and rights. Facility Meal Identification Policy dated 5/1/25, indicated: Policy: A meal identification (ID) and food preferences card (meal ID card/ticket) will be used to properly identify each individual's needs including food and beverage preferences. The meal ID card/ticket may be a permanent card that is gathered, cleaned, and sanitized after each meal, or may be printed daily from a database and disposed of after meals. The director of food and nutrition services or designee will visit a newly admitted individual to obtain food and beverage preferences, dislikes and food allergies/intolerances before a permanent meal ID card/ticket is written.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the current status and needs for 1 of 1 resident (R45) reviewed for MDS accuracy related to alarms.	F 641	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F641 Accuracy of Assessments CFR(s): 483.20(g).	6/8/25

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F 641	Continued From page 8 Findings include: R45's quarterly Minimum Data Set (MDS) assessment dated 4/9/25, indicated R45 had severe cognitive impairment, behaviors not directed toward others and wandering which occurred one to three days during the MDS look back period, and no rejection of cares. The MDS indicated R45 used a walker and had diagnoses which included diabetes mellitus, Alzheimer's disease, and anxiety. The MDS, Section P, indicated R45 used a wander/elopement alarm less than daily. R45's care plan dated 4/28/25, indicated R45 was on a locked unit due to elopement risk, with an edited date of 2/4/25, and did not indicate R45 used an alarm. R45's orders printed 4/30/25, indicated "okay for locked unit" dated 10/2/24 and did not indicate R45 used an alarm. R45's quarterly Supportive Devices assessment dated 4/9/25, indicated R45 did not use a wanderguard and lacked indication of other type of alarm. On 4/30/25 at 1:28 p.m., registered nurse (RN)-B stated R45 wandered at night and did not have a wander/elopement alarm since admission to the locked unit. On 4/30/25 at 2:29 p.m., the MDS coordinator stated the completed Section P based on information from unit managers and care plans. The MDS coordinator stated R45 was on a different unit prior to admission to the memory	F 641	Contributing factors to this finding is R45's elopement risk when he resided on a unsecured unit therefore requiring an elopement alarm. Once R45 was placed on the secured memory care unit, the alarm was removed and the MDS coordinator was not notified. Resident 45's MDS was modified at the time the finding was communicated to facility staff. *Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. The MDS Coordinator has received re-education using the facility's electronic learning system. 2. The IDT has reviewed the Resident Level Quality Indicator Report on the IQIES System to ensure that any resident that is triggered for a restraint and/or wander/elopement alarm has been properly assessed with appropriate MDS coding. The QAPI Committee will continue to monitor this report for ongoing compliance. 3. The RAI manual will be followed when assessing for restraints. The MDS Coordinator will review the medical record including but not limited to POs, NN, NAR documentation, etc & will be reviewed along with the POC in that look back period for any use of any type of restraints. Consulting with the nursing	

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F 641	Continued From page 9 care area, and R45's MDS selection for wander/elopement alarm was an error and would modify. On 4/30/25 at 2:59 p.m., the director of nursing (DON) stated MDS accuracy was important to ensure correct reimbursement and resident and/or responsible party payment. Centers for Medicare and Medicaid Service's Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2024, defined wander/elopement alarms as devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit sensor worn by/attached to the resident which activated an alarm and/or alerted the staff when the resident neared or exited a specific area or the building. Wander/elopement alarms included devices attached to the resident's assistive device or other belongings.	F 641	staff will also determine the residents cognitive and physical status or limitations. The use of any restraint will be reviewed quarterly by the IDT and observations are completed along with review of the current POC. Items discussed in weekly IDT meetings will include any type of removal or applying any type of restraint. Will also be discussed when moving residents into the secure unit. 4. The director of nursing and MDS coordinator will double check each section of the MDS for accuracy and watch for data or transcription discrepancies to ensure that sections of the MDS are completed correctly. Nursing leadership will ensure that MDS sections are congruent with what was identified during the observation period, nursing notes and POC to facilitate accuracy in coding the MDS. 5. Ongoing: The facility has contracted with a third party, MDS Solutions, to ensure accuracy of the entire RAI process. The IDT meets with the consultants on a weekly basis and receives reports on RAI accuracy to ensure compliance at F 644. These reports will be shared with the QAPI committee. Data obtained from the aforementioned reports will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the	

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F 641	Continued From page 10	F 641	requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated and the MDS corrected.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine removal of facial hair for 1 of 2 residents (R13) reviewed for activities of daily living (ADLs) who were dependent on staff for cares. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 4/23/25, indicated intact cognition, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). R13's care plan dated 3/3/25, indicated R13 required one assist with all ADL task, legally blind, staff assist resident with handing her things needed for tasks as well as describe where things are compared to a clock, interventions personal hygiene: extensive assistance from one staff with	F 677	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F 677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2). The facility's standard of practice is to ensure that all residents requiring assistance with ADL's, receive all of the help that they require. Contributing factors to this finding is NA-C's inadvertent omission of shaving the of the hair on R13's chin. NA-C received 'Just in Time' education on provision of resident ADL assistance, as it relates to shaving. R13 was shaved after it was discovered that the resident had hair on her chin. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. On May 1, 2025, nursing assistants	6/8/25

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F 677	Continued From page 11 grooming needs including combing hair, brushing teeth, shaving, washing/drying face/hands. On 4/28/25 at 3:52 p.m., R13 was observed with varied lengths (approximately ¼ inch to 1 inch) white hairs on her chin. R13 stated she was not sure if she had a razor. R13 stated she would like her chin hairs shaved and required assistance as she was legally blind. R13 stated some of her chin hairs were going into her mouth. R13 stated she got a bath once a week and staff had not shaved or offered her shaving. On 4/29/25 at 10:52 a.m., R13 was seated in wheelchair well groomed, with varied lengths of white whiskers on chin, and stated she thought she had an electric razor somewhere in her room. R13 again stated staff had not offered to shave her, and further stated staff should notice when she needed to be shaved. On 4/29/25 11:00 a.m., nursing assistant (NA)-C stated he assisted R13's with morning ADL cares this morning and confirmed R13 required staff assistance for hygiene cares and shaving. NA-C stated R13 was not offered shaving as expected with morning cares today. On 4/29/25 at 11:48 a.m., registered nurse (RN)-A, confirmed R13 needed assistance with cares and required staff to assist her with shaving. RN-A stated NA's were responsible for morning cares and assisting residents daily with shaving. On 4/30/25 at 7:16 a.m., the director of nursing (DON) confirmed R13's chin hairs were long and would have expected R13 offered shaving and shaved with morning cares.	F 677	received renewal education on the importance of providing proper personal hygiene for residents, including providing help with shaving all residents PRN and on bath days. 2. Orders initiated for the licensed nurse on the unit to check and off on facial hair hygiene being performed for every resident on bath days. 3. All nursing staff will be assigned a providing resident ADL and personal hygiene learning module to enhance compliance. 4. Ongoing: In response to identifying, and reviewing, how other residents potentially impacted, the facility will implement quarterly audits of a random sample of residents regarding facial hair shaving. Data obtained from the aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	

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F 677	Continued From page 12 Facility Activities of Daily Living policy dated 1/25, indicated: Grooming should be performed at least daily, including but not limited to combing, brushing teeth including denture cares, shaving residents, observing nails for cleanliness and trimming needs, etc.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a bowel movement (BM) protocol for 1 of 1 resident (R7) reviewed for constipation. Findings include: R7's five-day Minimum Data Set (MDS) assessment dated 5/30/23, indicated R7 had intact cognition, no rejection of care, utilized a walker and wheelchair, dependent on staff for toileting hygiene, required substantial/maximal assistance with toilet transfer, always continent of bowel, and diagnoses included constipation and lower back pain.	F 684	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F684 Quality of Care CFR(s): 483.25. The facility's standard of practice is to prevent resident constipation. Contributing factors to this finding includes a reliance on standing orders as an intervention for managing and preventing resident constipation. There wasn't a clear indication as to when to initiate those standing orders. Resident 7 is now on the newly developed bowel management plan.	6/8/25

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F 684	Continued From page 13 R7's care plan dated 3/11/25, indicated R7 required assist of one for toileting needs, occasional incontinent episodes, interventions encourage and provide adequate fluid, fiber, and exercise to promote elimination and prevent constipation, bowel meds PRN (as needed) per standing orders/protocol, document BMs (bowel movements) per NH (nursing home) protocol, update MD/NP/family as needed, (medical doctor/nurse practitioner), observe for s/e (side effect) and effectiveness, extensive assist of one staff for toileting needs, staff assist with peri care after each toileting, and assist of 1-2 for transfers on/off toilet/commode. R7's Medication Administration Record (MAR) dated 4/1/25-4/30/25, indicated Miralax (used to treat constipation) powder ; 17 gram/dose diagnosis constipation and administered on 4/25/25 at 5:28 p.m., reason no BM x 4 days. R7's document Bowel Movements printed 4/30/25, indicated : 4/20/25 at 9:40 a.m., Bowel Movement: Medium 4/20/25 at 3:21 p.m., Bowel Movement: Small 4/24/25 at 5:52 a.m., Bowel Movement: None 4/25/25 at 6:13 a.m., Bowel Movement: None 4/25/25 at 9:00 p.m., Bowel Movement: None 4/25/25 at 9:03 p.m., Bowel Movement: Small 4/28/25 at 2:46 p.m., Bowel Movement: Large On 4/28/25 at 4:20 p.m., R7 was observed lying in bed and reported experiencing ongoing issues with constipation. He stated that it was not unusual for him to go more than three days without a bowel movement. R7 reported not being aware of any constipation medications administered by nursing staff and denied receiving education or encouragement to	F 684	Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. The director of nursing developed a bowel management program and has arranged for each nurse to receive education on the new bowel management program. 2. In response to identifying, and reviewing, how other residents potentially impacted, the facility will run nightly reports of all residents' bowel status, to ensure that the residents are having routine bowel movements. The newly developed bowel management program will be implemented starting on day 2 of no bowel movement to decrease the probability of any bowel constipation. Ongoing: The facility will implement quarterly audits of a random sample of residents to ensure residents are having routine bowel movements and that the nurses are monitoring and implementing the program consistently. Data obtained from the aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated.	

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F 684	Continued From page 14 increase fluid intake. R7 stated that earlier in the day a nurse had to perform digital stool removal to relieve impaction. On 4/29/25 at 10:11 a.m., R7 was again observed in bed and stated that no stool softeners had been offered on 4/28 or 4/29. R7 expressed willingness to take a stool softener if it had been offered, noting that it may have helped alleviate his symptoms. On 4/29/25 at 3:17 p.m., licensed practical nurse (LPN)-C stated the facility had a bowel protocol and observed LPN-C to look through binders at the nursing station for the protocol. LPN-C asked registered nurse (RN)-C, known as the clinical coordinator, for the bowel protocol and RN-C stated she was not sure what the exact information was for the bowel protocol or standing orders or where the bowel interventions were located. RN-C stated if a resident had not had a bowel movement for three days prune juice would be initiated, and she knew that from nursing judgment. LPN-C was then observed and asked RN-A where the facility bowel protocol was located. RN-A stated she was taught on day two of no bowel movement the resident was put on nursing's "radar" and stated on day three she would offer a suppository or Senna (oral stool softener). RN-A stated the overnight nurse ran a list with the residents that had not had a bowel movement for three days and stated nursing was expected to look at the resident orders and if the resident had PRN medications for constipation, she would offer those medications to residents or initiate standing orders with the stool softeners. RN-A confirmed the standing orders included a variety of medication options for constipation and did not have specific directions.	F 684	Audits will be continued for not less than one year.	

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F 684	Continued From page 15 On 4/30/25 at 7:19 a.m., LPN-A stated the night shift prints a bowel movement list from the electronic medical record (EMR), and the list indicated residents who have not had a bowel movement for three days. LPN-A stated if a resident was on the bowel movement list the residents PRN orders for constipation were initiated. LPN-A further stated on day three of no bowel movement she would administer a suppository for a resident if they did not have PRN orders. LPN-A stated there was previously a bowel protocol to follow and now the residents have PRN orders on the electronic medical record to follow. LPN-A confirmed on 4/28/25, she digitally removed R7's hard impacted stool. LPN-A stated R7 had a PRN Miralax order for constipation, and confirmed she did not offer R7 Miralax. LPN-A stated having specific directions would be helpful to know the steps and what to administer for residents experiencing constipation. On 4/30/25 at 8:47 a.m., the director of nursing (DON) stated nursing was expected to monitor resident bowel movements every shift and use nursing judgment for offering medications for constipation. The DON stated nursing was expected to offer constipation relieving measures on the third day of a resident not having a bowel movement. The DON confirmed the standing orders were not specific on what day to initiate the standing orders. The DON stated nursing staff were expected to document bowel movements and interventions implemented for constipation. The DON confirmed R7 did not have a bowel movement from 4/21/25-4/24/25, and no constipation relieving interventions were implemented or documented. The DON stated on	F 684		

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F 684	Continued From page 16 4/28/25, staff were expected to have implemented other measures besides digital bowel removal or documentation of resident education. The DON confirmed the facility did not have a policy on constipation. Facility document titled Standing Orders for Skilled Nursing Facilities dated 4/22, indicated Bowel: Constipation (Perform steps Sequential) Consider rectal check to determine if impaction is present Encourage 2,000 ml (milliliter) daily fluid unless contraindicated Consult nutrition services for dietary recommendations Senna 2 tables PO (by mouth) at HS (bedtime) prn Reattempt Senna or Bisacodyl if no results after 24 hours and notify provider Monitor and record results from treatment	F 684		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		6/8/25

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F 880	Continued From page 17 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 18 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize infection control practices while assisting multiple residents (R19, R33, R34, R35) to eat at once in 1 of 3 dining areas. Also, the facility failed to utilize infection control practices for 1 of 1 resident (R47) reviewed for oxygen use. Findings include: MEAL ASSISTANCE WITHOUT HAND HYGIENE R19's quarterly Minimum Data Set (MDS) assessment dated 3/5/25, indicated R19 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. R19 was dependent on staff for eating and had diagnoses which included gastro-esophageal reflux disease (stomach acid flows back up into the esophagus and causes heartburn), Alzheimer's disease, and depression. R33's quarterly MDS assessment dated 2/5/25, indicated R33 had severe cognitive impairment and required substantial and/or maximal staff assistance with eating. R33's diagnoses included hypertension, dementia, and anxiety.	F 880	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F 880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f). The facility's standard of practice is to prevent infections by adherence to infection prevention and control standards of practice. MEAL ASSISTANCE WITHOUT HAND HYGIENE Contributing factors to this finding are NA-H's and NA-G's predominant use of their right hands, while assisting 2 residents to dine at the same time, because of a fear that they may spill hot liquids on the resident while using their non-dominant hands. Staff involved received 'Just in Time' education on hand hygiene while assisting residents to dine. Facility Wide Response Addressing Other Residents with the potential to be Affected:	

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F 880	Continued From page 19 R34's annual MDS assessment dated 2/19/25, indicated R34 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. R34 was dependent on staff for eating and had diagnoses which included coronary artery disease, hypertension, diabetes mellitus, Alzheimer's disease, anxiety, and depression. R35's significant change MDS assessment dated 2/19/25, indicated R35 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. R35 was dependent on staff for eating and had diagnoses which included chronic kidney disease and dementia. On 4/28/25 at 5:14 p.m., residents in the memory care area were assisted with dining. Nursing assistant (NA)-H sat between R34 and R35 and assisted them with food and beverages. NA-H switched between each residents' utensils and drinks primarily using their right hand and did not perform hand hygiene in between. On 4/28/25 at 5:48 p.m., NA-H stated they did not want to use their left, non-dominant hand to feed the other resident, because they did not want to spill on the resident. On 4/29/25 at 11:48 a.m., NA-G sat between R19 and R33 and assisted them with food and beverages. NA-G wore gloves and switched between residents' utensils and drinks primarily using their right hand and did not perform hand hygiene in between. On 4/29/25 at 12:25 p.m., NA-G verified they	F 880	1. Nursing assistants received hand hygiene renewal education on May 1, 2025. 2. The unit charge nurse will observe facility staff assisting residents to dine at meal time to ensure appropriate hand hygiene is being practiced. 3. Ongoing: In response to identifying, and reviewing, how other residents potentially impacted, the facility will implement quarterly audits of a random sample of residents during meal times to ensure appropriate hand hygiene principles are being followed. Data obtained from the aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year. NASAL CANNULA A contributing factor to the incident involving the oxygen nasal cannula was RN-B's concern to get the R47's oxygen back on, as quickly as possible. staff involved received 'Just in Time'	

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	245590	A. BUILDING _____ B. WING _____	C 04/30/2025

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

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F 880	Continued From page 20 used their right hand to feed both residents at the same time. NA-G stated they should use one hand for each resident if assisting at the same time but did not want to spill on the resident by using their non-dominant hand. On 4/30/25 at 1:28 p.m., registered nurse (RN)-B stated staff were allowed to assist two residents with meals at the same time but needed to use a different hand unless hand hygiene was performed between residents. On 4/30/25 at 2:59 p.m., the director of nursing (DON) expected staff to perform hand hygiene between assisting residents with meals or designate one hand per resident to avoid cross-contamination. Facility Hand Hygiene policy dated 5/21/24, indicated: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy applied to all staff working in all locations within the facility. The policy directed staff to perform hand hygiene between resident contacts and use of gloves did not replace hand hygiene. NASAL CANNULA R47's quarterly MDS assessment dated 2/12/25, indicated R47 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. R47 had disorganized thinking, no hallucinations, no delusions, no behavioral symptoms, and no rejection of care.	F 880	education on infection prevention practices when handling oxygen tubes and cannulas. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. Nursing staff have received oxygen therapy, including infection prevention measures regarding nasal cannulas, renewal education. 2. Ongoing: In response to identifying, and reviewing, how other residents potentially impacted, the facility will implement quarterly audits of a random sample of residents receiving oxygen therapy to ensure appropriate infection prevention principles are being followed while caring for residents. Data obtained from the aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	

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F 880	Continued From page 21 R47 had no impairment to upper or lower extremities, used a walker and wheelchair, and required substantial/maximal assistance with most activities of daily living. R47's diagnoses included heart failure, hypertension, diabetes mellitus, and aphasia (disorder which affects how you speak and understand language). R47's care plan dated 4/28/25, indicated R47 was at risk for disease related complications related to dementia, chronic respiratory failure with hypoxia, chronic kidney disease, type two diabetes mellitus, hypertension, encephalopathy (change in how the brain works due to underlying condition), chronic congestive heart failure, tachycardia, and history of TIA (transient ischemic attack; temporary blockage of blood flow to the brain). The care plan directed staff to monitor for changes in respiratory status and give supplemental oxygen as ordered. R47's orders indicated, okay for oxygen two liters per nasal cannula and titrate as able to keep oxygen saturation above 88 percent every shift with a start date of 1/3/25. An order dated 4/28/25, directed staff to change and date oxygen tubing weekly while resident is on oxygen use and to discontinue the order if oxygen was no longer needed. On 4/28/25 at 5:31 p.m., R47's nasal cannula oxygen tubing was observed on the ground behind her as she wheeled herself to the kitchenette window. R47 spoke with the culinary aid near two nursing assistants who assisted other residents with eating. At 5:35 p.m., registered nurse (RN)-B picked up R47's nasal cannula and placed on back of wheelchair. RN-B went to the medication cart and returned with a	F 880		

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F 880	Continued From page 22	F 880		

square wipe, cleaned R47's nasal cannula, and placed the nasal cannula back on R47. At 5:37 p.m., RN-B stated they used an alcohol wipe to clean R47's nasal cannula.

On 4/29/25 at 1:45 p.m., licensed practical nurse (LPN)-B stated they would replace a nasal cannula if was on the floor rather than clean, since nasal cannulas were placed in the nares. LPN-B stated they would use an alcohol wipe to clean a nasal cannula if the resident touched the tubing with sticky hands and made the tubing sticky. LPN-B stated staff tried to wean R47 off the supplemental oxygen, but R47 would get dizzy without the supplemental oxygen.

On 4/30/25 at 12:25 p.m., LPN-A stated they considered a nasal cannula contaminated if touched the floor and would replace with a new nasal cannula after checking resident's oxygen saturation level and if resident was breathing okay.

On 4/30/25 at 1:28 p.m., registered nurse (RN)-B stated they cleaned R47's nasal cannula after observed on the floor and placed back on R47, since they did not know how long R47 was without her supplemental oxygen. RN-B stated they would normally replace nasal cannulas observed on the floor.

On 4/30/25 at 2:59 p.m., the director of nursing (DON) stated staff would usually replace a nasal cannula which had dropped on the floor for infection prevention reasons. The DON was okay the staff cleaned the nasal cannula and placed on the resident, since staff did not know how long the resident was without their supplemental oxygen. The DON stated the resident's

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F 880	Continued From page 23 supplemental oxygen was important, so the resident's oxygen saturation level did not drop. The Salter Labs' Instruction for use with reference number "16SOFT-7", indicated: "Single patient use. Do not sterilize. Keep tubing straight and free from kinks." Facility Oxygen Administration policy dated 2/25/25, indicated: Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(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 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	F 883		6/8/25

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F 883	Continued From page 24 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. §483.80(d)(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 (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.	F 883		

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F 883	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pneumococcal (PCV20) vaccine was offered or administered as recommended by the Centers for Disease Control (CDC) for 4 of 5 residents (R7, R15, R10, R41) reviewed for immunizations. This had the ability to affect all residents residing in the facility who had not been offered the PCV 20 vaccine. Findings include: R7's face sheet printed 4/30/25, indicated diagnoses of chronic kidney disease, malaise, low back pain, and congestive heart failure. R7's discharge Minimum Data Set (MDS) dated 4/17/25, indicated intact cognition, no rejection of care, and substantial assistance with showering, dressing, and personal hygiene. R7's care plan dated 3/5/25, indicated resident at risk for disease related complications related to diagnoses and resident will be free of serious complications. Interventions included administer medications per provider orders, observe for adverse medication side effects and monitor effectiveness. R15's face sheet printed 4/30/25, indicated diagnoses of unspecified dementia, agitation, open wound of neck, and anxiety. R15's quarterly MDS dated 3/26/25, indicated moderately impaired cognition, no behavioral symptoms, and substantial assistance with toileting hygiene, bathing, and lower body dressing.	F 883	It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F883 Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2). The facility's standard of practice had been offering each resident a pneumococcal immunization, unless medically contraindicated or if the resident had been previously immunized. Contributing factors to this finding is the facility's oversight of the CDC Guideline that recommends that any resident, including those that had a complete immunization, must be offered the PCV20 or PCV21 vaccine if their complete vaccination had been greater than 5 years ago. All of the residents in the resident sample, have been offered the PCV20 or PCV21 vaccine. Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. All eligible residents, and/or resident representatives, have been offered the PCV20 or PCV21 Vaccine. Orders have been obtained from medical providers. Orders have been sent to the pharmacy and will be administered upon arrival. This intervention was completed by the director of nursing and the infection preventionist. 2. Pneumovax calculator from the CDC	

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F 883	Continued From page 26 R15's care plan dated 1/14/25, indicated resident had difficulty making needs known related to diagnoses of dementia and disorientation with goal of resident's needs will be met by staff. R10's face sheet printed 4/30/25, indicated diagnoses of arthritis, dysphagia (difficulty swallowing), retention of urine, and abnormal weight loss. R10's quarterly MDS dated 2/5/25, indicated intact cognition, no rejection of care, impairment of upper and lower extremities, and substantial assistance with personal hygiene. R10's care plan dated 12/12/23, indicated resident had impaired mobility related to contractures, disease progression, and activity tolerance and intervention of extensive assistance of one to two staff for transfers, turning, and repositioning. R41's face sheet printed 4/30/25, indicated diagnoses of repeated falls, restless leg syndrome, Alzheimer's disease, and age-related physical debility. R41's significant change MDS dated 2/5/25, indicated severely impaired cognition, no behavioral symptoms, dependent on staff for toileting hygiene, and substantial assistance with upper and lower body dressing. R41's care plan dated 11/13/23, indicated resident had cognitive deficits due to diagnoses, needed a secure memory care unit, and would make appropriate decisions and maintain current decision-making capacity.	F 883	has been downloaded on desktops and will be performed with every new admit. 3. The director of nursing and infection preventionist have reviewed updated vaccine recommendation schedule and all vaccine updates, including the CDC Vaccine Information Sheets information on PCV20 and PCV21, and have put them into practice. 4. The director of nursing and infection preventionist ensured that the facility is enrolled in MIIC updates about vaccines, CDC email list for informational opportunities, webinars and updates. Ongoing: In response to identifying, and reviewing, how other residents potentially impacted, the facility will implement quarterly audits of a random sample of residents regarding compliance with immunization recommendations. Audits and data will be obtained at residents' quarterly care conferences. Data obtained from the aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	

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F 883	Continued From page 27 During record review, there was no documentation in R7, R15, R10, or R41's EMR (electronic medical record) for the PCV 20 vaccine or evidence the facility had attempted to educate residents on or offer the PCV 20 vaccine. Additionally, there was no documentation in R7, R15, R10, or R41's record that they had refused previously offered vaccines or the PCV 20 vaccine. During interview on 4/29/25 at 11:45 a.m., licensed practical nurse (LPN)-D also known as infection preventionist stated R7, R15, R10, and R41 were up to date on their vaccine schedules and have no further vaccinations needed. During interview on 4/30/25 at 10:45 a.m., LPN-D stated she now realized she should have offered the PCV 20 vaccine to residents. LPN-D further stated she missed the updated information on vaccines and had not heard about the new pneumococcal vaccines that needed to be offered. LPN-D stated she would come up with a process to get the PCV 20 or 21 vaccine offered to residents based on CDC recommendations. During interview on 4/30/25 at 10:46 a.m., director of nursing (DON) stated she expected vaccines to be offered to all residents based on current CDC guidelines. Facility Pneumococcal Vaccine (Series) policy revised 4/1/25, indicated the following: It is our policy to offer our residents, staff and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. 1. Each resident will be assessed for	F 883		

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F 883	Continued From page 28 pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 5. The type of pneumococcal vaccine (PCV 15, PCV 20, or PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations.	F 883		

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

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

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	245590	A. BUILDING **01 - MAIN BUILDING 01 1951 ADDITION** B. WING _____	**04/30/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 04/30/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Lutheran Home Belle Plaine was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2025

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: THE LUTHERAN HOME BELLE PLAINE is a two-story building with a partial basement. The building was constructed at (5) different times. The original building was built in 1954, is one-story, has no basement, and was determined to be of Type V(111) construction. The 1st Addition was built in 1967, is one-story, has no basement, and was determined to be of Type II(111) construction. The 2nd Addition was built in 1971, is two-stories, has no basement, and was	K 000		

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K 000	Continued From page 2 determined to be of Type II(111) construction. The 3rd Addition was built in 1998, is one-story, has no basement, and was determined to be of Type II(111) construction. The 4th Addition was built in 2008, is one-story, has no basement, and was determined to be of Type II(111) construction. Because the original building and all subsequent additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 49 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the	K 222		5/23/25

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 _____	**04/30/2025**

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 222	Continued From page 3 rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS	K 222		

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	245590	A. BUILDING **01 - MAIN BUILDING 01 1951 ADDITION** B. WING _____	**04/30/2025**

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K 222	Continued From page 4 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with NFPA 101, 1012 Edition, chapters 7.2.1.6.1.1 and 19.2.2.2.4 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. This deficient finding could have a isolated affect on the residents and staff of this facility. Findings Include: On 04/30/2025 at 10:41 AM, based on observation and interview of the staff present, the delayed egress assembly installed on the door of Main Street West failed to open in the allowable time. The alarm took did not engage and the door would not latch properly. An interview with the Administrator, Director of Environmental Services and the Maintenance Supervisor confirmed this deficient finding at the time of the survey.	K 222	It is the policy, and intention, of The Lutheran Home: Belle Plaine, to be in full compliance with all regulations and requirements of both the Medicaid and Medicare Programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility's CREDIBLE ALLEGATION OF COMPLIANCE. The written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The facility wishes to preserve its right to dispute these findings in their entirety should any remedies be imposed. It is the intention of The Lutheran Home: Belle Plaine, to be in compliance with K222 Egress Doors CFR(s):NFPA 101. 1. Facility maintenance staff repaired the locking device on the door cited, Main Street West Door. 2. The facility maintenance supervisor contacted Securitas (door security	

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

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K 222	Continued From page 5	K 222	company) and the program for the door was changed. The door now opens at 15 seconds after pushing the crash bar. Facility Wide Response Addressing measures put into place to ensure the deficiency does not reoccur and monitoring measures to ensure solutions are sustained includes the environmental services director adding monthly testing to all facility doors. Monthly testing prompts will be established in our TELS System. Our maintenance team will be responsible for conducting the tests. Inspection data will be reviewed and acted upon by the environmental services director or her designee. Data obtained from the aforementioned inspections will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors	K 363		5/23/25

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

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K 363	Continued From page 6 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5, NFPA 80, Standard for Fire Doors.. This deficient finding could have a isolated impact on the residents within the facility. Findings include:	K 363	It is the intention of The Lutheran Home: Belle Plaine, to be in compliance with K363 Corridor Doors CFR(s):NFPA 101. 1. Facility maintenance staff installed a door sweep to the laundry room doors on May 22, 2025.	

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K 363	Continued From page 7 On 4/30/2025/2024 at 11:01 AM, it was revealed by observation that the 1 hour fire rated doors to the laundry room hand a gap greater than 1/8". An interview with the Administrator, Director of Environmental Services and the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 363	Facility Wide Response Addressing measures put into place to ensure the deficiency does not reoccur and monitoring measures to ensure solutions are sustained includes the environmental services director ensured that yearly inspections to all facility doors occurs. Yearly inspection prompts has been established in our TELS System. Our maintenance team will be responsible for conducting the inspections. Inspection data will be reviewed and acted upon by the environmental services director or her designee. Data obtained from the aforementioned inspections will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		5/23/25

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K 372	Continued From page 8 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/30/2025 at 10:27 AM, it was revealed by observation that the smoke barrier above the smoke barrier doors near first floor TCU had a penetration that was not sealed. 2. On 04/30/2025/2025 at 10:31 AM, it was revealed by observation that the smoke barrier above the smoke barrier doors near room 110 had penetrations that were not sealed. An interview with the Administrator, Director of Environmental Services and the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 372	It is the intention of The Lutheran Home: Belle Plaine, to be in compliance with K372 Subdivision of Building Spaces-Smoke Barriers CFR(s):NFPA 101. 1. Facility maintenance staff inspected all smoke barriers and repaired those noted in the survey results on May 1, 2025. Facility Wide Response Addressing measures put into place to ensure the deficiency does not reoccur and monitoring measures to ensure solutions are sustained includes the environmental services director ensuring that biannual inspections of all smoke barriers occur. Every 6 month smoke barrier inspections prompts will be established in our TELS System. Our maintenance team will be responsible for conducting the tests. Inspection data will be reviewed and acted upon by the environmental services director or her designee. Data obtained from the aforementioned inspections will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 24, 2025

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

RE: CCN: 245590
Cycle Start Date: April 30, 2025

Dear Administrator:

On June 18, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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