DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 21, 2023

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

RE: CCN: 245590
Cycle Start Date: May 31, 2023

Dear Administrator:

On May 31, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On May 23, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered

professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 31, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Lutheran Home: Belle Plaine is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 31, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

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

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 21, 2023

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

Re: Event ID: ZRQ411

Dear Administrator:

The above facility survey was completed on May 31, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/31/23, a standard abbreviated 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 following complaints were reviewed with no deficiencies cited: H5590123C (MN82054) H55902577C (MN89997) H55902586C (MN83619) H55902587C (MN85227) H55902588C (MN91773) H55902589C (MN92590) The following complaint was reviewed: H55902463C (MN93836) and a deficiency was issued at (F689) at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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

Electronically Signed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision for 1 of 1 resident (R1), who was at risk for elopement. R1 unknowing left a secured memory care unit and was found outside near the street which resulted in an immediate jeopardy. The facility implemented corrective action and is being issued at past non-compliance. The IJ began on 5/22/23 when R1 exited the building through the screen porch double doors of the secured memory care unit unsupervised. The facility's administrator, director of nursing (DON), and registered nurse clinical coordinator (RCC) were notified of the IJ at 5:37 p.m. on 5/31/23. The facility implemented immediate corrective action on 5/23/23, prior to the start of the survey and was issued as past non-compliance (PNC). Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 3/29/23, identified diagnoses including dementia (brain disease causing memory loss) and anxiety (condition causing persistent worry or fear). R1 had severely impaired cognition, disorganized thinking and inability to recall recent events. Furthermore, the MDS indicated R1 exhibited wandering behaviors that occurred less than daily but did not identify whether behaviors were significant enough to place R1 at significant risk for getting into a dangerous place. R1 required set-up to limited assistance of one staff to meet activities of daily living (ADLs), was ambulatory without use of assistive devices, but required limited assistance of one staff when ambulating off unit.	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 R1's care plan, dated 1/17/23, indicated R1 was at risk for falls; had impaired cognition with memory loss, decreased attention span, and disorganized thinking. Care plan indicated R1 exhibited wandering and exit-seeking behaviors, and had a history of elopement Care plan interventions for R1 included staff would observe/monitor for changes in behavior, would monitor wandering activity, and would be always supervised when off the unit to reduce the risk of elopement. R1's physician orders, printed on 5/31/23, indicated staff to monitor R1's behaviors related to anxiety and wandering, to determine effectiveness of psychoactive medications (Risperidone, Buspar, and Citalopram). Behavioral assessment, reviewed from 5/17/23-5/31/23, indicated R1 displayed behaviors including being socially offensive towards others, was physically aggressive towards others, refused cares, wandered/paced, hoarding dirty clothing and napkins, rummaging, and going in and out of other residents' rooms without permission. During period reviewed, R1 exhibited behaviors 15 times over course of all shifts, staff provided interventions, R1's behaviors remained unchanged. Elopement risk assessment, dated 1/4/23, indicated R1 was at risk for elopement based upon factors including having a predisposing disease, was ambulatory, had intermittent confusion, took psychoactive medications, had a history of elopement in past 6 months. A fall risk assessment, completed on 3/31/23 and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3 again on 4/16/23, indicated R1 was at risk for falls. The fall risk assessment identified R1 had two falls in past 2 months. Facility incident report, dated 5/22/23 at 8:01 p.m., indicated at approximately 4:45 p.m., licensed practical nurse (LPN)-Z returned to unit following break at 4:45 p.m., observed other staff bringing residents to dining area for dinner meal, heard staff member calling R1's name looking for her. LPN-Z began looking for R1 as well, observed the code keypad on wall next to double doors, marked "Screen Porch," had a green colored light, indicating doors were not secured. LPN-Z indicated she was able to get through double doors of "Screen Porch," held open both doors to wait for audible alarm to sound, which LPN observed audible alarm did not sound for either door checked. LPN-Z indicated exit from "Screen Porch" doors led outside of gated area, which R1 would have had access to facility yard, sidewalk, and road. LPN-Z returned inside facility, manually secured with keys both doors of the "Screen Porch," ambulated towards front of unit, noted R1 being returned to unit per SW-A and administrator. Facility incident report indicated elopement having occurred on 5/22/23 between approximately 5-5:30 p.m. During a phone interview, on 5/30/23 at 4:32 p.m. family member (FM)-E indicated R1's cognition was poor, required staff assistance and reminders to meet ADL needs, required 1 staff to accompany R1 if going off memory care unit if R1 goes off unit. FM-E reported awareness of R1 displaying behaviors of anxiety, wandering, and exit-seeking; stated prior to recent elopement incident, R1 had attempted to elope one other time approximately 2 years ago. FM-E indicated	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 she had been notified per staff on 5/22/23, R1 had eloped earlier that day from secure memory unit of facility through an unlocked door found, R1 was found outside in front of facility building per staff and was brought back to memory care unit per administrator. FM-E indicated nurse who contacted her informed her following 5/22/23 elopement incident, R1 was placed on 15-minute visual checks per staff and staff had ensured all doors to memory unit were now secured. During an interview, on 5/31/23 at 10:13 a.m., nursing assistant (NA)-A indicated was familiar with R1's care needs. NA-A stated R1 was mainly independent with ADLs, required constant reminders from staff throughout the day to complete ADL tasks, occasionally refused cares, wandered, and tried to open doors on unit frequently, required 1 staff to accompany R1 anytime when going off unit. NA-A stated staff relied upon secured system to ensure doors on unit were locked appropriately. NA-A indicated awareness of R1's care plan needs when wandering or exit-seeking, which included re-direction per staff, engage R1 with an activity. NA-A stated she was informed of R1's recent elopement incident, had occurred on 5/22/23 while NA-A was working in another unit of facility. NA-A reported she had been informed by other staff that R1 was found outside per administrator, unaware of how incident occurred as all doors on memory unit should have been secured. NA-A indicated R1 had an incident of elopement one other time, approximately 1 year ago. NA-A stated since R1's recent elopement on 5/22/23, staff were to check on R1's whereabouts every 15-minutes and all staff needed to complete two courses of elopement re-training online through Relias.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 While observed, on 5/31/23 at 10:33 a.m., it was noted all four doors to memory unit were secured, visualization of code keypad next to doors were all colored red, indicative of being locked. All doors to memory unit remained secured when tried to manually open. During an interview, on 5/31/23 at 10:48 a.m., maintenance (M)-A indicated maintenance staff were available to take care of maintenance issues, even after business hours, staff aware maintenance could be contacted with emergencies 24 hours per day, 7 days per week; if maintenance concerns arose non-emergently, staff aware to send work order through the TELS computer system. M-A reported doors to memory care unit were secured doors, held closed per magnetic hold, managed by Summit Fire. M-A indicated all secured doors have a code keypad on wall next to doors, required a certain code to unlock secured doors. M-A stated code keypad next to secured doors had a colored button to indicate whether the doors were secured, if button was red in color the doors were secured, if button was green in color the doors were unsecured. M-A reported if secured doors became unlocked, not only would the code keypad button turn green in color, but staff would then need to secure door manually with a key. M-A indicated if a power outage occurs, power outage will automatically unsecure doors to facility, which had occurred recently on 5/21/23, staff aware to lock all doors manually with key to ensure security of doors. M-A reported maintenance staff did not routinely check secured doors, only if a concern was brought to their attention or upon yearly inspection, stated there had never been a problem to check secured	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 doors routinely until recently when a resident had eloped. M-A indicated awareness of an unsecured door on memory unit, "Screen Porch" doors affected, as a staff member noticed a button on code keypad next to doors on wall was colored green, indicative of doors being unsecured. M-A stated staff notified him of incident right away, staff had manually secured doors by locking them with key, unsecured doors were addressed per maintenance staff the next morning following the elopement incident and ensured to be working appropriately. Since recent elopement incident, on 5/22/23, M-A reported maintenance staff would check and keep a record log to ensure secured doors were working appropriately following a power outage. Maintenance was unsure why the door was not secured, but implemented routing door checks after a power outage and nursing staff to check them on each shift. While interviewed, on 5/31/23 at 11:09 a.m., licensed practical nurse (LPN)-A indicated she had worked on and off at facility for approximately 1 year, was familiar with R1's care needs. LPN-A indicated R1 was mainly independent, needed reminders to complete ADLs, shuffled feet when ambulating and required staff to accompany R1 when off unit for safety. LPN-A reported R1 was known to wander and exit-seek, exhibited "sundowning" behaviors daily around 3:00 p.m., where R1 became more anxious, confused, agitated, and would occasionally yell at staff and refuse cares. . LPN-A reported R1 was at high risk for elopement due to her behaviors and elopement risk assessment completed. LPN-A reported awareness of R1's elopement incident that had occurred on 5/22/23. LPN-A reported when doors became unsecured, a "clicking"	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 sound could be heard, the button on the code keypad on wall next to doors turned green indicating doors were unsecured. LPN-A indicated awareness if doors on memory care unit were unsecured, staff had to manually lock all the doors with a key, key located at nurse's station in the locked medication cart and notify maintenance. Since R1's 5/22/23 elopement incident, LPN-A also reported staff must visually check on R1 every 15-minutes. During an interview, on 5/31/23 at 11:53 a.m., social services (SS)-A indicated involvement in R1's 5/22/23 elopement incident. SS-A stated when she was leaving work for the day at approximately 4:50 p.m., she had gotten in her car, left employee parking lot, drove around to front of facility building, saw R1 on sidewalk about to approach street area at approximately 4:55 p.m. SS-A reported she immediately stopped car, got out of car, ran over to R1's location to keep R1 from crossing street. SS-A indicated she attempted to assist R1 back to facility, but R1 was resistive, R1 stated she needed to go home to find her kids. SS-A stated she had her cell phone with her, contacted administrator to inform of situation and need for assistance. Administrator immediately responded to assist with R1, administrator conversed with R1, administrator and SS-A assisted R1 back to facility at approximately 5:00 p.m. SS-A reported no injuries noted to R1 upon brief visualization following elopement incident. SS-A initially stated it was unknown how R1 eloped from secured memory unit, through investigation findings, staff determined double doors of "Screen Porch" had been unsecured, as licensed nurse on unit that day noticed button on code keypad code next to doors was colored in green, indicative of	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 unsecured doors. SS-A reported "Screen Porch" doors were located outside of the memory care unit's fenced area and if R1 had used those doors to leave facility, R1 would have been able to ambulate on sidewalk or through the paved parking lot towards street in front of facility. SS-A indicated R1 was at risk for elopement as had left secured memory care unit one other time approximately 1 year ago. During an observation on 5/31/23 at 12:48 p.m., together with SS-A and Occupational Therapy (OT)-A, walked the route R1 had approximately taken when left the facility, OT-A measured approximately distance using a measuring wheel. R1 ambulated on uneven terrain including grass, a pavement, rock/sand debris, potholes, a parking lot containing construction equipment, onto a sidewalk that led in front of facility towards a busy street. SS-A identified approximate location site on sidewalk where she had found R1 standing, which was approximately 2 ft away from stepping into a busy street. Total distance measured per OT-A using measuring wheel was 186 yards. While observed, on 5/31/23 at 3:53 p.m., R1 was noted sitting at table in the living/common room area of secured memory unit, R1 was looking at a magazine provided per staff, R1 appeared calm in manner at time. Nursing staff present at nursing station, R1 within nursing staff view. Activity staff member observed occasionally interacting with R1 and other residents in living/common room area. During an interview, on 5/31/23 at 4:50 p.m., administrator indicated involvement with R1's 5/22/23 elopement incident, stated he received a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 phone call from SS-A at approximately 4:55 p.m., SS-A found R1 unsupervised on sidewalk in front of facility entrance, SS-A requested additional staff assistance to escort R1 back to facility, as R1 was being resistive. Administrator stated he immediately responded to SS-A's request for additional assistance, and able to converse with R1, administrator and SS-A assisted R1 back to facility's secured memory unit at approximately 5:00 p.m. Administrator indicated unawareness of how R1 eloped from secured memory unit, stated he initially believed secured doors to memory unit became unsecured following a power outage on 5/21/23. Administrator stated he had contacted the night nurse who had worked following power outage, night nurse had stated she had checked all doors on memory care unit and all doors were secured. Administrator reported investigation findings of R1's 5/22/23 elopement incident indicated staff had last visualized R1 in memory care unit on 5/22/23 at approximately 4:30-4:45 p.m. as staff were escorting other residents to dining area, staff realized R1 was not present in dining room. Administrator indicated staff in memory care unit immediately began unit room searches looking for R1 and calling out R1's name, LPN-Z working on unit that day noticed the "Screen Porch" doors button on code keypad on wall next to doors were colored green, indicative of unsecured doors. Administrator stated a staff member was about to leave memory care unit to go outside to look for R1, but administrator and SS-A were returning to memory care unit with R1. Administrator reported R1 had been out of facility unsupervised for no more than 15 minutes. Administrator indicated memory care unit relied on a magnetic-alarm system to ensure security of all doors on unit. Administrator further stated staff should have	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 been trained at time of hire and/or orientation to unit floor on each resident's care plan and maintenance concern process, including what to do if a power outage occurs, staff should have received education to check all secured doors to memory unit as was expected to be performed daily on night shift. Administrator verified R1 should not have been off memory care unit unsupervised. . Facility policy, titled Resident Elopement/Resident Missing, reviewed 3/22/23, consisted of all staff responsibility to prevent any resident who attempts to elope. The PNC IJ began on 5/22/23, was removed on 5/23/23, and verified the facility implemented the following actions; -15-minute safety checks for R1 - placed a small picture of R1 behind each nurse's station and at front desk to alert staff if R1 seen outside of secure memory care unit -physician evaluation of R1 to rule out any medical concerns and to further evaluate mental health condition, and medication changes made -created sign off sheets to ensure all doors were secured on memory care unit and required two staff signatures at each change of shift daily -staff completed re-education on elopement.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00605	A. BUILDING: _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/31/23 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed with no deficiency issued:	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00605	A. BUILDING: _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 H5590123C (MN82054) H55902463C (MN93836) H55902577C (MN89997) H55902586C (MN83619) H55902587C (MN85227) H55902588C (MN91773) H55902589C (MN92590) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00605	A. BUILDING: _____ B. WING _____	C 05/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		