

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER The Lutheran Home: Belle Plaine		STREET ADDRESS, CITY, STATE, ZIP CODE 611 West Main Street Belle Plaine, MN 56011	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of deprivation of good within 2-hours to the State Agency (SA) for 1 of 1 resident (R1), who reported staff refused to transfer her to the toilet when requested and was incontinent of urine. Findings include:R1's nursing home incident report (NHIR) dated 6/16/25 at 3:07 p.m., identified R1 reported from 6/14/25-6/15/25 she put her call light on around midnight to use the toilet and sit in her recliner. Two aides came into the room and rudely told her What do you want to get up for and it is time for bed. The aides turned off the call light and left the room. Staff did not come back to the room until 2:30 a.m. and told R1 they were very busy. R1 reported that she hated it but had to urinate in her brief because they would not help her. R1 stated she waited in the wet brief until the morning when new staff were available to help her. R1 also indicated when she asked staff to transfer her according to her preference, staff responded I'm not going to lose my license, so we are not going to transfer you. Facility identified the nursing assistants through camera footage.R1's face sheet dated 7/9/25, identified diagnoses of mechanical complication of internal right hip prosthesis (presence of an artificial device to replace a missing body part), presence of artificial right hip.R1's comprehensive Minimum Data Set (MDS) dated [DATE], identified no issues with cognition, no behaviors towards staff or residents. Impairment on one side of lower extremity. Dependent on staff for toileting hygiene, lower body dressing, footwear; substantial assistance with movements in bed. Continent of bowel but frequent incontinence of urine.R1's care plan on 6/10/25, identified R1 was a vulnerable adult and staff should report any witnessed or suspected abuse per facility protocol.During an interview on 7/8/25 at 1:10 p.m., R1 stated the two nursing assistants should never have been nursing assistants. They are authoritative and drag one foot in front of the other. R1 felt that they just were not doing their jobs. If R1 asked for something it would take forever for them to do it but that night, they were not budging. R1 stated she had to use the bathroom, and they had gotten her up and were on the way and then could not do it saying things like they would lose their license and all sorts of things. R1 decided that it would be best to pee in my pants and not damage my leg. R1 decided that she should report the aides that morning and the aides were gone quick after she reported the incident.During a phone interview on 7/9/25 at 9:59 a.m., registered nurse (RN)-A stated she had worked the overnight shift on 6/14/25 into 6/15/25. NA-F had come to her because she felt unsafe transferring R1 using a mechanical lift because of the way R1 was demanding to be transferred. NA-F was very adamant about not transferring R1 in that manner. RN-A asked NA-E to transfer R1. It was not until the next morning or two days later that RN-A discovered that R1 had never been transferred. R1 was sleeping in her recliner that night and had never gotten into bed. NA-E was working on R1's unit that night and NA-F was scheduled as the float person that would help other NA's where needed. As far as RN-A was aware, NA-E and NA-F were never in R1's room together. RN-A had never had any issues with NA-E or NA-F prior to this. RN-A stated she reported the incident during shift to shift report the morning of 6/15/25. RN-A had not received concerns from R1 or about R1 that occurred during the night other than the transfer incident.During an interview on 7/8/25 at 1:45 p.m., licensed practical nurse (LPN)-A believed it was the morning of 6/14/25 when RN-A reported R1 was upset with the NA's for not transferring her the way she wanted to be transferred; NAs had thought the way R1 wanted to be transferred was unsafe so they did not transfer her the rest of the night to the bathroom. LPN-A did not know which NAs were involved. LPN-A thought the incident happened around 3:00 am and R1 was really frustrated the NAs would not listen. LPN-A explained she reported R1 was unhappy about the concerns pertaining to R1's transfers to LPN-B sometime that morning.During an interview on 7/9/25 at 9:53 a.m., LPN-B stated LPN-A had called her on 6/15/25 and said there was an issue with R1's transfer status and questions between the nurses and aides on night shift with turning off her light. LPN-B notified the director of nursing (DON) of the situation and tried to get ahold of RN-A to discuss what had happened. During an interview on 7/9/25 at 1:14p.m., DON stated LPN-B had reached out to her on 6/15/25 that there were some complaints regarding staff with R1. DON did not feel that what was reported seemed neglectful from her perception, if it had, an investigation would have begun. After R1's interview on the afternoon of 6/16/25, management staff felt that rather than provide education to staff, the incident needed to be reported. During an interview on 7/9/25 at 9:46 a.m., NA-A stated she reported to social worker (SW)-A on 6/16/25 that R1 was mad because the night aides would not take her to the bathroom because they did not feel comfortable with her toe-touch R1's brief was soaked when NA-A assisted her on the morning of 6/15/25</p>		