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	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lutheran Home: Belle Plaine	611 West Main Street Belle Plaine, MN 56011

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively assess and monitor for signs and symptoms of fluid overload for 1 of 3 residents (R1) who had diagnoses of congestive heart failure (CHF), was administered diuretics, and required daily weights. This resulted in an Immediate Jeopardy (IJ) for R1 who had 16-pound weight gain in 10 days, required hospitalization for diuresis then discharged home on hospice with acute renal (kidney) failure. The IJ began on 10/19/25, after the facility failed to comprehensively assess and notify the physician of nearly 7.5-pound weight gain which led to hospitalization on 10/23/25. The Administrator and director of nursing (DON) were notified of the IJ on 10/30/25 at 2:22 p.m. The IJ was removed on 11/4/25 at 3:00 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy.R1's face sheet dated 10/29/25, identified diagnoses of heart failure (heart does not pump blood as it should), hypertension (elevated blood pressure), and localized edema (swelling caused by fluid trapped in the tissues).R1's hospital Discharge summary dated [DATE], identified R1 was hospitalized for cellulitis (skin infection). The summary identified R1 was discharged to the facility on [DATE] with a new order for torsemide (diuretic medication) 80 milligrams (mg) daily to begin 10/14/25 (changed from previous diuretic of Furosemide 80 mg daily; summary did not include why this medication was changed). R1's first dose of the torsemide 80 mg was administered at the hospital. Diet orders included daily fluid intake of 2,000 milliliters (mL)/day.R1's physician orders dated 10/13/25, identified Torsemide 80 mg daily, fluid restriction of 2,000 mL, and daily weights (no parameters identified).The facility standing orders dated 9/25/25, included under heart failure management to call for weight gain 3 pounds (lbs) or greater in 24 hours or 5lbs. in one week, assess lung sounds, peripheral edema, and respiratory status daily unless directed otherwise. This order set was not transcribed into R1's electronic physician orders. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive deficits, no behaviors, and was dependent on staff to bring drinks to her mouth. R1's baseline care plan dated 10/13/25, identified a 2,000 mL fluid restriction, low sodium, and needs to be fed. R1's care plan identified on 10/19/25, interventions of daily wt., however there were no other interventions identified for the management of fluid volume status. Review of R1's weight (wt) record in conjunction with fluid intake and urine output included the following recorded values between 10/13/25 through 10/23/25, there was no indication comprehensive assessments were completed to determine if weight gain was fluid gains versus nutritional gains, no indication fluid intake was compared with urine output to determine adequate hydration needs and/or renal function status. On 10/13/25: 185.5 lbs., with intake of 680 mL, and urine out was not recorded. 10/14/25: 183.9 lbs., with intake of 1,160 mL, and medium amount of urine output at 8:07 p.m.10/15/25: 187.6 lbs., with intake of 960 mL, and urine out was not recorded. 10/16/25: 188 lbs., with intake of 2,680 mL, and urine out was not recorded.10/17/25: 190.8 lbs., with intake of 1,380 mL, and urine out was not recorded.10/18/25: 189 lbs., with intake of 800 mL, and urine out was not recorded.10/19/25: 193 lbs., with intake of 860 mL, and urine out was not recorded.10/20/25: no weight recorded, with intake of 720 mL, and urine out was not recorded.10/21/25: 198.6 lbs., with intake of 1,540 mL, and medium amount of urine output at 2:14 p.m.10/22/25: 200.4 lbs., with intake of 1,620 mL, and large amount of urine output at 1:59 p.m.10/23/25: 202.4 lbs., with intake of 300 mL, and urine out was not recorded. Review of R1's record between 10/13/25 through 10/18/25, did not identify physician notification of the 4 lbs. weight increase. Further, there was no indication the physician was made aware of R1's weight gains since admission to the facility on [DATE]. In addition, the record did not include any assessments and/or monitoring for signs/symptoms of fluid volume overload and renal failure. R1's physician visit dated 10/18/25 directed staff to continue torsemide 60 mg daily every a.m., follow-up labs, continue daily weights, and consider discontinuing fluid restriction. (The visit note did not address weight gain of 4 lbs. since admit nor identify why R1's Furosemide was changed to Torsemide upon discharge from the hospital). During a phone interview on 10/30/25 at 9:02 a.m., physician assistant (PA)-A verified that the 60 mg was written in error, and he expected R1 to continue with torsemide 80mg daily. PA-A stated at the time of the visit he was not aware R1's weight had increased 4 lbs. since admission on [DATE]. During a phone interview on 10/30/25 at 8:57 a.m., pharmacist (PC) stated torsemide is stronger than furosemide and that furosemide is usually discontinued and torsemide started if a person is not seeing results from furosemide. The combination of fluid restriction and high dose of torsemide would dehydrate R1. PC thought if the rounding