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	12/30/2025

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

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow care plan interventions related to a resident transfer. Nursing assistant (NA)-A independently transferred 1 of 3 residents (R1) who required assist of 2 staff. This resulted in actual harm when R1 fell during a transfer in a lift, was sent to the emergency department for increased pain to her right arm and was diagnosed with a closed fracture of proximal end of right humerus (fracture of the shoulder joint). The facility took action to correct the deficient practice on [DATE], prior to start of the survey. Therefore, the deficiency was issued at past noncompliance (PNC)Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had mild cognitive impairment and required staff assistance with transfers, toileting, dressing, and bed mobility. R1 used a wheelchair, and diagnoses included vascular dementia, hemiplegia (paralysis on one side of the body), history of transient ischemic attacks ((temporary disruption of blood flow to the brain that resolves without permanent damage), chronic pain, and age-related osteoporosis. R1's Functional Abilities assessment dated [DATE], identified she transferred with an EZ stand (mechanical sit to stand lift) and required assist of two for all transfers. R1 was non-ambulatory. R1's care plan intervention dated [DATE], identified R1's transfer intervention as total assist of two with EZ stand for transfers on/off toilet/commode. R1's progress notes indicated: -[DATE] at 12:38 p.m., R1 received a shower; was very sleepy on bath days; did not go out to dining room for lunch until 12:15 p.m.-[DATE] at 11:15 p.m., indicated R1 had a fall at 1:15 p. m., (late entry) unknown if resident hit her head, was being transferred in the EZ stand and let go of the handles. When the resident let go, the NA tried to get the wheelchair behind her and resident fell. Resident stated her shoulder hurt initially and by 3:30 p.m. resident stated her whole right side of her body was hurting. Ambulance was called due to not knowing the extent of her injuries. R1 returned from the ER (emergency room) at 9:05 p.m. with diagnoses of closed fracture of proximal end of right humerus. R1 had a right arm sling on; morphine (narcotic pain medication) given in ER; new order for hydrocodone-acetminophen5-325mg (milligrams) take one tablet by mouth every 6 [six] hours as needed for pain (narcotic pain medication). R1's After Visit Summary from the emergency department dated [DATE], identified the reason for visit was fall with shoulder pain and diagnoses of closed fracture of proximal end of right humerus. R1's Physician order dated [DATE] at 7:25 p.m., instructed give one Norco (narcotic pain medication) every six hours as needed for pain; please be very gentle with movement of right arm as this arm/shoulder is broken; sling applied over clothes to right arm for comfort. The facility's document titled LTC (long term care) Floor Cards last updated [DATE], identified R1's transfer instructions as assist of two EZ stand or EZ lift when weaker, medium harness. The facility's Event Report closed on [DATE] at 7:47 p.m., identified on [DATE] at 1:15 p.m., R1 was transferred with EZ stand, let go, and fell against bed; unknown if R1 hit head. Pain observation was a 10 (ten) defined as excruciating pain, worst possible, interfered with ability to carry on with daily routines, socialization, or sleep. R1 refused to allow nurse to complete ROM (range of motion) to right arm. R1 sent to ED for evaluation. The facility evaluation included R1 let go of the handles of the EZ stand during a transfer; complained of right arm pain and later right leg pain after the incident; sent to the ER; diagnoses of humerus fracture; returned to the facility and changed to an EZ lift for transfers; sent back to the ER the following day due to low O2 (oxygen) sats (saturations) and increased respirations; died during hospital stay. When interviewed on [DATE] at 1:40 p.m., NA-B stated R1 always needed assist of two staff with the EZ stand transfer because R1 had a habit of just letting go of the handles NA-B further identified R1 would have spells where she just went blank and would take a few minutes to respond to them. NA-B stated the second person that assisted R1 with the transfer would be responsible to watch R1's hands closely and either remind R1 to keep her hands on the handlebar or put hand over R1's hand as a reminder; without that second person, she was likely to fall if she let go. NA-B also stated if R1 was tired like after her bath, she would not be able to stand or hold on so staff would transfer her with the EZ lift. NA-B stated she heard about R1's fall from the lift on [DATE] but was not working at the time. When interviewed on [DATE] at 1:49 p.m., director of nursing (DON) stated the facility investigation into R1's fall identified that NA-A transferred R1 independently when R1 was supposed to have two people to assist during transfers. The facility floor cards (care cheat sheets) had two (staff) assists with EZ stand transfers and the care plan said two assist with EZ stand transfers. The DON said it was her expectation that all staff followed the care planned interventions. The DON stated NA-A was a newer NA but had completed her initial