

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 08/06/2024
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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073</p> <p>Based on interview and document review, the facility failed to ensure written notice of transfer was provided to the resident and/or resident representative for 1 of 2 residents (R44) reviewed for hospitalization .</p> <p>Findings include:</p> <p>R44's facesheet, included diagnoses of Alzheimer's disease, retention of urine, and urinary tract infection.</p> <p>R44's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R44's impaired cognition R44 was usually understood and could usually understand. R44 did not walk and was dependent on staff for most activities of daily living (ADL).</p> <p>R44's care plan with revised date of 7/30/24, indicated indwelling catheter related to urinary retention; staff were to manage the catheter to prevent UTI and obstruction in drainage.</p> <p>During an interview on 8/4/24 at 1:33 p.m., family member (FM)-E stated R44 had been hospitalized overnight in April 2024 for a urinary tract infection. FM-E did not recall receiving a written notice of transfer. This document was not seen in the scanned documents section of the electronic medical record (EMR).</p> <p>Progress note dated 4/18/24 at 5:00 a.m., indicated R44 was experiencing abdominal distention and discomfort, a fever, and his urinary catheter was not draining well. An okay was received by the hospice provider to send R44 to the emergency room .</p> <p>Progress note dated 4/19/24 at 2:55 p.m., indicated R44 was still in the hospital.</p> <p>Progress note dated 4/21/24 at 6:05 p.m., indicated R44 would be returning to the facility that evening.</p> <p>During an interview on 8/5/24 at 4:34 p.m., registered nurse (RN)-A provided transfer documentation for R44's April hospitalization , but the documentation did not include written notice of transfer to be given to the resident representative and the ombudsman.</p> <p>(continued on next page)</p>

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/6/24 at 10:31 a.m., RN-A stated she did not know who in the facility completed a written notice of transfer when a resident was transferred to the hospital, adding nursing did not.</p> <p>During an interview on 8/06/24 at 10:50 a.m., the director of nursing stated nursing did not complete a written notice of transfer when a resident was transferred to the hospital and thought social services might do that.</p> <p>During an interview on 8/06/24 at 11:04 a.m., resident and family liaison (RFL)-B stated social services did not complete a written notification of transfer form of any kind and thought nursing might do that. RFL-B stated she did inform the ombudsman each month of residents who were transferred.</p> <p>During an interview on 8/6/24, at 11:45 a.m., the DON stated they facility did not have a policy on written notice of transfer.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764</p> <p>Based on observation, interview and document review, the facility failed to implement therapy recommendations in a timely manner to maintain strength and mobility for 1 of 1 resident (R41) reviewed for range of motion (ROM).</p> <p>Findings include:</p> <p>R41's face sheet, indicated diagnoses of Parkinson's disease, age-related physical debility, and weakness.</p> <p>R41's admission Minimum Data Set (MDS) assessment dated [DATE], identified no cognitive impairment, the ability to understand and be understood, no rejection of care, limited range of motion on both sides of upper and lower extremities, and physical assist with personal hygiene, bed mobility, dressing, toilet use, and transfers.</p> <p>R41's care plan dated 6/26/2024 and revised 8/5/2024, indicated staff were to assist resident with ROM (range of motion) to bilateral upper and lower extremities as resident tolerates and resident totally dependent on staff for all transfers and mobility.</p> <p>R41's PT (physical therapy) Therapist Evaluation Summary dated 6/11/2024, indicated staff were to assist R41 with upper and lower body passive range of motion programs daily and to see attachments for passive stretches recommended. Also instructed to provide slow and gentle stretches during range of motion and to ensure R41's tolerance with verbal and visual pain assessments.</p> <p>R41's OT (occupational therapy) Therapist Evaluation Summary dated 6/12/2024, indicated a recommendation of bilateral upper extremity PROM (passive range of motion) for staff to perform daily to prevent worsening muscle contractures.</p> <p>R41's Kardex (used by nursing assistance's) dated 8/5/2024, failed to include any reference to PROM exercises.</p> <p>R41's orders dated 8/5/2024, failed to include any reference to PROM exercises.</p> <p>On 8/5/2024 at 10:26 a.m., R41 was observed in his wheelchair with arms bent up towards his chest. R41 stated staff had not completed exercises with him and he would have liked them to do exercises and stretching with him.</p> <p>On 8/5/2024 at 3:33 p.m., registered nurse (RN)-C stated the PROM exercises were missed when therapy recommended them and the recommendations for R41 had not been started. RN-C further stated that going forward the recommendations will be implemented right away.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/2024 at 8:40 a.m., occupational therapist (OT)-F stated the therapy department gave the recommendation to nursing on 6/12/2024. OT-F further stated the lack of PROM did not cause change in functional ability for R41 due to already severely impaired active movement and functional control of extremities. OT-F also stated R41 would still benefit from implementation of the PROM recommendations.</p> <p>On 8/6/2024 at 10:45 a.m., director of nursing (DON) stated she would expect PROM recommendations to be implemented timely to prevent decline in functional abilities.</p> <p>A policy titled Prevention of Decline in Range of Motion revised 1/2024, stated the following:</p> <p>a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion.</p> <p>b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: assistance as needed (active assisted, passive, and supervision).</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>40614</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and document review, the facility failed to ensure nurse staff postings were accurate and up-to-date on a daily basis. This had the potential to affect all 50 residents who resided in the facility and/or any visitors who may have wished to view the information.</p> <p>Findings include:</p> <p>During interview on 8/4/24 at 12:00 p.m., trained medication assistant indicated he was called in to work this morning to assist, as a nurse on the unit had called in for the shift.</p> <p>During observation on 8/4/24, at 7:06 p.m., staff posting dated Friday 8/2/24 was posted on a back wall by the reception desk. The form included date, census, registered nurse (RN), licensed practice nurse (LPN's), trained medication assistant (TMA) and nursing assistant (NA) for each scheduled shift with total hours all listed at 8 hours. Total hours was present for each shift.</p> <p>During observation and interview on 8/5/24 at 8:33 a.m., the receptionist indicated she is not responsible for changing the posted staffing for the day. The staff posting remained dated as Friday 8/2/24.</p> <p>During interview on 8/5/24 at 8:36 a.m., the scheduler (S)-D indicated on Friday she will post the Saturday and Sunday postings behind Friday. S-D indicated she frequently comes in on Monday and Friday remains the posted staff hours. S-D stated she will review the working schedules staff use to make any corrections that occurred over the weekends to staffing such as call ins. S-D confirmed a licensed practical nurse (LPN) called in for Sunday 8/5/24 and a trained medication assistant (TMA) replaced the LPN position. S-D stated she will make the necessary changes to the posted hours usually after the nursing posted hours are taken down as that is when she discovers the call ins which sometimes requires changes. S-D is unsure who is responsible for ensuring the correct date posting is posted but thought it would be the charge nurse who is working over the weekend. S-D added sometimes the charge nurse is on-call versus being in the building though.</p> <p>During observation and interview on 8/5/24 at 8:45 a.m., the director of nursing (DON) confirmed the posted hours remained on Friday 8/2/24. The DON indicated there is always a charge nurse in the building on weekends.</p> <p>A policy and procedure on nursing staffing posts was requested but none received.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>42073</p> <p>Based on observation, interview and record review, the facility failed to ensure doses of a controlled substance were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerators observed for medication storage.</p> <p>Findings include:</p> <p>During an observation on 8/6/24 at 7:52 a.m., observed two nurses, licensed practical nurse (LPN)-A and registered nurse (RN)-B perform shift change narcotic reconciliation in a medication cart at the Mainstreet nurses station. At the end of the narcotic count, LPN-A stated they also needed to count the narcotics in the refrigerator. During an observation of the small dorm-size refrigerator in the locked medication room, an opened, multi-dose bottle of lorazepam (a medication to relieve anxiety) concentrate, 2 mg/ml (milligrams per milliliter) was observed on a shelf on the door of the refrigerator - not in a separately locked, permanently affixed compartment in the refrigerator.</p> <p>During an interview on 8/6/24 at 12:38 p.m., the director of nursing (DON) was informed of the observation and stated she was unaware lorazepam, a schedule IV medication, needed to be in a separately locked, permanently affixed compartment in the refrigerator.</p> <p>Facility Medication Storage policy dated 7/24, indicated if a medication was supplied in a unit-dose system, schedule III-IV medications could be stored in trays with other medications.</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>40614</p> <p>Based on interview, and record review, the facility failed to inform the resident or representative of the right to not sign the arbitration agreement as a condition of admission or as a requirement to continue to receive care at the facility.</p> <p>Findings include:</p> <p>An Admission Agreement, undated, included a portion titled Arbitration Agreement Clause that included subsections including contractual and/or property damage disputes, personal injury, wrongful death or medical malpractice, exclusion from arbitration, right to legal counsel, location of arbitration, time limitation for arbitration, limitation on damages and allocation of costs and limited resident right to rescind this binding agreement clause. The next page of the admission agreement included Signatures of Parties to Agreement for the entire document. Two pages behind the signature page is a Notice of Right to Rescind Binding Arbitration Clause informing they have a right to rescind the agreement regarding binding arbitration within 30 days and must send the notice certified mail or hand deliver no later than 30 days from admission agreement signature. The Admission Agreement and Arbitration Agreement Clause did not include a section to inform the resident or representative of the right to not sign the arbitration agreement.</p> <p>During interview on 8/5/24 at 12:38 p.m., the director of nursing stated no residents or representatives have signed the arbitration agreement at the facility and no residents have filed a dispute.</p> <p>During interview on 8/5/24 at 1:59 p.m., admissions coordinator (AC)-A indicated all the residents in the facility have signed the arbitration agreement which is part of the admission agreement. They do not require separate signatures. AC-A stated none of the residents or families have submitted the Notice of Right to Rescind. AC-A indicated she gives a verbal explanation of arbitration prior to the resident or representative signing the admission agreement but does not inform them of the right to not sign the Arbitration Agreement section.</p> <p>During interview on 8/5/24 at 2:00 p.m., the administrator stated only one signature is required for admission which includes the arbitration agreement also and if the resident doesn't want to agree to arbitration, they are required to submit the Notice of Right to Rescind Binding Arbitration Clause. The administrator indicated there is an assumption that could be made since the admission agreement is required for admission.</p> <p>During interview on 8/5/24 at 4:14 p.m., the administrator confirmed the current agreement does not include written documentation that arbitration is not a requirement of admission to the facility or continuation of care.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073</p> <p>Based on observation and interview, the facility failed to follow proper procedures to prevent the spread of infection when emptying a urinary drainage bag for 1 of 1 resident (R44) observed for infection control practices.</p> <p>Findings include:</p> <p>R44's facesheet, included diagnoses of Alzheimer's disease, retention of urine, and urinary tract infection (UTI).</p> <p>R44's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R44's was cognitively impaired. R44 was usually understood and could usually understand. R44 did not walk and was dependent on staff for most activities of daily living (ADL).</p> <p>Physician orders dated 11/14/23, included monitoring Foley (a type of indwelling catheter) output each shift.</p> <p>R44's care plan with revised date of 7/30/24, indicated indwelling catheter related to urinary retention; staff were to manage the catheter to prevent UTI. The drainage bag was to be emptied every shift.</p> <p>During an interview on 8/4/24 at 1:28 p.m., family member (FM)-E stated R44 had a urinary catheter in place because, His urine doesn't come out. FM-E stated R44 had a bad UTI in April 2024 and was hospitalized .</p> <p>During an observation on 8/5/24 at 1:24 p.m., in R44's room, nursing assistants (NA)-A and NA-B moved R44 from his wheelchair to the toilet via an EZ-stand (a device that helps someone stand up from a chair). While R44 sat on the toilet, NA-A set the urinary drainage bag directly on the floor next to the toilet and emptied the urine from the urinary drainage bag into a urinal.</p> <p>During an interview on 8/5/24 at 1:36 p.m., NA-A was informed of the observation of the urinary drainage bag on the floor. NA-A stated she had to do that to get the clamp open on the port to drain out the urine. NA-A indicated it could cause bacteria to enter R44's urinary drainage system and stated, He's had infections.</p> <p>During an interview on 8/5/24 at 2:47 p.m., registered nurse (RN)-A indicated, That's a big infection control issue and stated she would have expected the urinary drainage bag to be hooked onto something when emptying it.</p> <p>During an interview on 8/6/24 at 10:50 a.m., the director of nursing (DON) was informed of the observation of a NA setting a urinary drainage bag on the floor of the bathroom to empty it and acknowledged that was not the proper way to empty the bag and could contribute to a UTI.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Catheter Care policy dated 7/3/23, indicated it was the policy of the facility to ensure residents with indwelling catheters received appropriate catheter care when an indwelling catheter was in use; to ensure the drainage bag was not touching floor surfaces unless barrier was provided.		