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	07/07/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to administer intravenous (IV) medication according to professional standards of practice for 1 of 1 resident (R18) reviewed for IV medication administration. Findings include:R18's face sheet received on 7/7/26, indicated diagnoses of multiple sclerosis (chronic autoimmune disease of the central nervous system), functional quadriplegia (complete inability to move due to severe disability), with recent hospitalization for bacterium (bacteria in the blood stream) and urinary tract infection. R18's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R18 was dependent upon staff for all activities of daily living and had an indwelling urinary catheter. R18 used a motorized wheelchair for mobility.R18's physician orders dated 6/26/26 - 7/31/26, cefazolin (antibiotic) in dextrose solution; 2 gram/100 mL (milter); 2 grams; intravenous for bacteremia, every eight hours; 7:00 a.m., 3:00 p.m., 11:00 p.m.R18's care plan dated 5/28/26, indicated R18 required an indwelling urinary catheter and would have care to prevent signs of infection.R18's provider discharge summary from the hospital dated 6/24/26, indicated discharge diagnosis of staphylococcus aureus bacteremia secondary to urinary tract infection and antibiotics for six weeks. During an observation on 7/6/26 at 6:10 p.m., observed R18 maneuver his motorized wheelchair into the dining room after returning from an outing.During an observation on 7/6/26 at 6:37 p.m., observed LPN-C assemble supplies to administer R18's IV antibiotic in the dining room. LPN-C stated that was where R18 wanted to receive the medication as he would eat supper right afterwards. LPN-C set supplies including gloves, packages of prefilled syringes of normal saline (NS), alcohol wipes, and cefazolin 2 grams in 120 ml NS via Easy Pump ball (also known as elastomeric pump - a medical device that slowly gives liquid medicine into veins) onto a wheelchair-height countertop outside of the kitchenette. The surface had not been cleaned or disinfected, nor had a barrier been set down first. A large trash receptable without a cover was positioned right next to the counter. With the assistance of registered nurse (RN)-C who was also a nurse manager, LPN-C began the process of flushing R18's PICC (peripherally inserted central catheter - a long thin flexible tube inserted into a vein in the upper arm) lumens. LPN-C opened a prefilled 10 ml syringe of NS. LPN-C removed the cap of the syringe and wiped the tip with an alcohol wipe, then attached the syringe to a PICC line lumen and flushed the line. Once complete, LPN-C obtained the Easy Pump, removed the cap from the distal tip of the IV tubing and wiped it with an alcohol wipe, then inserted the tip into the lumen and started the infusion. During an observation on 7/7/26 at 7:28 a.m., in R18's room, observed LPN-D administer cefazolin 2 grams in 120 ml NS via Easy Pump ball. Just prior to attaching the sterile IV tubing to the PICC line lumen, LPN-D wiped the sterile tip with an alcohol wipe. During an interview on 7/7/26 at 9:18 a.m., RN-C was informed of observations the evening prior with LPN-C and the morning of with LPN-D when they administered IV medication to R18. RN-C who was present the evening prior, stated she had not noticed/been aware of LPN-C wiping the tip of the prefilled syringe of NS with an alcohol wipe prior to flushing the PICC line lumen, nor had she noticed LPN-C wipe the tip of the sterile IV tubing prior to attaching it to the PICC line lumen. RN-C admitted that was not appropriate practice since the tip of the syringe of NS and the tip of the IV tubing were sterile and alcohol wipes were not, (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potentially causing contamination. RN-C stated they would need to do training on administering IV medications. During an interview on 7/7/26 at 1:40 p.m., the director of nursing (DON) was informed of findings with nurses administrating IV medication to R18: administering an IV medication in a public/contaminated location and using improper technique when they were observed wiping off the tip of the syringe of NS, and the distal tip of sterile IV tubing, potentially contaminating them. The DON acknowledged both were unacceptable practices and could cause contamination. Training for administrating IV medication for both nurses had been requested.During an interview on 7/7/26 at 3:24 p.m., LPN-D was informed of observation of wiping the sterile tip of the IV tubing with an alcohol wipe. LPN-D admitted doing so and stated she should not have because the tip of the IV tubing was sterile and the alcohol wipe was not; adding she must have been nervous. LPN-D stated she did not learn about IVs in nursing school, and it was at the facility she learned from observing other nurses.In an email dated 7/8/26 at 7:33 a.m., the DON stated LPN-C and LPN-D had not received formal education on administering IV medication to residents - just verbal training. The DON indicated she planned to give written education to them the next time they worked. Facility IV (intravenous) Medication Administration: Elastomeric policy, dated 2020, were instructions from vendor: option care health. The instructions outlined step by step the process and included photos. Instructions pertaining to survey observations included: use a clean work area, do not touch the tip of the syringe of NS after removing the cap; discard the syringe if it touches any unclean surface. Remove the protective cap from the medication tubing and attach the medication tubing firmly to the needleless connector on the IV catheter. Instructions did not direct staff to wipe off tip of NS syringe nor the distal insertion tip of medication tubing with an alcohol wipe.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure individualized fall prevention interventions were communicated and implemented for 1 of 3 residents (R17) reviewed for falls. Findings Include: R17's admission Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, dependent with toileting, toilet transfer, sit to stand; required substantial assistance with dressing, shower, roll left to right, sit to lying; partial/moderate assistance with personal hygiene, utilized a manual wheelchair, diagnoses included fractures and other multiple trauma, Alzheimer's disease, history of falling; had a fall in the last month, fracture related to a fall in the 6 months prior to admission, and a fall since admission. R17's care plan dated 7/2/26, is at risk for falls R/T (related to) cognitive and physical impairment. Dx (diagnosis) of unspecified fracture of right patella, subsequent encounter for closed fracture with routine healing and dementia, does not recognize her limitations, hx (history) of falls, drug regimen also places her at risk for falls. Fall 6/27/26/ and 7/1/26, indicated encourage rest periods when increasingly weak, do not leave alone in bathroom, walker next to bed/recliner to remind resident to use it if self-transferring, anti-roll back (auto locks) placed on w/c (wheelchair), check for functioning qd. (everyday), assure resident is wearing proper and well-maintained footwear, assure the floor is free of clutter, glare, liquids, R17's event report dated 7/1/26, indicated unwitnessed fall in R17's bathroom, attempting to self-transfer. R17's orders dated 7/2/26, indicated fall prevention-walker next to bed, low bed as needed when restless and after all needs have been met-toileting, hunger pain, etc. Document titled LTC Floor Cards dated 7/2/26, indicated R17 was A-2 (assist of two) EZ lift med sling, wheelchair, right knee fractures, brace on at all times, high fall risk, freq checks, hallucinates, non-weight bearing left wrist, low bed. The floor card failed to indicate R17's walker next to bed. On 7/1/26 at 10:29 a.m., R17 was observed seated in a wheelchair next to the bed with the left arm in a sling, a brace on the right leg, and the wheelchair positioned at the end of the bed, out of R17's reach.On 7/6/26 at 4:00 p.m., R17 was observed lying in bed with the bed in the low position. The wheelchair and walker were located at the end of the bed, and the walker was not positioned at the bedside.On 7/6/26 at 4:03 p.m., registered nurse (RN)-A stated R17 was a fall risk with interventions including a low bed, supervision, frequent checks, and assistance with transfers.On 7/6/26 at 4:05 p.m., RN-B, known as the nurse manager, was observed in R17's room while R17 remained in bed awaiting assistance from an additional staff member for a transfer. RN-B stated R17 was admitted with a right leg injury following a fall and sustained a fractured left wrist at the facility after self-transferring to the bathroom. RN-B stated therapy recommended keeping R17's walker at the bedside following the most recent fall. RN-B confirmed the walker, observed at the end of the bed, was not located at the bedside as expected. RN-B stated resident-specific interventions were expected to be included on the care sheets.On 7/6/26 at 4:20 p.m., nursing assistant (NA)-A stated fall interventions were located on the resident care sheet. NA-A stated they were unsure whether R17's walker was supposed to be within reach because that intervention was not on the care sheet and stated they would need to ask another staff member about R17's specific fall interventions.On 7/6/26 at 4:23 p.m., licensed practical nurse (LPN)-A, known as the evening clinical supervisor, stated they stated R17 was a fall risk and would expect the fall interventions on the resident care sheet, in the electronic medical record (EMR) fall event, in the 24-hour report, and R17's care plan.On 7/6/26 at 4:27 p.m., during a follow up interview NA-A stated R17's walker was expected to be at the bedside within reach and stated staff would not know that intervention was expected if it was not included on the care sheet.On 7/6/26 at 4:29 p.m., NA-B stated fall interventions were available on the resident care sheets and in the EMR. After reviewing the EMR, NA-B confirmed the order to keep the walker at the bedside was present in the point-of-care record but was not included (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the resident care sheet as expected.On 7/6/26 at 4:33 p.m., NA-C, stated they had provided care to R17 that day, stated staff relied on verbal report and the resident care sheets for fall interventions. NA-C stated the walker was intentionally kept out of R17's reach because otherwise R17 would attempt to walk independently.On 7/6/26 at 4:36 p.m., RN-B and director of nursing (DON), DON stated R17's fall intervention to keep the walker next to the bed had been implemented on 7/1/26, and was part of the resident's point-of-care orders in the EMR. RN-B stated she updates the care sheets and confirmed the care sheet was not updated to include the walker at bedside and would have expected the intervention to appear there.On 7/7/26 at 3:16 p.m., the DON stated R17's fall intervention of the walker at bedside was expected documented on the 24-hour report, added to the resident's care card, and incorporated into the resident's care plan.Facility Fall Prevention and post fall management policy and procedure dated 9/25, indicated :Communicating Fall Risk Status 1. The resident's fall risk status and appropriate interventions are communicated using SBAR with nursing and other licensed ancillary staff: a. Communicate High Fall Risk status at shift report and current interventions in place. E DOCUMENTATION 1.Complete a fall risk score upon admission and repeated as reassessed must be documented in the resident health record. 2.Notification of high fall risk status to resident, and family 3.Teaching to resident and/or family. 4. Document risk for injury related to fall risk on care plan. POST FALL FOLLOW UP 6.Implement fall risk precautions if not already in force. 9.If a resident falls more than once, discuss with RN on call or manager further interventions. G Reporting Resident Falls a. Resident Falls must be reported through the standard incident reporting process which is available to throughout the facility. H Education and Competency of the Staff Education for Fall Risk Program includes how to identify residents at risk for falls, how to communicate the risk level to the resident, family and other members of the health care team, and the use of fall precautions and interventions. I. Analysis and Review of Resident Falls Data a. The Lutheran Home Interdisciplinary Team is responsible for analysis and review of resident fall data, causation, and intervention. Fall data will be reported to The Lutheran Home Campus Quality Assurance committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure staff consistently adhered to enhanced barrier precautions (EBP) in accordance with the Centers for Disease Control and Prevention (CDC) guidelines to reduce the potential spread of infection for 2 of 10 residents (R4 and R5) reviewed infection control practices. Findings include:R4's face sheet received on 7/8/26, included diagnosis of methicillin resistant staphylococcus aureus (a bacteria resistant to many antibiotics) infection to left thigh. R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R4 required substantial assistance for activities of daily living (ADLs) and did not get out of bed.R4's physician orders dated 6/8/26, indicated orders for cleaning and dressing left lateral thigh wound, once a day. There were no orders for EBP.R4's care plan dated 3/9/26, indicated R4 had a left thigh and knee wound abscess. Care plan did not include EBP.During an interview and observation on 7/6/26 at 1:05 p.m., observed an over-the-door PPE (personal protective equipment) holder on R4's door. There was no sign on the door indicating if R4 was in enhanced barrier precautions (EBP) or transmission-based precautions (TBP). R4 stated she had a draining wound to her left thigh and that nurses wore gowns when they changed the dressing, but not for bed baths or when she used the bedpan.During an interview on 7/6/26 at 3:25 p.m., nursing assistant (NA)-C stated if a resident was on EBP, there would be a sign on the door to indicate EBP. NA-C stated for a resident who was on EPB, she would wear a gown and gloves while emptying a urinary drainage bag, but not if changing a residents clothing. During an observation at 7/6/26 at 6:55 p.m., EPB sign now on R4's door. During an observation on 7/7/26 at 7:40 a.m., in R4's room, NA-D and NA-E starting to provide morning cares. Neither had PPE on. During an interview 7/7/26 at 10:25 a.m., NA-D and NA-E both admitted they did not wear PPE when washing up and dressing R4. They stated they were aware R4 had a wound on her leg but didn't think they needed to wear gowns since they didn't do anything with her wound or wound dressing. R5's face sheet received on 7/8/26, included diagnosis of retention of urine. R5's admission MDS assessment dated [DATE], indicated moderately impaired cognition, clear speech, was understood and could usually understand. R5 required substantial assistance or was dependent upon staff for ADLs. R5 had an indwelling urinary catheter.R5's physician orders dated 4/21/26, indicated change foley catheter one time monthly for retention of urine. There were no orders for EBP.R5's care plan dated 5/15/26, included indwelling urinary catheter due to urinary retention. Care plan did not include EBP.During an interview and observation on 7/6/26 at 3:41 p.m., observed a urinary drainage bag hooked under R5's wheelchair. According to family member (FM)-B, staff did not wear a gown when they emptied R5's urinary drainage bag. During an observation on 7/7/26 at 7:17 a.m., observed NA-D assist R5 into the bathroom via wheelchair and assist R5 onto the toilet. NA-D had not worn PPE. NA-D left R5 with call light and exited the room. During an observation on 7/7/26 at 7:22 a.m., observed NA-F enter R5's room without donning PPE and assisted R5 from toilet to wheelchair, then wheeled R5 to the dining room. NA-F had not worn PPE. During an interview on 7/7/26 at 10:32 a.m., NA-D stated EBP was used when a resident had an infection. Together went to R5's room and read the EPB sign on the door which indicated: enhanced barrier precautions, everyone must wear gloves and gown for the following high contact activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device and wound care. NA-D was informed of the observation that morning, putting R5 on the toilet without PPE. NA-D stated, I guess I should have. NA-D stated she had training on EBP online and the infection preventionist sometimes went around and asked questions and provided education. During an interview on 7/7/26 at 10:50 a.m., NA-F was informed of an observation of her assisting R5 off the toilet without wearing PPE. Together went to R5's room and looked at the EBP sign on the door. R5 admitted she had not worn PPE when assisting R5 and stated she should have in order to prevent her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uniform from becoming soiled.During an interview on 7/7/26 at 1:40 p.m., the director of nursing (DON) was informed of findings of staff not wearing PPE when providing high contact activities to residents on EPB. The DON stated the infection preventionist nurse did observations and on the spot retraining of staff but acknowledged they had a hard time getting staff to be compliant all of the time. The DON stated she expected staff to follow EBP for the protection of residents.Facility Enhanced Barrier Precautions policy with review date of 4/1/26, indicated the facility implemented enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions referred to the use of gown and gloves during high-contact resident care activities including dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and any skin opening requiring a dressing. All staff received training on enhanced barrier precautions upon hire and at least annually and were expected to comply with all designated precautions. Clear signage would be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment, and the high-contact resident care activities that require the use of gown and gloves.