Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
September 25, 2024

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: September 12, 2024

Dear Administrator:

On September 12, 2024, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 12, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 10, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective October 10, 2024 , (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 10, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 12, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of

alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Luther Haven is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 12, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132

Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145

St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2024

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: State Nursing Home Licensing Orders
Event ID: 76ZZ11

Dear Administrator:

The above facility was surveyed on September 9, 2024 through September 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/09/24 through 9/12/24 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/09/24 through 9/12/24, a standard recertification survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 8/29/24, when the facility failed to appropriately assess and/or follow the care plan and ensure safe transfers were performed for 3 of 3 residents (R11, R16, and R37) while using sit-to-stand mechanical lifts (EZ stand) (requires a resident to be partial weight-bearing) to prevent or mitigate falls or risk thereof. This resulted in an immediate jeopardy (IJ) for both R11 and R16 who fell from and EZ-stand and required hospital evaluation and treatment) and had the potential for serious harm, injury, impairment, or death.. The administrator, and director of nursing (DON) were notified of the IJ on 9/10/24 at 2:37 p.m.. The IJ was removed on 9/12/24 at 7:46 a.m..	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/04/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 The above findings constituted Substandard Quality of Care and an extended survey was conducted from 9/10/24 through 9/12/24. The following complaints were reviewed: H52597908C (MN106322 and MN106553) had deficiencies cited at F609, F610, F689, F726 and F838. H52597975C (MN106554) (MN106554) had a deficiency cited at F585 and F677. The following complaints were reviewed: H52597690C (MN106228), H52597691C (MN106230), H52597692C (MN106231), H52597693C (MN106232), and H52597720C (MN106227). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		10/11/24

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F 585	Continued From page 2 furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 585		

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F 585	Continued From page 3 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

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F 585	Continued From page 4 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 grievance policy and procedures were followed. The facility failed to post the grievance policy prominently and throughout the facility and provide forms to submit a grievance anonymously if desired. In addition, the facility also failed to document all grievances, the action taken to resolve grievances and the summary of the resolution to each grievance. This had the ability to affect all 54 residents. Findings include: Interview on 9/9/24 at 12:09 p.m., with R39 who reported that he must wait for someone to come help him. He likes to get up around 7:30 a.m., and no one came to help him until 9:00 a.m. and he was so mad he could have "burnt the place up". Interview on 9/9/24 at 1:27 p.m. with R9 who reported the staff are good when they have time. The staff try however, this morning she had put her call light on to get up and had to wait 2 hours before someone came to help her and that is not unusual. Interview on 9/11/24 at 2:43 p.m., with R48's family member identified she had complained about long call light wait times however, nothing	F 585	Luther Haven ensures that the facility meets the requirements of F585 and provides residents with a clear and accessible grievance process to voice concerns without fear of retaliation. All residents in the facility have the potential to be affected by this alleged incident. The facility failed to establish and maintain a grievance process that allows residents to voice concerns, including neglect, abuse or others potential violations of their rights. Upon review, it was determined that this lapse occurred due to: - Lack of formal policy outlining grievance procedures - Insufficient training for staff on how to handle grievances - Inadequate communication to residents about their rights to file grievances and the available channels to do so As of 10/1/2024: • A new grievance form was created and made available in accessible areas of the facility • All residents and families have been notified of their right to file grievances. Written communication was provided to all residents detailing the grievance process, including timelines for addressing grievances.	

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LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

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F 585	Continued From page 5 had ever occurred related to long wait time. Review of the grievances for the last year provided was a word document that listed dates and concerns and included identified long call light wait times reported on 9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24. Only follow up documentation was on 12/13/23, as the concern identified resident was currently in quarantine due to COVID-19 and family was educated on infection control process and the call light review found that the call light had not been turned on. All other grievances related to long call light times had no action taken or resolution identified. The surveyor requested the investigation and resolution of the reported long call light wait time concerns with no further documentation provided. Interview on 9/11/24 at 1:39 p.m., with licensed social worker (LSW)-A who identified she was unsure of who all the grievances were for the dates that had been requested (9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24) however, she was able to figure out some of the residents. She reported the call lights go through the call phone and staff report they do not have enough call phones. She further reported she had no formal grievances it was just residents telling her and she would make a note on the word document that she had provided. She confirmed that she did not fill out a grievance form. Upon admission the facility reviews how to make a grievance and provided a copy of the grievance policy. She revealed there was no form for the residents or families to utilize to make a grievance. She reported families will make concerns known by email or just tell her. She identified the process	F 585	• In-service training was provided to staff regarding the residents' rights to voice grievances and the appropriate process for addressing complaints • The facility has a designated Grievance Officer to oversee the receipt, documentation, investigation, and resolution of grievances. This officer reports directly to the Director of Nursing and Administrator. A new, comprehensive grievance policy has been developed to comply with F585 requirements. A grievance log will be maintained to track all grievances, their investigations, and resolutions. This log will be reviewed monthly by the Grievance Officer, Director of Nursing, and Administrator. A Quality Assurance (QA) team will conduct quarterly audits of grievance procedures and logs to ensure that the process is being followed, grievances are resolved in a timely manner, and compliance with regulatory requirements is maintained. The Director of Nursing will be responsible for the implementation and monitoring of the corrective action plan. The Grievance Officer will ensure that all grievances are handled in accordance with the facility's policy and federal guidelines. Progress will be reported to the facility's Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings. Next	

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F 585	Continued From page 6 was for the resident and/or family to go to the source first, if not resolved they could come to her or the administrator, and if still not resolved they may be referred to the ombudsman or to make a state report. Interview on 9/11/24 at 2:07 p.m., with R53 who was unsure how to report a complaint. R53 reported she would just tell her son and contact the attorney downtown. Interview on 9/11/24 at 2:12 p.m., with R5 who identified he did not know what to do or who to tell if he had a complaint or concern. Interview on 9/11/24 at 2:13 with R20 who identified she would not tell anyone if she had a complaint as she did not want to "Russell" up the place. She identified she would tell her family and they would tell her to just keep it to yourself. She reported she did not want to "ruffle any feathers" so she does not complain. Interview on 9/11/24 at 2:19 with R9 who identified she reports to registered nurse (RN)-C or the social worker if she has any concerns. She also revealed that other residents will come to her and ask her to report as they do not want to bother the staff. Interview on 9/11/24 at 2:39 p.m., with FM-F reported they were unsure how to make a complaint no one had ever explained that to them. Interview on 9/11/24 at 2:43 p.m., with family member (FM)-E was not sure of a policy or process but would tell the nurse working if had a concern.	F 585	QAPI meeting: 10/15/2024. The corrective actions will be fully implemented by 10/11/2024 with continued monitoring and evaluation to ensure sustained compliance.	

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F 585	Continued From page 7 Review of the blank September 2023, Grievance Form identified the following area's to be documented on: 1) Resident name 2) Date and time of concern 3) Details of concern 4) Statement of witness regarding concern 5) List any contributing factors 6) What immediate action was taken place upon learning of the concern 7) Actions taken 8) Comment or recommendation 9) Signature of individual completing the form There were following pages of the form, that included a place to document by the grievance officer if concern was reportable, the type of concern it was, a place to document investigation findings and summary of investigation. A page to document the resolution or action taken to resolve the grievance, the time and date the resident and/or representative was notified of the resolution, a place to document if the physician was notified of resolution, ombudsman if applicable, the director of nursing and the administrator. Interview on 9/11/24 at 4:34 p.m., with director of nursing (DON) identified grievance were handled by the social worker. All grievances should be documented and kept for records. She agreed there should be forms available for residents, families, or staff to assist residents with if they have a complaint, and for anonymous grievances also. The DON stated there needed to be improvement in this area for sure. Interview on 9/12/24 at 8:47 a.m., with administrator identified any time a grievance	F 585		

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F 585	Continued From page 8 comes forward it was reported to LSW-A, the DON, or himself. All grievances were overseen by the social worker and reviewed at the daily interdisciplinary team meeting (IDT). He reported during the IDT meeting we come up with an action plan and then the social worker would review that with the resident and family. He reported the facility also reviewed grievances during the QAPI meeting. He would expect that the policy would be followed, and the facility would utilize the forms available to document grievances on. He further agreed that the grievance forms should be available for residents, staff, and representatives to fill out or make an anonymous complaint and kept for records for a minimum of 3 years. He was unaware the facility grievance forms had not been utilized for documenting grievances. Review of the September 2023, Grievance policy and procedure identified the facility encourage residents and/or representatives to communicate grievances verbally or in writing. The facility further, encouraged residents and/or representatives to first discuss their concern informally among themselves. If grievance was not resolved then the grievance should be brought to the attention of the grievance officer, the administrator or the designee for assistance to direct the resident or representative to the proper department for resolution. If a resolution has not occurred, the grievance shall be reduced to written form and the grievance officer, administrator or designee would address as soon as possible but no later than five working days when possible. If resident or representative was not satisfied with the decision of the grievance officer, administrator or designee they may contact the Office of Ombudsman or Office of	F 585		

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F 585	Continued From page 9 Health Facility Complaints. The policy indicated that the grievance officer would keep on file paper or electronic written grievance documents for 3 years. The policy had no mention that the facility would document grievances, the action taken to resolve the grievance and the summary of the resolution. The policy further had no mention that the policy would be posted throughout the facility and residents or representatives could make anonymous grievances if desired.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		10/11/24

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F 609	Continued From page 10 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a fall with injury and potential neglect was reported to the State Agency (SA) for 1 of 3 residents (R11) reviewed for falls. Findings include: R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure. R11's fall report indicated on 8/29/24, R11 had a fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation. In review of Facility Reported Incidents (FRI), it was not evident R11's fall was reported to the State Agency. R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples. R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on	F 609	On 9/9/24, it was identified that the facility failed to report an allegation of abuse involving Resident R 11 within the required timeframe. The incident occurred on 8/29/24 and the facility did not report the alleged violation to the Administrator or State Agency within 2 hours of discovery as required by federal guidelines. Resident R11was assessed by the nursing team to ensure safety and was subsequently transferred to ED for further evaluation and treatment. NA-A was advised of facility expectation that staff review resident care sheets, each shift prior to initiating cares. NA-A received additional education on facility s mechanical lift policy. Plan for Compliance: 1. Education: All staff, including nursing and support personnel, will undergo mandatory re-education regarding the facility s abuse reporting policy, specifically the requirement to report all alleged violations within the federally mandated 2-hour time frame. This training will be completed by [date]. 2. Policy Review: The facility will review and, if necessary, update the current Abuse Prevention Policy to ensure all staff members are clear about their responsibilities in identifying, reporting, and documenting suspected abuse or neglect. The policy review will be	

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F 609	Continued From page 11 8/29/29. Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff "don't want to switch to the Hoyer [total lift]". R11's annual Minimum Data Set (MDS) dated 7/15/24, identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand related to a recent fall. Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. R11's Fall Risk Assessment dated 7/9/24, indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to	F 609	completed by [date]. 3. Audit Process: Random audits will be conducted to ensure compliance with reporting timelines. Audits will include reviewing documentation to ensure all allegations of abuse, neglect, or misappropriation are reported within the required timeframe. Audits will occur weekly for 4 weeks, then biweekly for 3 months, and then quarterly. Audits will be brought to QAPI for review/oversight. Next QAPI will be 10/15/24. All reportable events will be reviewed at QAPI. 4. Monitoring: The facility s Administrator or designee will monitor all allegations to ensure timely reporting and proper documentation. The results of this monitoring will be reviewed during the monthly Quality Assurance meetings to ensure continued compliance. 5. Communication with Residents: All residents and their families will be informed about the facility s commitment to a safe and abuse-free environment, including instructions on how to report any concerns regarding potential abuse. The Director of Nursing (DON) and Administrator will be responsible for ensuring all corrective actions are implemented and compliance is maintained. Completion Date: 10/11/2024	

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F 609	Continued From page 12 perform that function. An option for "required the use of assistive devices such as a cane, walker or wheelchair" was left blank. During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell. NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts. During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the	F 609		

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F 609	Continued From page 13 verbal reminder to follow care sheet. Her expectation was that all staff would be educated on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being "unpredictable" in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management. During an interview on 9/12/24 at 8:13 a.m., with the administrator identified his expectation was that all staff including agency staff, would have been trained to follow care sheets and care plans and would have followed the care sheets and care plan for R11. Further stated he expected the facility would have reported R11's fall to the SA per facility policy. Review of a facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property revised 7/24, identified Neglect was defined as a failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Further identified it was the facility's policy to report and suspected Abuse, Neglect, Exploitation, Mistreatment, or Misappropriation of Resident Property immediately.	F 609		

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete an accurate and thorough investigation of falls to determine the root cause, if the care plan was followed, and if the fall was reportable to the State Agency (SA) for 1 of 3 residents (R11) reviewed for falls. Findings include: R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure. R11's fall report indicated on 8/29/24, R11 had a fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the	F 610	The facility did not initiate an investigation upon discovering an alleged incident that occurred on 8/29/24, involving resident R11. Upon identifying the failure to investigate, the facility immediately began an internal investigation including interviews with involved staff and residents, and a thorough review of all relevant documentation. R11 was assessed to ensure that they were safe and not in distress following the alleged incident. All staff will undergo mandatory re-education regarding the facility s abuse prevention and investigation protocols. This training will be included in	10/11/24

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F 610	Continued From page 15 sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation. R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples. R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29. Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff "don't want to switch to the Hoyer [total lift]". R11's annual Minimum Data Set (MDS) dated 7/15/24, identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand	F 610	new staff orientation, with annual refresher training for all current staff. The facility revised its Investigation Policy to ensure clarity regarding: " The process for initiating investigations immediately after alleged violations are reported. " The timelines for completion of the investigation (within 5 working days of the report). " Requirements for proper documentation of all investigative steps, interviews, and conclusions. The revised policy will be reviewed at the next QAPI meeting on 10/15/24. " The Administrator and DON will continue to monitor compliance with investigation policies and procedures, conducting random audits of completed investigations to ensure thoroughness and accuracy. Non-compliance will result in corrective action, including disciplinary measures for staff, if warranted " Immediate feedback and education will be provided to any staff found non-compliant with investigation policies. • Audits will occur weekly for 4 weeks, then biweekly for 3 months, and then quarterly. Audits will be brought to QAPI for review/oversight. Next QAPI will be 10/15/24. All reportable events will be reviewed at QAPI. " Audits will be reviewed monthly at QAPI meetings to ensure continued compliance. " The facility will increase transparency with residents and families by providing clear guidelines on how to report concerns of abuse or neglect. In addition,	

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F 610	Continued From page 16 related to a recent fall. Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. R11's Fall Risk Assessment dated 7/9/24, indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to perform that function. An option for "required the use of assistive devices such as a cane, walker or wheelchair" was left blank. During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell. NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts. During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS	F 610	families will be informed of the investigation process and will receive updates on the status of investigations that involve their loved ones. Completion Date: 10/11/24.	

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F 610	Continued From page 17 nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the verbal reminder to follow care sheet. Her expectation was that all staff would be educated on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being "unpredictable" in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management. R11's records lacked evidence that a thorough investigation and/ or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29.	F 610		

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F 610	Continued From page 18 During an interview on 9/11/24 at 3:17 p.m., director of nursing (DON) verified a thorough investigation of R11's fall including an RCA and contributing factors had not been done. DON stated her expectation was that a thorough investigation of R11's fall would have been completed to reduce future falls for residents and to mitigate any injuries related to resident falls. During an interview on 9/12/24 at 8:13 a.m., administrator stated the investigation of R11's fall was not thorough enough to determine if the care plan was followed or that neglect did or did not occur. Administrator stated his expectation was that a thorough investigation of R11's fall would have been done to prevent future falls. Review of a facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property revised 7/24, identified Neglect was defined as a failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identified Investigation is the process used to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause analysis investigation and analysis would have been completed. The information gathered was to be given to administration.	F 610		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		10/11/24

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F 677	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure call lights were answered timely for 4 of 4 residents (R9, R29, R39, and R48) reviewed for activities of daily living (ADL's). Findings include: R39 Interview on 9/9/24 at 12:09 p.m., with R39 who reported that he must wait for someone to come help him. He likes to get up around 7:30 a.m., and no one (satff) came to help him until 9:00 a.m., and he was "so mad" he could have "burnt the place up". He reported the pool staff are really "crabby" they do not give a [expletive] as they are only here a short time. One time a pool staff came and fell asleep in the parking lot in her car. R39's 8/30/24, quarterly Minimum Data Set (MDS) identified Brief Interview for Mental Status (BIMS) score as 15 cognition was intact. He had verbal behaviors directed towards others andrequried sustantial to partial assistance by staff for cares. He took scheduled pain medication, an antidepressant, anticoagulant, and a diuretic. R39 had diagnoses of anemia, coronary artery disease, hypertension, demenia, and depression. R39's 9/9/24, Care Sheet identified he was a fall risk, he was to get up first by 7:00 a.m., needed 1 staff assistance for cares and then was independent with transfers and toileting in his room. R9	F 677	Upon identifying the deficiency, the nursing staff tested the call cords in all the resident rooms to ensure the system was functioning appropriately. IDT met with members of direct care team to complete Root Cause Analysis. Ineffective Surveillance: The facility failed to develop a system to ensure that call lights were being answered in a timely fashion. Systemic Changes and Preventative Measures: 1. IDT will review call light reports and follow up on calls with response times that exceed ten minutes to determine root cause. 2. Interdisciplinary care team meetings will be held weekly to address residents' needs and any gaps in care or changes in their condition. 3. All nursing staff will receive mandatory re-education on • Call light response times; Expectation < 0 - 10 minutes with a goal of 5 minutes or less. • Individualized care planning and documentation. • Overview of facility call light system, call light reports • Call response times exceeding ten minutes to be reviewed and investigated for cause This training will be completed by 10/11/2024 and will be led by the Director of Nursing (DON) or a qualified trainer. New staff members will receive this training during orientation, and all staff will	

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F 677	Continued From page 20 Interview on 9/9/24 at 1:27 p.m. with R9 who reported the staff are "good when they have time. The staff "try" however, this morning she had put her call light on to get up and had to wait 2 hours before someone came to help her and that is not unusual. R9's 8/16/24, quarterly MDS identified her BIMS score was 15 and her cognition was intact. She had no behaviors and required partial assistance with cares. She had frequent pain and rated her pain an 8 on a scale of 1 to 10. She took daily pain medication, antianxiety, antidepressant, antibiotic, diurtic, and hypglycemic medications and she was on oxygen. R9 had diagnoses of heart failure, heypertension, uanxiety, depression, asthma, and imflammatory bowel disease. R9's 9/9/24, Care Sheet identified she was a fall risk, used an EZ sit to stand lift with one staff or pivot transfer with 2 staff, and she was unable to walk at this time. She needed assistance of one staff for cares and toileting. Interview on 9/11/24 at 9:45 a.m., with registered nurse (RN)-C who identified the call light response time was a "problem". There were many variables that could be the reason why the call lights were not addressed timely, but it was an issue staff were aware of. When the facility had an interim administrator, the call light response time was being addressed at QAPI and the interim administrator was out on the floor all the time and the call light average response time was down to about 10-20 minutes however, that has not continued since the interim was no longer present in the facility. R48	F 677	receive annual refresher courses. 4. IDT will conduct random audits biweekly for the next six months to review: • Timely response to call lights. • Proper function of call system, including CNA phones • Resident satisfaction with regard to call light response times. The results of these audits will be reviewed at monthly QAPI meetings to ensure compliance and to identify any areas needing further improvement. Next QAPI meeting 10/15/2024. All corrective actions will be fully implemented by 10/11/2024.	

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F 677	Continued From page 21 Interview on 9/11/24 at 2:43 p.m., with R48's family member identified she had complained to facility staff about long call light wait times however, nothing had ever occurred related to long wait time, or was conveyed as to what the facility would do to decrease the time or investigate why it was occurring. R48's 8/12/24, significant change MDS identified her BIMS score was 15 and her congition was intact. She had no behaviors and required partial assistance with cares. She had one fall since her last assessment with no injury. She had frequent pain and rated her pain an 8 on scale of 1-10. She took daily pain medication, antipsychotic, antianxiety, antidepressant, diuretic, and hypoglycemic medicatoins and she was on oxygen. R48 had diagnoses of cancer, anemia, thyroid disorder, and anxiety. R48's 9/9/24, Care Sheet identified she was a fall risk and she required one staff for cares. Review of call light logs from 9/5/24 through 9/10/24 found: 1) R39 on 9/8/24 activated his call light at 7:04 a.m., and it was on for 86 minutes. 2) R9 on 9/8/24 activated her call light at 9:23 a.m., and it was on for 41 minutes and again activated her light at 1:48 p.m., and it was on for 49 minutes. On 9/9/24 R9 activated her call light at 7:28 a.m., and it was on for 82 minutes and again activated her call light at 7:41 p.m., and it was on for 50 minutes. On 9/10/24 she activated her light at 8:25 a.m., and it was on for 42 minutes. 3) R48 on 9/6/24 activated her call light at 11:57 a.m., and it was on for 52 minutes. On 9/7/24 she activated her call light at 10:18 a.m., and it was	F 677		

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F 677	Continued From page 22 on for 54 minutes and again at 11:09 a.m. she activated her light, and it was on for 58 minutes. On 9/9/24 she activated her call light at 8:01 a.m., and it was on for 42 minutes. Review of staff assignment sheets for the day shift identified on 9/6/24 there had been a staff call-in (unable to work) however, a replacement was found. On 9/7/24 there had been one staff call-in and an area identified as a split with no staff assigned to work that area. It was unknown if the facility was down a second staff on the day shift. On 9/8/24 it was identified that there was one staff call-in and one staff that arrived to work late. On 9/9/24 there no call-ins. On 9/10/24 there had been one staff call-in. R29 R29's quarterly Minimum Data Set dated 6/10/24, identified R29 had intact cognition and had diagnosis which included myasthenia gravis (a disease that weakens your muscles), low iron in the blood, and high blood pressure. R29 required staff assistance with ADL's which included toileting, dressing, and transferring. R29 was incontinent of bladder. R29's care plan dated 10/20/20 identified R29 required assist with toileting. R29 was to call for assistance and staff were to answer R29's call light promptly. R29's care sheet dated 9/9/24, identified R29 needed assist of one staff as needed with transfers and toileting. During an interview on 9/11/24 at 9:48 a.m., R29 stated there were a few times in the past few weeks where staff had helped him to the	F 677		

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F 677	Continued From page 23 bathroom but did not return when he put on the call light so he had to get himself off the toilet. R29 stated "I could have fallen". During an interview on 9/11/24 at 9:51 a.m., NA-D stated it was difficult to answer call lights timely. NA-D stated "Sometimes we are in another room assisting a resident which makes it hard to answer all the call lights timely". NA-D identified the goal was to answer call lights within 5 minutes but that it was "difficult to do". Review of R29's call light logs from 8/30/24 through 9/10/24 revealed: On 8/29/24 R29 activated his call light by the bed at 9:16 a.m., and it was on for 54 minutes. On 8/29/24 R29 activated his bathroom call light at 11:37 a.m., and it was on for 189 minutes. On 9/4/23 R29 activated his bathroom call light at 10:55 a.m., and it was on for 180 minutes. Review of the grievances from September 2023 through September 2024 identified long call light wait times were grieved by residents and/or families on 9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24. The only follow up documentation for the avove mentioned dates was on 12/13/23, as the concern identified a resident was currently in quarantine due to COVID-19, and family was educated on infection control process and the call light review found that the call light had not been turned on. All other grievances related to long call light time grievances had no resolution identified or proposed action to be taken. Interview on 9/11/24 at 4:34 p.m., with director of nursing (DON) identified she would expect call lights to be answered within 5-10 minutes.	F 677		

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F 677	Continued From page 24 Interview on 9/11/24 at 4:49 p.m., with nursing assistant (NA)-C identified that it was hard at times to get the call lights answered timely. She revealed if staff are in another room assisting another resident staff could not "just leave to go answer a call light". She reported the goal was that call lights would be answered within 5 minutes but that was hard to do. NA-C was unaware if her or other staff's failures to answer call lights were brought forth to management to identify concerns by staff on the ability to assist residents timely with ADL's. Interview on 9/11/24 at 4:55 p.m., with licensed practical nurse (LPN)-A identified there was a "problem" with call lights being answered timely. She felt it was because there were several residents who required 2 staff and a mechanical lift, and several residents who required total assistance with cares. The staff are not charting how much work they are doing and that was why they were staffed the way they were. She felt if staff would do a better job on charting the heavy cares they are doing would show and that would get them more assistance on the floor. "I have tried to educate the direct care staff to chart more frequently as they can chart right from their phones". She further noted staff could chart while in a resident's room while waiting for a resident to finish using the bathroom. Staff were supposed to try to get the call lights answered within 10-15 minutes. LPN-A had not voiced her concerns to management, however call light audits had been done. Interview on 9/12/24 at 8:59 a.m., with administrator identified his expectation was that call lights would be answered timely, and no	F 677		

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F 677	Continued From page 25 resident should have to wait an hour to have their call light answered. Review of the 8/14/21, Call Light, Use Of policy identified staff were to respond promptly to resident call lights. Call lights will signal to the Ariel phones and appear on the marquee. Staff were to answer call lights promptly and never make a resident feel like staff are too busy to give assistance.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess and/or follow the care plan and ensure safe transfers were performed for 3 of 3 residents (R11, R16, and R37) while using sit-to-stand mechanical lifts (EZ stand) (requires a resident to be partial weight-bearing) to prevent or mitigate falls or risk thereof. This resulted in an immediate jeopardy (IJ) for both R11 and R16 who fell from and EZ-stand and required hospital evaluation and treatment). Both events had the potential for serious harm, injury, impairment, or death. The IJ began on 8/29/24, when nurse aide (NA)-A failed to follow R11's care plan and ensure 2 staff	F 689	The facility failed to maintain a hazard free environment appropriately assess and / or follow the care plan ensure safe transfers were performed for residents R 11, R 16, and R 37 while using sit to stand mechanical lift. All residents who are dependent in transfers requiring the use of a mechanical lift are those identified who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance. The facility has taken the following actions	10/11/24

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F 689	Continued From page 26 transferred R11 while using an EZ-Stand. R11 let go of the bars on the EZ -Stand and fell backwards out of the sling, resulting in a laceration to the back of her head. R11 was previously identified in June 2023 to be "inconsistent" with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff "don't want to switch to the Hoyer [total lift]". Staff failed to identify NA-A's failure to follow the care plan. On 8/31/24, NA-B failed to follow the care plan for R16 and transfer her with 2 staff performing the transfer using an EZ-Stand. During the 1 staff transfer, R16 held her breath, passed out while she was supposed to be partial weight bearing, and was lowered to the floor. R16 was then transferred to the hospital for further evaluation and treatment. R16 was identified previously to be unsafe to use an EZ stand in June 2024, due to her inability to always bear weight and behaviors of holding her breath, but was not re-assessed by staff for the need to use a total lift for transfers. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 9/10/24 at 2:37 p.m. The immediate jeopardy was removed on 9/12/24 at 7:46 a.m., but noncompliance remained at a lower scope and severity of a D: No actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R11 R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure. R11's fall report indicated on 8/29/24, R11 had a	F 689	to ensure the removal of the immediate jeopardy to ensure residents are safe. A. The facility has reviewed/updated the Activities of Daily (ADLs), Supporting policy; Using the Care Plan; and EZ Lift and/or EZ Stand policies. The EZ Lift/EZ Stand policy now includes that care sheets be reviewed each shift prior to providing cares. B. Employee training has been initiated for all nursing employees (including agency). Employees will be required to complete the EZ Way Competency Checklist with a Charge Nurse, Nurse Manager, or the Director of Nursing before providing cares at next shift. Employees (including agency) will also be given a Care Sheet Competency Checklist that will be reviewed with them prior to providing cares at their next shift by a Charge Nurse, Nurse Manager, or the Director of Nursing. Both competencies are enclosed. Staff will review the care sheets and their components to ensure understanding. A note will be placed in the timeclock room to notify staff to report to the charge nurse, nurse manger, or Director of Nursing prior to the start of their shift to review and complete competencies. Staff training will be completed by 8:00am on September 12, 2024. If staff are not available to be trained by this date/time, they will receive the training prior to the start of their next scheduled shift. C. Staff will also be trained on incident reporting by reviewing the orange VA cards. This will be completed with the Care Sheet Competency Checklist. This	

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F 689	Continued From page 27 fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation. R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples. R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29. Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff "don't want to switch to the Hoyer [total lift]". R11's annual Minimum Data Set (MDS) dated 7/15/24, identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited	F 689	will be completed by 8:00am on September 12, 2024 and staff who are not available for training will receive the training prior to the start of their next scheduled shift. D. The facility has updated its orientation checklist for agency staff. This now includes a line item to review care sheets with agency staff, review the proper use of EZ Lift/Stands and they will be required to complete the EZ Way Competency Checklist before starting their shift. The checklist will need to be reviewed and completed with agency staff before they will be allowed to provide care. This will be completed by the scheduler, charge nurse, nurse manager, or Director of Nursing. The revised agency orientation checklist is enclosed. E. Therapy, Nurse Manager, or Director of Nursing will reassess residents currently using a mechanical lift for transfers to determine appropriate assistance. If changes occur, care plans will be updated. Assessments will be completed by 8:00am on September 12, 2024. All residents in the facility had the potential to be affected by this alleged incident. Upon review, it was determined that this lapse occurred due to: • Insufficient orientation and training of temporary agency staff. • Inadequate supervision of staff adherence to care plan. • NA-A was given immediate reeducation at the point of care,	

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F 689	Continued From page 28 and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand related to a recent fall. Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. R11's Fall Risk Assessment dated 7/9/24, indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to perform that function. An option for "required the use of assistive devices such as a cane, walker or wheelchair" was left blank. During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell. NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts.	F 689	emphasizing the proper use of mechanical lifts and the importance of adhering to care plans. • Staff reviewed the care plans of all residents requiring mechanical lifts to ensure that they are accurate and up to date. • Increased supervision and monitoring of residents being transferred with mechanical lifts to ensure compliance with safety protocols. • All nursing staff will complete mandatory Inservice training on fall prevention, resident supervision, and proper use of assistive devices. • Surveillance: DON or designee will conduct daily observation of transfers for residents that require a mechanical lift or sit to stand daily x 30 days to ensure staff are following care plan, then random audits 3 x weekly audits x 6 months to maintain compliance. Audits will be brought to QAPI for review/oversight. Next QAPI is 10/15/24. Date of compliance 10/11/2024.	

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F 689	Continued From page 29 During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the verbal reminder to follow care sheet. Her expectation was that all staff would be educated on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being "unpredictable" in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management. R16 Review of the 9/1/24, at 1:40 p.m., report to the State Agency (SA) identified on 8/31/24 at 9:09 a.m., R16 had a fall at 9:09 a.m.. At	F 689		

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F 689	Continued From page 30	F 689		

approximately 11:30 a.m., R16 began experiencing pain in her left lower extremity and was transferred to the local ER, was found to have a fracture in her leg (noted later by the radiologist to be consistent with a disease process vs the fall) and had to be transferred to a regional hospital for further evaluation and treatment.

A follow up email to the SA dated 9/5/24 at 10:35 from director of nursing (DON) stating during the investigation it was revealed that a nursing assistant had been using the EZ-Stand independently and had not been following R16's care plan.

R16's fall report identified on 8/31/24 at 9:15 a.m., R16 had been lowered to the floor in the EZ-Stand. R26 was later sent to the ER, and subsequently hospitalized for a leg fracture and a report had been filed with the SA and an investigation initiated. No other details were included on the fall report.

Review of the facility's investigation file identified R16 required assist of two staff with EZ-Stand with transfers. The investigation determined only one staff had been used for the transfer, but could not determine through their root cause analysis as the care plan had not been followed, however, it was also noted R16 likely "passed out" from holding her breath during the transfer.

R16's Face sheet dated 9/8/24, identified R16 had diagnosis which included diabetes mellitus (DM), hypertension (elevated blood pressure), and vertigo (dizziness).

R16's Comprehensive Care Area Assessment

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F 689	Continued From page 31 (CAA) dated 10/19/23, identified R16 had an activities of daily living (ADL) deficit related to impaired mobility and chronic pain. R16 had a history of falls. R16 was noted to have moderate cognitive impairment identified on her ADL section of her CAA. R16 had no behaviors noted. R16's quarterly Minimum Data Set (MDS) dated 7/16/24, identified R16 had intact cognition. R16 required substantial/ maximum assist for sit to stand and for toileting. R16 had no behaviors noted. R16's care plan dated 10/26/24, identified R16 had self-care deficits with ADL's and was at risk for falls related to impaired mobility and a history of falls. R16 required two assist with use of the E-Z Stand for transfers. Review of nursing assistant (NA) care sheet dated 8/30/24, identified R16 required the assist of two staff with use of an EZ-Stand for transfers. R16's fall risk assessment dated 7/11/24, identified R16 was at high risk for falls. R16 was noted to have intermittent confusion, poor recall, judgement, and safety awareness. R16 was not able to stand on both feet, without holding onto anything to walk and was not noted to use an assistive device, such as a can, walker, or wheelchair and was chair-bound. Review of a PT note dated 12/26/23, identified R16 was referred to PT as she held her breath during transfers using the EZ stand. Per the registered nurse, this caused some bursting of blood vessels in her facial area. The physician had requested the referral. Pt noted per staff "nothing had changed". The room was very "tight"	F 689		

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F 689	Continued From page 32 (not a lot of room to maneuver a mechanical lift). R16 was not open to suggestions most of the time and staff had to cue her to not hold her breath. Physically, she did well hanging onto the EZ stand. "Patient can be very stubborn and abusive to staff and therapy". There was no indication R16 was assessed for partial weight bearing as required for use an EZ stand or if PT recommended the use of a total lift since they were aware staff reported her holding her breath to the point of extreme (bursting blood vessels), which could lead to an episode of unconsciousness. Review of a progress note dated 6/6/24, indicated EZ-Stand is not recommendable anymore because R16 does "chicken wings" elaborating her elbows were not straight (in line with her body) and had an outward V formation and anytime can "give up and fall". R16's progress notes identified on: 1) 6/9/24, indicated resident was "doing chicken wings" and gets "purple/red" (faced from holding her breath) during transfers. 2) 8/31/24 at 9:09 a.m., identified R16 held breath during transfer in EZ stand causing her to pass out and be lowered to the ground. R16 did not want to be seen in the ER. 3) 8/31/24 at 9:15 p.m., identified around 11:30 a.m., R16 began having left leg pain. Previously, she only allowed ice at the time but has now agreed to be seen in the ER and was transferred to the ER. 4) 9/1/24 at 1:05 a.m., identified ER called and stated R16 was being transferred to another facility due to a left leg fracture. R16's CT scan titled "final report" dated 9/1/24 at	F 689		

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F 689	Continued From page 33 7:34 a.m., identified R16 had a left leg fracture. During a telephone interview on 9/10/24 at 4:14 p.m., NA-B stated she had worked the evening of 8/31/23, when R16 was lowered to the floor. NA-B stated while she was assisting R16 off the toilet alone without other staff in attendance, using the EZ-Stand. While transferring, R16 held her breath, blacked out and slid out of the lift sling. NA-B stated she had to lower R16 to the floor. NA-B stated she was aware she was suppose to use two staff and the EZ-Stand to transfer R16 but she had not asked for help because R16 "does not like a lot of the other staff". NA-B stated the nursing assistant (NA) care sheet says to use two staff but that is difficult because R16 only liked certain staff. NA-B stated it was important to use two staff with the EZ-Stand while transferring R16 because of safety related to R16 had history of holding her breath during transfers. During an telephone interview on 9/10/24 at 9:03 am., medical director (MD) stated he was aware that certain residents required the EZ-Stand and two staff assist to transfer. MD stated his expectation was that staff would have followed R11 and R16's care plan and the facility policy regarding the use of lifts. Assessments should be performed upon admission, quarterly, yearly, or as needed to correlate with residents abilities or changes. During a telephone interview on 9/11/23 at 7:58 a.m., licensed practical nurse (LPN)-E stated R16 has struggled and was unable to hold her arms in line with her body, and her arms would V out aka "chicken wing" for "some time now" while using the EZ-Stand. R16 required assist of two staff to	F 689		

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F 689	Continued From page 34 use the EZ-Stand because of R16 not being able to have proper arm alignment (chicken wings) while using the EZ-Stand. LPN-E further stated R16 was "not safe" to be transferred with only one staff member with the EZ-Stand related to the potential for a fall. LPN-E was aware R16 was known to hold her breath and likely fell related to that, and not following the care plan by ensuring 2 staff were present. During an interview on 9/10/24 at 7:17 a.m., clinical manager CM-A stated it was discovered NA-B had transferred R16 alone with the EZ-Stand instead of using two staff per R16's care plan and care sheet. CM-A stated staff were to use the care sheets for all transfers. CM-A stated NA-B stated she had performed R16's transfer with the EZ-Stand independently because R16 "did not like many of the other staff". CM-A stated NA-B was aware that two staff and the EZ-Stand were required for all of R16's transfers. CM-A was aware R16 had a history of holding her breath during transfers, and noted it was "important" to use two staff and the EZ-Stand for all transfers to try to prevent falls and to mitigate any injuries from falls. R16 had not been assessed to identify if she would require the use of a total body lift for safety. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated R16 had been seen by therapy this past year related to R16 holding her breath in the EZ-Stand. PT-A stated therapy had recommended to continue using two staff assist with the EZ-Stand to transfer R16 for safety related to R16 holding her breath during transfers. PT-A stated her expectation was the all staff would have followed R16's care plan and PT recommendations for R16.	F 689		

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F 689	Continued From page 35 R37 Review of R37's 7/17/24, quarterly MDS assessment identified her cognition was intact. R37 had diagnosis of heart failure, history of a tibia fracture, and history of falling. she was independent with her wheelchair, and required substantial/maximal assistance with transfers, dressing, personal hygiene, and bed mobility. Review of the facilities current nurse aide care sheets identified R37 was non-ambulatory due to right leg fracture, required assistance of 1 staff for transfers using a sit to stand mechanical lift for transfers, and a full body mechanical lift as needed. The care sheet did not identify what parameters staff should use to identify when it was appropriate to use a full mechanical lift rather than a sit to stand lift. Observation on 9/9/24 at 1:34 p.m., identified nursing assistant (NA)-A placed the harness across R37's back and connect the straps to the sit to stand, placed feet on the platform, and secured the safety strap. NA-A used the lift to stand R37 for a transfer, R37's knees were bent, her elbows were pointing outward vs next to her person, and she appeared to not be able to bear weight. Interview on 9/9/24 at 1:35 p.m., with NA-A identified she uses her care sheets to identify how many staff or what level of assistance the resident requires. She was unable to identify what would prompt her to use a full mechanical lift rather than a sit to stand lift or when she would notify the nurse that the resident is not safe to use the sit to stand lift if they cannot bear weight as an EZ stand requires.	F 689		

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F 689	Continued From page 36 During an interview on 9/10/24 at 11:46 a.m., director of nursing (DON) verified both R11 and R16 required two staff assist and EZ-Stand for all transfers. DON verified staff were to be using the care sheets to care for the residents. DON stated NA-A had not known about the care sheets and facility had no documentation of training on care plans or care sheets for NA-A prior to or after R11's fall. DON stated there was not a "good process" for orientation of agency staff but "going forward" there would be a better process. DON also verified the only education that was received after both of the above falls was verbal reminders for staff to ensure that the care sheets are followed. She was was unable to determine if all staff had received the verbal reminders. The DON stated she was unsure of when/if all staff received mechanical lift competencies. DON stated her expectation was that all staff would have received education about the care sheets after R11 and R16's falls and would have followed the care sheets for R11 and R16, but could not ensure all staff were notified. The reason R11 and R16 required two staff and the EZ-Stand was to reduce falls and mitigate any injuries from falls. DON further stated competency training "should" be given to all employees to reflect current knowledge of the facility's resident specific needs and services. During an interview on 9/12/24 at 8:13 a.m., with the administrator identified his expectation was that care sheets and care plans for R11 and R16 should have been followed. All staff including agency staff would have received education on care sheets and care plans prior to working at the facility.	F 689		

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F 689	Continued From page 37 Review of a facility policy titled EZ Lift and/or EZ Stand revised 8/11/15, identified staff were to ensure resident safety at all times while using the EZ Lift/ EZ Stand assist of two staff is required at all times unless care plan states assist of one. Review of a facility policy titled Fall Protocol undated identified fall events would be completed in Matrix and immediate interventions put into place related to fall. The immediate jeopardy that began on 8/29/24, was removed on 9/12/24, when it was verified the facility: 1) Reviewed and updated policies related to care sheets, care plans, and using the EZ Lift/Stand. 2) Educated all licensed staff and nursing assistants including agency staff and performed competencies on how to appropriately use the EZ Stand and Care sheets. 3) Updated the orientation checklist for agency staff. 4) Re-assessed all residents currently using an EZ Stand to determine if they were able to be partial weight bearing per manufacturer's guidelines in order to use the EZ Stand. 5) Educated staff on incident reporting to the SA.	F 689		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 726		10/11/24

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F 726	Continued From page 38 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to ensure 8 of 8 nursing assistants ((NA)-A, NA-B, NA-F, NA-G, NA-H, NA-I, NA-J, and NA-K) 4 of 4 registered nurses (RN)-D, RN-E, RN-F and the infection preventionist (IP)), and 1 of 1 licensed practical nurse (LPN)-F were deemed competent on the operatioon of mechanical lifts and following care plans and care sheets, upon hire, yearly thereafter, or as needed when identified concerns with competence were noted. This had the potential to affect all 54 residents who had/may use mechanical lifts, and had care plans and care sheets. Findings include:	F 726	The facility failed to ensure that all nursing were deemed to be competent on the operation of the EZ Way mechanical lifts. All residents in the facility had the potential to be affected by this alleged incident. Upon review, it was determined that this lapse occurred due to: " Insufficient orientation and training of nursing staff, including temporary staff contracted through outside agency. " Inadequate supervision of staff adherence to resident care plan. " NA-A was given immediate	

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F 726	Continued From page 39 Review of the NA employee files identified: 1. NA-A had a hire date of 8/27/24. 2. NA-B had a hire date of 2/4/22. 3. NA-F had a hire date of 3/27/24. 4. NA-G had a hire date of 6/11/24. 5. NA-H had a hire date of 5/15/23. 6. NA-I had a hire date of 1/22/4. 7. NA-J had a hire date of 7/17/24. 8. NA-K had a hire date of 4/25/24. None of the above mentioned NA staff had competencies performed for the use of mechanical lifts, following care plans, and care sheets. Review of the licensed and registered nursing staff employee files identified: 1. The IP had a hire date of 5/9/11. 2. RN-D had a hire date of 5/31/24. 3. RN-E had a hire date of 7/31/24. 4. RN-F had a hire date of 5/9/24. 5. LPN-F had a hire date of 12/21/22. None of the above mentioned staff had competencies performed for the use of mechanical lifts, following care plans, and care sheets. During an interview on 9/9/24 at 5:11 p.m., NA-A stated she worked for a staffing agency and was new to the facility. NA-A had been working independently at the facility for a few weeks now. NA-A could not recall receiving any training and/or had competencies performed on the operation of mechanical lifts, care plans, or care sheets prior to being allowed to work independently at the facility. During an interview on 9/10/24 at 4:14 p.m., NA-B stated she had worked at the facility for over 2	F 726	reeducation at the point of care, emphasizing the proper use of mechanical lifts and the importance of adhering to care plans. " Staff reviewed the care plans of all residents requiring mechanical lifts to ensure that they are accurate and up to date. " Increased supervision and monitoring of residents being transferred with mechanical lifts to ensure compliance with safety protocols. " All nursing staff will complete mandatory Inservice training on fall prevention, resident supervision, and proper use of mechanical lifts. The training will be included as part of annual education and new hire orientation " Surveillance: DON or designee will conduct daily observation of transfers for residents that require a mechanical lift or sit to stand daily x 30 days to ensure staff are following care plan, then random audits 3 x weekly audits x 6 months to maintain compliance. Audits will be brought to QAPI for review/oversight. Next QAPI is 10/15/24. Date of compliance 10/11/2024.	

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F 726	Continued From page 40 years now. NA-B was unsure if she had received training and/or had competencies performed on the operation of mechanical lifts, care plans, or care sheets During an interview on 9/11/24 at 3:16 p.m., the director of nursing (DON) verified there were no competencies regarding operation of the mechanical lifts, or following care plans or care sheets upon hire or yearly. The DON stated the orientation process for all staff including agency staff "could be improved". Her expectation was that all staff including agency staff would have been competent on the operation of mechanical lifts, and following care plans and care sheets to ensure resident safety. The DON further stated competency training should be given to all employees to reflect current knowledge of the facility's resident specific needs and services as outlined in the facility assessment. Review of the Luther Haven Staff Development Policy revised May of 2019, identified all personnel must participate in initial orientation and regularly scheduled in-service training classes. Staff were to receive training on topics required by federal and state guidelines, based on the employee's department department/specific job, and on topics identified through the facility assessment. Training records were be filed in employee's personnel file and/or maintained by the scheduler.	F 726		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		10/11/24

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F 761	Continued From page 41 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to follow their policy and ensure discontinued medications for 5 of 5 residents (R12, R16, R52, R55, R108) were removed timely and not co-mingled with other current medication supply located in the East and West double locked narcotic medication drawer within the medication cart. Findings include: Observation and interview on 9/10/24 at 2:26 p.m., of the west medication cart narcotic count between registered nurse (RN)-A and licensed	F 761	Survey Findings: • Improper storage of medications. • Expired medications not disposed of per facility policy. • All residents in the facility have the potential to be affected by this alleged incident Corrective Actions: Staff immediately remove and destroy the discontinued medication per facility policy. The facility medication destruction policy was reviewed and revised to clarify which staff members are responsible for medication destruction. • Implement a strict medication storage	

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F 761	Continued From page 42 practical nurse (LPN)-A. During the controlled substance count it was identified that R12 had 4 bottles of morphine 100 milligrams (mg)/5 milliliter (ml) with 3 of the bottles being partially used and one bottle being unopened who staff reported had passed away on 9/2/24. R108 had 2 bottles of morphine 100 mg/5 ml that were unopened who staff reported had discharged on 9/6/24. R55 also had 2 bottles of morphine 100 mg/5 ml that were unopened in the cart, staff reported she had passed away on 8/27/24. R12's 9/2/24, Physician Order Report identified morphine concentrate 100 mg/5 ml 0.25 ml three times a day for chronic pain. R12's 9/2/24, progress note identified resident passed away at 4:15 a.m., hospice was notified and family. R108's 9/6/24, Physician Order Report identified morphine solution 10 mg/5 ml administer 1.25 ml every 4 hours as needed for shortness of breath. R108's 9/6/24, progress note identified discharge to the U of M for a couple weeks with no bed hold wanted. R55's 8/27/24, Physician Order Report identified morphine solution 20 mg/ml administer 0.5 ml every hour as needed for adult failure to thrive. Morphine solution 20 mg/ml administer 0.75 ml every hour as needed for adult failure to thrive. Morphine solution 20 mg/ml administer 1 ml every hour as needed for adult failure to thrive. R55's 8/27/24, progress note identified resident expired at 7:15 a.m., Hospice was notified and family.	F 761	and disposal policy. • Increase surveillance by nursing including routine cart audits to check for expired medications. • The facility discharge checklist will be updated to include medication destruction • Pharmacy consultant to provide routine cart audits for compliance. Staff Responsibilities: • Check medication labels and expiration dates regularly. • Report and properly dispose of expired or unused medications. Audits will be completed by DON or designee and reviewed monthly at QAPI to maintain compliance. Revised policy and procedure will also be reviewed at next QAPI meeting on 10/15/24. Date of compliance 10/11/24.	

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F 761	Continued From page 43 Observation and interview on 9/10/24 at 2:40 p.m., of the east medication cart narcotic count between LPN-B and LPN-C. During the controlled substance count it was identified that R52 had 5 Fentanyl 25 mcg/hr patches and 9 hydrocodone/APAP 5/325 mg. Staff reported those medications had been discontinued. R16 had 15 oxycodone 5 mg tables, 3 punch cards of hydrocodone/APAP 5/325 mg tablets totaling 86 tablets, and morphine solution 100 mg/5 ml with 18.5 ml remaining. Staff reported that R16 passed away on 9/8/24. LPN-B confirmed that the nurse should be removing the discontinued medications out of the medication cart as soon as possible and destroying. The controlled medications require 2 licensed staff to destroy and with the staffing challenges it has been really hard to get the medication destroyed. LPN-C further confirmed as licensed nurses when someone passes away or discharges the medications should be removed from the medication cart and destroyed. R52's 9/6/24, Physician's Orders identified an order to discontinue Fentanyl patch and start morphine SR 30 mg PO twice a day as needed for break through pain. R52's 9/9/24, Physician's Orders identified an order to discontinue Norco. R16's 9/8/24, Physician Order Report identified morphine concentrate 100 mg/5 ml administer 0.5 ml every hour as needed for severe pain or shortness of breath. Physician order report had no mention of Oxycodone 5 mg or hydrocodone 5/325 mg.	F 761		

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F 761	Continued From page 44 R16's 7/23/24, label on the Individual Narcotic Record sheet identified hydrocodone/APAP 5 mg/325 mg every 6 hours as needed for severe pain. R16's 9/4/24, individual narcotic record sheet identified oxycodone 5 mg every 6 hours as needed for moderate pain or severe pain. R16's 9/8/24, progress note identified resident passed away at 5:10 p.m., family and hospice notified. Interview on 9/10/24 at 2:48 p.m., with RN-B confirmed discontinued medications should not be kept in with active medications and should be removed and destroyed right away. Interview on 9/10/24 at 2:50 p.m., with director of nursing identified she had not had time to review the medication destruction policy but confirmed that discontinued medications should not be kept in the cart co-mingled with other active medication very long. Review of the 5/26/21, Medication Destruction/Disposal policy identified medication would be destroyed and disposed of in a timely manner that complies with both federal and state guidelines in addition to guidelines set by the Board of Pharmacy and recommended by the pharmacist.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		10/11/24

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F 812	Continued From page 45 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were not co-mingling personal food and effects with resident food. This had the potential to affect all 54 residents who ate food prepared from the kitchen. Findings include: Observation on 9/9/24 at 10:45 a.m., during the initial tour of the facility kitchen with the dietary manager present, a reach-in refrigerator in the baking area of the kitchen had two separate compartments. The top compartment contained 5 tumbler style drink cups with straws sticking out of staff's, and 2 Tupperware containers containing staff personal food. The refrigerator also contained food used for residents including butter, frosting, liquid eggs, ice cream topping, and glucerna supplements. The bottom compartment was not cooling and contained staff effects including shoes, pretzels, clothing, and bags containing unknown items of staff's.	F 812	The facility failed to ensure staff were not co-mingling personal food and effects with resident food. All residents in the facility had the potential to be affected by this alleged incident. Personal belongings and food items were immediately removed from the storage compartment. The facility reviewed Storage of Personal Belongings and Hygiene policy, and no changes were recommended. All dietary staff were re-educated on Storage of Personal Belongings and Hygiene policy expectation that all personal belongings must be stored in the breakroom refrigerator or their locker. All staff will receive education on this deficient practice at Survey Training beginning 10/7/24. Director of Nutritional Services or designee will complete random weekly audits x 4 months and then monthly	

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F 812	Continued From page 46 Interview on 9/10/24 at 1:17 p.m., with the dietary manager identified she agreed with the above findings and did not know why staff had been storing things in the resident kitchen refrigerator. She would expect staff to follow policy and use the staff break room fridge and lockers to store their food and personal items. Review of the facilities 2017, Personal Hygiene Training Policy identified street clothing, coats, purses, packages, and other personal effects will be stored in employee lockers and not in the kitchen.	F 812	thereafter to maintain compliance. Audits will be brought to QAPI for review/oversight. Next QAPI is 10/15/24. Substantial compliance to be achieved by 10/11/24.	
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population,	F 838		10/11/24

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F 838	Continued From page 47 using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources,	F 838		

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F 838	Continued From page 48 such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.	F 838		

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F 838	Continued From page 49 §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement 1 of 1 facility assessment protocol related to ensuring staff competencies were identified and completed respective to staff duties performed. Findings include: Refer to F726 Interview on 9/12/24 at 9:04 a.m., with administrator stated the facility competency requirements listed on the facility assessment did not reflect the practice of staff training on the floor. The facility had recently made changes to the facility assessment, under the direction of regulation mandated for nursing homes in July of 2024. All staff were not informed and were not updated of the facility assessment changes recently. The Quality Assessment and Assurance (QAA) committee was to approve the assessment	F 838	The deficient practice had the potential to affect all residents residing in the facility. The facility revised its general orientation training section in the facility assessment on 10/1/2024 to ensure new hires and agency staff received sufficient training and competencies at the time of starting at Luther Haven. The new hire orientation checklist for NA-R and RN/LPN were updated as well as orientation checklists for agency personnel. Staff training on this survey topic will begin the week of October 7. The Administrator or designee will complete a weekly audit of orientation checklists to verify completion and	

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F 838	Continued From page 50 revision and would relay to all staff the facility's operational goals related to person-centered cares, staffing services, and resources. Review of 9/2024 Luther Haven Nursing Home 2024 Facility Assessment Tool identified staff education and competencies were necessary to provide support for the residents. The facility identified staff education, training, certifications, testing, and facility policies to support the care needed for the residents. In addition, the facility would identify processes and oversight that would meet residents needs through regulatory, operational, maintenance and staff training requirements. Lastly, the facility would review resources annually, and would evaluate day to day operations, including emergencies, to ensure residents care maintain their highest practicable physical, mental and psychosocial well-being.	F 838	compliance. Results of audits will be brought to QAPI for review and monitoring. Duration of audits will be determined by the QAPI committee. Next QAPI meeting will be 10/15/2024. Date of compliance 10/11/24.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		10/15/24

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F 867	Continued From page 51 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems	F 867		

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	245259	A. BUILDING _____ B. WING _____	C 09/12/2024

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F 867	Continued From page 52 level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance.	F 867		

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F 867	Continued From page 53 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 54 residents. Findings include: Review of the quarterly QAPI meetings covering March of 2024 through July of 2024, identified the facility departments were submitting data to be reviewed by the committee as follows: QAPI minutes dated 3/28/24 identified: 1) The facility departments had brought forth concerns regarding urinary tract infections (UTI's) with contributing factors of standing order concerns with providers, antibiotic stewardship, and staff training. The QAPI committee did not	F 867	The facility revised its QAPI agenda on 10/1/2024. The revised agenda now includes current quality assessment and assurance activities, current performance improvement projects, new issues/opportunities that need to be addressed, and concerns reported by residents, families, or staff. Our current assessment and assurance activities and current performance improvement projects will now include who the champion will be, what the measure is, what our goal is, and what the status is. We will have a discussion on each topic and there will be action at each meeting regarding each topic or project to ensure areas identified have oversight and appropriate outcomes. The Administrator or designee will be responsible for ensuring the QAPI agenda	

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F 867	Continued From page 54 identify a analysis of the data, a measurable goal, or an action plan to help reduce the prevalence of UTI's in the facility. 2) The infection preventionist identified the facility had 5 UTI's, 2 residents with pneumonia, 2 with respiratory symptoms, 2 with confirmed norovirus, and 34 residents on precautions due to norovirus. 2 staff had tested positive for covid, and 35 call ins with varying symptoms. The committee discussed the need for audits to be completed, however the minutes did not identify that the data had been analyzed to identify a root cause, a measurable goal, or an action plan to help reduce the risk for spread of infection. QAPI minutes dated 4/22/24 identified: 1) The facility licensed social worker brought forth grievances and State Agency reporting for residents concerned with rough care, falls with multiple fractures, resident with multiple bruising, call lights being answered timely, and resident to resident altercations. The QAPI minutes did not identify an analysis of the date to identify a root cause, a measurable goal, or an action plan. QAPI minutes dated 7/9/2024, identified: 1) The facility had an ongoing performance improvement project (PIP), the minutes identified they had been consulting with wound care for recommendations, they had 4 residents with pressure ulcers 1 present on readmission, then 2 present on admission, and 1 facility acquired. The minutes did not identify an analysis of the data to determine a root cause, a measurable goal, or a meaningful action plan to help reduce the risk for pressure ulcers and improve skin integrity. 2) During the month of June the facility had 10 falls with no injury or minor injury and 4 falls with major injury. The QAPI minutes again did not	F 867	is completed on time and completely. A QAPI principle will be reviewed at each meeting and root cause analysis training will occur at the next QAPI meeting which is scheduled for 10/15/24. Staff training on this survey topic will be held beginning the week of October 7. The Administrator or designee will complete monthly audits for 3 months to ensure projects and activities are being completed and followed-up on. Results will be reviewed at QAPI. Duration of audits will be determined by the QAPI committee. Next QAPI meeting is 10/15/24. Date of compliance 10/11/24.	

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F 867	Continued From page 55 identify an analysis of the data to determine a root cause, a measurable goal, or an action plan to help reduce the risk of falls or injuries. Interview on 9/11/24 at 4:48 p.m., with the administrator identified they had not been working on anything but the Performance Improvement Project (PIP) for skin, the PIP had stared in January of 2023, at that time they had a rate of 7.4 percent and a goal of 4.4% but they had not analyzed the data since starting the project. He was not sure what the action plan was other than to consult with the wound care nurses. He identified he would expect they should be following the facility QAPI plan. The Facility Quality Assurance Plan dated May 2022, identified the QAPI team would review data and input monthly to look for potential topics for improvement, they would analyze data, and review feedback and input from residents, staff, families, volunteers, providers, and stakeholders. would complete a systematic analysis and systemic action by completing a root cause analysis to identify the underlying cause and contributing factors. The QAPI team will develop action to address identified root cause and contributing factors of issues or events that will affect change at the systems level. They were to test actions and revise policies and or procedures as appropriate. To ensure the planned changes or interventions are implemented and effective in making and sustaining improvements, the facility would choose measures that tie directly to the new action and they would conduct ongoing periodic measurements and audits. The QAPI team would review the results to ensure that the new action has been effective.	F 867		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/09/24 through 9/12/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/04/24

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2 000	Continued From page 1 the survey: H52597908C (MN106322 and MN106553) and H52597908C (MN106554) with a deficiency cited at F609, F610, F677, F689 and F726. The above findings constituted Substandard Quality of Care and an extended survey was conducted from 9/10/24 through 9/12/24. The following complaints were reviewed: H52597908C (MN106322 and MN106553) had licensing orders issued at 1980, 830, 300 and 240. H52597975C (MN106554) had licensing orders issued at 1880 and 920. The following complaints were reviewed: H52597690C (MN106228), H52597691C (MN106230), H52597692C (MN106231), H52597693C (MN106232), and H52597720C (MN106227). NO licensing orderes were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 240	MN Rule 4658.0065 Subp. 3 Resident Safety and Disaster Planning Subp. 3. Written disaster plan. A nursing home must have a written disaster plan specific to the nursing home with procedures for the protection and evacuation of all persons in the case of fire or explosion or in the event of floods, tornadoes,	2 240		10/11/24

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2 240	Continued From page 2 or other emergencies. The plan must include information and procedures about the location of alarm signals and fire extinguishers, frequency of drills, assignments of specific tasks and responsibilities of the personnel on each shift, persons and local emergency departments to be notified, precautions and safety measures during tornado alerts, procedures for evacuation of all persons during fire or floods, planned evacuation routes from the various floor areas to safe areas within the building, or from the building when necessary, and arrangements for temporary emergency housing in the community in the event of total evacuation. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement 1 of 1 facility assessment protocol related to ensuring staff competencies were identified and completed respective to staff duties performed. Findings include: Interview on 9/12/24 at 9:04 a.m., with administrator stated the facility competency requirements listed on the facility assessment did not reflect the practice of staff training on the floor. The facility had recently made changes to the facility assessment, under the direction of regulation mandated for nursing homes in July of 2024. All staff were not informed and were not updated of the facility assessment changes recently. The Quality Assessment and Assurance (QAA) committee was to approve the assessment revision and would relay to all staff the facility's operational goals related to person-centered cares, staffing services, and resources.	2 240	Corrected.	

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2 240	Continued From page 3 Review of 9/2024 Luther Haven Nursing Home 2024 Facility Assessment Tool identified staff education and competencies were necessary to provide support for the residents. The facility identified staff education, training, certifications, testing, and facility policies to support the care needed for the residents. In addition, the facility would identify processes and oversight that would meet residents needs through regulatory, operational, maintenance and staff training requirements. Lastly, the facility would review resources annually, and would evaluate day to day operations, including emergencies, to ensure residents care maintain their highest practicable physical, mental and psychosocial well-being. SUGGESTED METHOD OF CORRECTION: The administrator or designee should, in cooperation with the QAPI committee and Governing Body, conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update the assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment and ensure all aspects are appropriately identified and implemented. The administrator is responsible to provide and/or designate management to re-educate staff and perform competencies identified in the assessment, and have measurable audits to ensure actions identified in the assessment are carried out. The results of those audits should be taken to the QAPI committee to determine compliance.	2 240		

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2 240	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 240		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 54 residents. Findings include: Review of the quarterly QAPI meetings covering March of 2024 through July of 2024, identified the	2 255	Corrected.	10/11/24

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2 255	Continued From page 5 facility departments were submitting data to be reviewed by the committee as follows: QAPI minutes dated 3/28/24 identified: 1) The facility departments had brought forth concerns regarding urinary tract infections (UTI's) with contributing factors of standing order concerns with providers, antibiotic stewardship, and staff training. The QAPI committee did not identify a analysis of the data, a measurable goal, or an action plan to help reduce the prevalence of UTI's in the facility. 2) The infection preventionist identified the facility had 5 UTI's, 2 residents with pneumonia, 2 with respiratory symptoms, 2 with confirmed norovirus, and 34 residents on precautions due to norovirus. 2 staff had tested positive for covid, and 35 call ins with varying symptoms. The committee discussed the need for audits to be completed, however the minutes did not identify that the data had been analyzed to identify a root cause, a measurable goal, or an action plan to help reduce the risk for spread of infection. QAPI minutes dated 4/22/24 identified: 1) The facility licensed social worker brought forth grievances and State Agency reporting for residents concerned with rough care, falls with multiple fractures, resident with multiple bruising, call lights being answered timely, and resident to resident altercations. The QAPI minutes did not identify an analysis of the date to identify a root cause, a measurable goal, or an action plan. QAPI minutes dated 7/9/2024, identified: 1) The facility had an ongoing performance improvement project (PIP), the minutes identified they had been consulting with wound care for recommendations, they had 4 residents with pressure ulcers 1 present on readmission, then 2	2 255		

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2 255	Continued From page 6 present on admission, and 1 facility acquired. The minutes did not identify an analysis of the data to determine a root cause, a measurable goal, or a meaningful action plan to help reduce the risk for pressure ulcers and improve skin integrity. 2) During the month of June the facility had 10 falls with no injury or minor injury and 4 falls with major injury. The QAPI minutes again did not identify an analysis of the data to determine a root cause, a measurable goal, or an action plan to help reduce the risk of falls or injuries. Interview on 9/11/24 at 4:48 p.m., with the administrator identified they had not been working on anything but the Performance Improvement Project (PIP) for skin, the PIP had stared in January of 2023, at that time they had a rate of 7.4 percent and a goal of 4.4% but they had not analyzed the data since starting the project. He was not sure what the action plan was other than to consult with the wound care nurses. He identified he would expect they should be following the facility QAPI plan. The Facility Quality Assurance Plan dated May 2022, identified the QAPI team would review data and input monthly to look for potential topics for improvement, they would analyze data, and review feedback and input from residents, staff, families, volunteers, providers, and stakeholders. would complete a systematic analysis and systemic action by completing a root cause analysis to identify the underlying cause and contributing factors. The QAPI team will develop action to address identified root cause and contributing factors of issues or events that will affect change at the systems level. They were to test actions and revise policies and or procedures as appropriate. To ensure the planned changes or interventions are implemented and effective in	2 255		

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2 255	Continued From page 7 making and sustaining improvements, the facility would choose measures that tie directly to the new action and they would conduct ongoing periodic measurements and audits. The QAPI team would review the results to ensure that the new action has been effective. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administratior will be reponsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and record review, facility failed to ensure 8 of 8 nursing assistants ((NA)-A, NA-B, NA-F, NA-G, NA-H, NA-I, NA-J, and NA-K) 4 of 4 registered nurses (RN)-D, RN-E, RN-F and the infection preventionist (IP)), and 1 of 1 licensed practical nurse (LPN)-F were deemed	2 300	Corrected.	10/11/24

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2 300	Continued From page 8 competent on the operatioon of mechanical lifts and following care plans and care sheets, upon hire, yearly thereafter, or as needed when identified concerns with competence were noted. This had the potential to affect all 54 residents who had/may use mechanical lifts, and had care plans and care sheets. Findings include: Review of the NA employee files identified: 1. NA-A had a hire date of 8/27/24. 2. NA-B had a hire date of 2/4/22. 3. NA-F had a hire date of 3/27/24. 4. NA-G had a hire date of 6/11/24. 5. NA-H had a hire date of 5/15/23. 6. NA-I had a hire date of 1/22/4. 7. NA-J had a hire date of 7/17/24. 8. NA-K had a hire date of 4/25/24. None of the above mentioned NA staff had competencies performed for the use of mechanical lifts, following care plans, and care sheets. Review of the licensed and registered nursing staff employee files identified: 1. The IP had a hire date of 5/9/11. 2. RN-D had a hire date of 5/31/24. 3. RN-E had a hire date of 7/31/24. 4. RN-F had a hire date of 5/9/24. 5. LPN-F had a hire date of 12/21/22. None of the above mentioned staff had competencies performed for the use of mechanical lifts, following care plans, and care sheets. During an interview on 9/9/24 at 5:11 p.m., NA-A stated she worked for a staffing agency and was new to the facility. NA-A had been working independently at the facility for a few weeks now.	2 300		

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2 300	Continued From page 9 NA-A could not recall receiving any training and/or had competencies performed on the operation of mechanical lifts, care plans, or care sheets prior to being allowed to work independently at the facility. During an interview on 9/10/24 at 4:14 p.m., NA-B stated she had worked at the facility for over 2 years now. NA-B was unsure if she had received training and/or had competencies performed on the operation of mechanical lifts, care plans, or care sheets During an interview on 9/11/24 at 3:16 p.m., the director of nursing (DON) verified there were no competencies regarding operation of the mechanical lifts, or following care plans or care sheets upon hire or yearly. The DON stated the orientation process for all staff including agency staff "could be improved". Her expectation was that all staff including agency staff would have been competent on the operation of mechanical lifts, and following care plans and care sheets to ensure resident safety. The DON further stated competency training should be given to all employees to reflect current knowledge of the facility's resident specific needs and services as outlined in the facility assessment. Review of the Luther Haven Staff Development Policy revised May of 2019, identified all personnel must participate in initial orientation and regularly scheduled in-service training classes. Staff were to receive training on topics required by federal and state guidelines, based on the employee's department department/specific job, and on topics identified through the facility assessment. Training records were be filed in employee's personnel file and/or maintained by the scheduler.	2 300		

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2 300	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired nursing staff to include nurse aides. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/11/24

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2 830	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess and/or follow the care plan and ensure safe transfers were performed for 3 of 3 residents (R11, R16, and R37) while using sit-to-stand mechanical lifts (EZ stand) (requires a resident to be partial weight-bearing) to prevent or mitigate falls or risk thereof. This resulted in an immediate jeopardy (IJ) for both R11 and R16 who fell from and EZ-stand and required hospital evaluation and treatment). Both events had the potential for serious harm, injury, impairment, or death. Findings include: R11 R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure. R11's fall report indicated on 8/29/24, R11 had a fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation. R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples. R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on	2 830	Corrected.	

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2 830	Continued From page 12 8/29/29. Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff "don't want to switch to the Hoyer [total lift]". R11's annual Minimum Data Set (MDS) dated 7/15/24, identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand related to a recent fall. Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. R11's Fall Risk Assessment dated 7/9/24, indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to perform that function. An option for "required the	2 830		

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2 830	Continued From page 13 use of assistive devices such as a cane, walker or wheelchair" was left blank. During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell. NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts. During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the verbal reminder to follow care sheet. Her expectation was that all staff would be educated	2 830		

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2 830	Continued From page 14 on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being "unpredictable" in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management. R16 Review of the 9/1/24, at 1:40 p.m., report to the State Agency (SA) identified on 8/31/24 at 9:09 a.m., R16 had a fall at 9:09 a.m.. At approximately 11:30 a.m., R16 began experiencing pain in her left lower extremity and was transferred to the local ER, was found to have a fracture in her leg (noted later by the radiologist to be consistent with a disease process vs the fall) and had to be transferred to a regional hospital for further evaluation and treatment. A follow up email to the SA dated 9/5/24 at 10:35 from director of nursing (DON) stating during the investigation it was revealed that a nursing assistant had been using the EZ-Stand independently and had not been following R16's care plan. R16's fall report identified on 8/31/24 at 9:15 a.m., R16 had been lowered to the floor in the EZ-Stand. R26 was later sent to the ER, and subsequently hospitalized for a leg fracture and a	2 830		

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2 830	Continued From page 15 report had been filed with the SA and an investigation initiated. No other details were included on the fall report. Review of the facility's investigation file identified R16 required assist of two staff with EZ-Stand with transfers. The investigation determined only one staff had been used for the transfer, but could not determine through their root cause analysis as the care plan had not been followed, however, it was also noted R16 likely "passed out" from holding her breath during the transfer. R16's Face sheet dated 9/8/24, identified R16 had diagnosis which included diabetes mellitus (DM), hypertension (elevated blood pressure), and vertigo (dizziness). R16's Comprehensive Care Area Assessment (CAA) dated 10/19/23, identified R16 had an activities of daily living (ADL) deficit related to impaired mobility and chronic pain. R16 had a history of falls. R16 was noted to have moderate cognitive impairment identified on her ADL section of her CAA. R16 had no behaviors noted. R16's quarterly Minimum Data Set (MDS) dated 7/16/24, identified R16 had intact cognition. R16 required substantial/ maximum assist for sit to stand and for toileting. R16 had no behaviors noted. R16's care plan dated 10/26/24, identified R16 had self-care deficits with ADL's and was at risk for falls related to impaired mobility and a history of falls. R16 required two assist with use of the E-Z Stand for transfers. Review of nursing assistant (NA) care sheet dated 8/30/24, identified R16 required the assist	2 830		

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2 830	Continued From page 16 of two staff with use of an EZ-Stand for transfers. R16's fall risk assessment dated 7/11/24, identified R16 was at high risk for falls. R16 was noted to have intermittent confusion, poor recall, judgement, and safety awareness. R16 was not able to stand on both feet, without holding onto anything to walk and was not noted to use an assistive device, such as a can, walker, or wheelchair and was chair-bound. Review of a PT note dated 12/26/23, identified R16 was referred to PT as she held her breath during transfers using the EZ stand. Per the registered nurse, this caused some bursting of blood vessels in her facial area. The physician had requested the referral. Pt noted per staff "nothing had changed". The room was very "tight" (not a lot of room to maneuver a mechanical lift). R16 was not open to suggestions most of the time and staff had to cue her to not hold her breath. Physically, she did well hanging onto the EZ stand. "Patient can be very stubborn and abusive to staff and therapy". There was no indication R16 was assessed for partial weight bearing as required for use an EZ stand or if PT recommended the use of a total lift since they were aware staff reported her holding her breath to the point of extreme (bursting blood vessels), which could lead to an episode of unconsciousness. Review of a progress note dated 6/6/24, indicated EZ-Stand is not recommendable anymore because R16 does "chicken wings" elaborating her elbows were not straight (in line with her body) and had an outward V formation and anytime can "give up and fall". R16's progress notes identified on:	2 830		

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2 830	Continued From page 17 1) 6/9/24, indicated resident was "doing chicken wings" and gets "purple/red" (faced from holding her breath) during transfers. 2) 8/31/24 at 9:09 a.m., identified R16 held breath during transfer in EZ stand causing her to pass out and be lowered to the ground. R16 did not want to be seen in the ER. 3) 8/31/24 at 9:15 p.m., identified around 11:30 a.m., R16 began having left leg pain. Previously, she only allowed ice at the time but has now agreed to be seen in the ER and was transferred to the ER. 4) 9/1/24 at 1:05 a.m., identified ER called and stated R16 was being transferred to another facility due to a left leg fracture. R16's CT scan titled "final report" dated 9/1/24 at 7:34 a.m., identified R16 had a left leg fracture. During a telephone interview on 9/10/24 at 4:14 p.m., NA-B stated she had worked the evening of 8/31/23, when R16 was lowered to the floor. NA-B stated while she was assisting R16 off the toilet alone without other staff in attendance, using the EZ-Stand. While transferring, R16 held her breath, blacked out and slid out of the lift sling. NA-B stated she had to lower R16 to the floor. NA-B stated she was aware she was suppose to use two staff and the EZ-Stand to transfer R16 but she had not asked for help because R16 "does not like a lot of the other staff". NA-B stated the nursing assistant (NA) care sheet says to use two staff but that is difficult because R16 only liked certain staff. NA-B stated it was important to use two staff with the EZ-Stand while transferring R16 because of safety related to R16 had history of holding her breath during transfers. During an telephone interview on 9/10/24 at 9:03	2 830		

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2 830	Continued From page 18 am., medical director (MD) stated he was aware that certain residents required the EZ-Stand and two staff assist to transfer. MD stated his expectation was that staff would have followed R11 and R16's care plan and the facility policy regarding the use of lifts. Assessments should be performed upon admission, quarterly, yearly, or as needed to correlate with residents abilities or changes. During a telephone interview on 9/11/23 at 7:58 a.m., licensed practical nurse (LPN)-E stated R16 has struggled and was unable to hold her arms in line with her body, and her arms would V out aka "chicken wing" for "some time now" while using the EZ-Stand. R16 required assist of two staff to use the EZ-Stand because of R16 not being able to have proper arm alignment (chicken wings) while using the EZ-Stand. LPN-E further stated R16 was "not safe" to be transferred with only one staff member with the EZ-Stand related to the potential for a fall. LPN-E was aware R16 was known to hold her breath and likely fell related to that, and not following the care plan by ensuring 2 staff were present. During an interview on 9/10/24 at 7:17 a.m., clinical manager CM-A stated it was discovered NA-B had transferred R16 alone with the EZ-Stand instead of using two staff per R16's care plan and care sheet. CM-A stated staff were to use the care sheets for all transfers. CM-A stated NA-B stated she had performed R16's transfer with the EZ-Stand independently because R16 "did not like many of the other staff". CM-A stated NA-B was aware that two staff and the EZ-Stand were required for all of R16's transfers. CM-A was aware R16 had a history of holding her breath during transfers, and noted it was "important" to use two staff and the EZ-Stand	2 830		

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2 830	Continued From page 19 for all transfers to try to prevent falls and to mitigate any injuries from falls. R16 had not been assessed to identify if she would require the use of a total body lift for safety. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated R16 had been seen by therapy this past year related to R16 holding her breath in the EZ-Stand. PT-A stated therapy had recommended to continue using two staff assist with the EZ-Stand to transfer R16 for safety related to R16 holding her breath during transfers. PT-A stated her expectation was the all staff would have followed R16's care plan and PT recommendations for R16. R37 Review of R37's 7/17/24, quarterly MDS assessment identified her cognition was intact. R37 had diagnosis of heart failure, history of a tibia fracture, and history of falling. she was independent with her wheelchair, and required substantial/maximal assistance with transfers, dressing, personal hygiene, and bed mobility. Review of the facilities current nurse aide care sheets identified R37 was non-ambulatory due to right leg fracture, required assistance of 1 staff for transfers using a sit to stand mechanical lift for transfers, and a full body mechanical lift as needed. The care sheet did not identify what parameters staff should use to identify when it was appropriate to use a full mechanical lift rather than a sit to stand lift. Observation on 9/9/24 at 1:34 p.m., identified nursing assistant (NA)-A placed the harness across R37's back and connect the straps to the sit to stand, placed feet on the platform, and secured the safety strap. NA-A used the lift to	2 830		

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2 830	Continued From page 20 stand R37 for a transfer, R37's knees were bent, her elbows were pointing outward vs next to her person, and she appeared to not be able to bear weight. Interview on 9/9/24 at 1:35 p.m., with NA-A identified she uses her care sheets to identify how many staff or what level of assistance the resident requires. She was unable to identify what would prompt her to use a full mechanical lift rather than a sit to stand lift or when she would notify the nurse that the resident is not safe to use the sit to stand lift if they cannot bear weight as an EZ stand requires. During an interview on 9/10/24 at 11:46 a.m., director of nursing (DON) verified both R11 and R16 required two staff assist and EZ-Stand for all transfers. DON verified staff were to be using the care sheets to care for the residents. DON stated NA-A had not known about the care sheets and facility had no documentation of training on care plans or care sheets for NA-A prior to or after R11's fall. DON stated there was not a "good process" for orientation of agency staff but "going forward" there would be a better process. DON also verified the only education that was received after both of the above falls was verbal reminders for staff to ensure that the care sheets are followed. She was was unable to determine if all staff had received the verbal reminders. The DON stated she was unsure of when/if all staff received mechanical lift competencies. DON stated her expectation was that all staff would have received education about the care sheets after R11 and R16's falls and would have followed the care sheets for R11 and R16, but could not ensure all staff were notified. The reason R11 and R16 required two staff and the EZ-Stand was to reduce falls and mitigate any injuries from falls.	2 830		

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2 830	Continued From page 21 DON further stated competency training "should" be given to all employees to reflect current knowledge of the facility's resident specific needs and services. During an interview on 9/12/24 at 8:13 a.m., with the administrator identified his expectation was that care sheets and care plans for R11 and R16 should have been followed. All staff including agency staff would have received education on care sheets and care plans prior to working at the facility. Review of a facility policy titled EZ Lift and/or EZ Stand revised 8/11/15, identified staff were to ensure resident safety at all times while using the EZ Lift/ EZ Stand assist of two staff is required at all times unless care plan states assist of one. Review of a facility policy titled Fall Protocol undated identified fall events would be completed in Matrix and immediate interventions put into place related to fall. The immediate jeopardy that began on 8/29/24, was removed on 9/12/24, when it was verified the facility: 1) Reviewed and updated policies related to care sheets, care plans, and using the EZ Lift/Stand. 2) Educated all licensed staff and nursing assistants including agency staff and performed competencies on how to appropriately use the EZ Stand and Care sheets. 3) Updated the orientation checklist for agency staff. 4) Re-assessed all residents currently using an EZ Stand to determine if they were able to be partial weight bearing per manufacturer's guidelines in order to use the EZ Stand. 5) Educated staff on incident reporting to the SA.	2 830		

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2 830	Continued From page 22 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They should re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure call lights were answered timely for 4 of 4 residents (R9, R29, R39, and R48) reviewed for activities of daily living (ADL's). Findings include: R39 Interview on 9/9/24 at 12:09 p.m., with R39 who	2 920	Corrected.	10/11/24

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2 920	Continued From page 23 reported that he must wait for someone to come help him. He likes to get up around 7:30 a.m., and no one (satff) came to help him until 9:00 a.m., and he was "so mad" he could have "burnt the place up". He reported the pool staff are really "crabby" they do not give a [expletive] as they are only here a short time. One time a pool staff came and fell asleep in the parking lot in her car. R39's 8/30/24, quarterly Minimum Data Set (MDS) identified Brief Interview for Mental Status (BIMS) score as 15 cognition was intact. He had verbal behaviors directed towards others andrequried sustantial to partial assistance by staff for cares. He took scheduled pain medication, an antidepressant, anticoagulant, and a diuretic. R39 had diagnoses of anemia, coronary artery disease, hypertension, demenia, and depression. R39's 9/9/24, Care Sheet identified he was a fall risk, he was to get up first by 7:00 a.m., needed 1 staff assistance for cares and then was independent with transfers and toileting in his room. R9 Interview on 9/9/24 at 1:27 p.m. with R9 who reported the staff are "good when they have time. The staff "try" however, this morning she had put her call light on to get up and had to wait 2 hours before someone came to help her and that is not unusual. R9's 8/16/24, quarterly MDS identified her BIMS score was 15 and her cognition was intact. She had no behaviors and required partial assistance with cares. She had frequent pain and rated her pain an 8 on a scale of 1 to 10. She took daily	2 920		

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2 920	Continued From page 24 pain medication, antianxiety, antidepressant, antibiotic, diurtic, and hypglycemic medications and she was on oxygen. R9 had diagnoses of heart failure, heypertension, uanxiety, depression, asthma, and imflammatory bowel disease. R9's 9/9/24, Care Sheet identified she was a fall risk, used an EZ sit to stand lift with one staff or pivot transfer with 2 staff, and she was unable to walk at this time. She needed assistance of one staff for cares and toileting. Interview on 9/11/24 at 9:45 a.m., with registered nurse (RN)-C who identified the call light response time was a "problem". There were many variables that could be the reason why the call lights were not addressed timely, but it was an issue staff were aware of. When the facility had an interim administrator, the call light response time was being addressed at QAPI and the interim administrator was out on the floor all the time and the call light average response time was down to about 10-20 minutes however, that has not continued since the interim was no longer present in the facility. R48 Interview on 9/11/24 at 2:43 p.m., with R48's family member identified she had complained to facility staff about long call light wait times however, nothing had ever occurred related to long wait time, or was conveyed as to what the facility would do to decrease the time or investigate why it was occurring. R48's 8/12/24, significant change MDS identified her BIMS score was 15 and her congition was intact. She had no behaviors and required partial assistance with cares. She had one fall since her last assessment with no injury. She had frequent	2 920		

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2 920	Continued From page 25 pain and rated her pain an 8 on scale of 1-10. She took daily pain medication, antipsychotic, antianxiety, antidepressant, diuretic, and hypoglycemic medicatoins and she was on oxygen. R48 had diagnoses of cancer, anemia, thyroid disorder, and anxiety. R48's 9/9/24, Care Sheet identified she was a fall risk and she required one staff for cares. Review of call light logs from 9/5/24 through 9/10/24 found: 1) R39 on 9/8/24 activated his call light at 7:04 a.m., and it was on for 86 minutes. 2) R9 on 9/8/24 activated her call light at 9:23 a.m., and it was on for 41 minutes and again activated her light at 1:48 p.m., and it was on for 49 minutes. On 9/9/24 R9 activated her call light at 7:28 a.m., and it was on for 82 minutes and again activated her call light at 7:41 p.m., and it was on for 50 minutes. On 9/10/24 she activated her light at 8:25 a.m., and it was on for 42 minutes. 3) R48 on 9/6/24 activated her call light at 11:57 a.m., and it was on for 52 minutes. On 9/7/24 she activated her call light at 10:18 a.m., and it was on for 54 minutes and again at 11:09 a.m. she activated her light, and it was on for 58 minutes. On 9/9/24 she activated her call light at 8:01 a.m., and it was on for 42 minutes. Review of staff assignment sheets for the day shift identified on 9/6/24 there had been a staff call-in (unable to work) however, a replacement was found. On 9/7/24 there had been one staff call-in and an area identified as a split with no staff assigned to work that area. It was unknown if the facility was down a second staff on the day shift. On 9/8/24 it was identified that there was one staff call-in and one staff that arrived to work	2 920		

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2 920	Continued From page 26 late. On 9/9/24 there no call-ins. On 9/10/24 there had been one staff call-in. R29 R29's quarterly Minimum Data Set dated 6/10/24, identified R29 had intact cognition and had diagnosis which included myasthenia gravis (a disease that weakens your muscles), low iron in the blood, and high blood pressure. R29 required staff assistance with ADL's which included toileting, dressing, and transferring. R29 was incontinent of bladder. R29's care plan dated 10/20/20 identified R29 required assist with toileting. R29 was to call for assistance and staff were to answer R29's call light promptly. R29's care sheet dated 9/9/24, identified R29 needed assist of one staff as needed with transfers and toileting. During an interview on 9/11/24 at 9:48 a.m., R29 stated there were a few times in the past few weeks where staff had helped him to the bathroom but did not return when he put on the call light so he had to get himself off the toilet. R29 stated "I could have fallen". During an interview on 9/11/24 at 9:51 a.m., NA-D stated it was difficult to answer call lights timely. NA-D stated "Sometimes we are in another room assisting a resident which makes it hard to answer all the call lights timely". NA-D identified the goal was to answer call lights within 5 minutes but that it was "difficult to do". Review of R29's call light logs from 8/30/24 through 9/10/24 revealed: On 8/29/24 R29 activated his call light by the bed	2 920		

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2 920	Continued From page 27 at 9:16 a.m., and it was on for 54 minutes. On 8/29/24 R29 activated his bathroom call light at 11:37 a.m., and it was on for 189 minutes. On 9/4/23 R29 activated his bathroom call light at 10:55 a.m., and it was on for 180 minutes. Review of the grievances from September 2023 through September 2024 identified long call light wait times were grieved by residents and/or families on 9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24. The only follow up documentation for the avove mentioned dates was on 12/13/23, as the concern identified a resident was currently in quarantine due to COVID-19, and family was educated on infection control process and the call light review found that the call light had not been turned on. All other grievances related to long call light time grievances had no resolution identified or proposed action to be taken. Interview on 9/11/24 at 4:34 p.m., with director of nursing (DON) identified she would expect call lights to be answered within 5-10 minutes. Interview on 9/11/24 at 4:49 p.m., with nursing assistant (NA)-C identified that it was hard at times to get the call lights answered timely. She revealed if staff are in another room assisting another resident staff could not "just leave to go answer a call light". She reported the goal was that call lights would be answered within 5 minutes but that was hard to do. NA-C was unaware if her or other staff's failures to answer call lights were brought forth to management to identify concerns by staff on the ability to assist residents timely with ADL's. Interview on 9/11/24 at 4:55 p.m., with licensed practical nurse (LPN)-A identified there was a	2 920		

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2 920	Continued From page 28 "problem" with call lights being answered timely. She felt it was because there were several residents who required 2 staff and a mechanical lift, and several residents who required total assistance with cares. The staff are not charting how much work they are doing and that was why they were staffed the way they were. She felt if staff would do a better job on charting the heavy cares they are doing would show and that would get them more assistance on the floor. "I have tried to educate the direct care staff to chart more frequently as they can chart right from their phones". She further noted staff could chart while in a resident's room while waiting for a resident to finish using the bathroom. Staff were supposed to try to get the call lights answered within 10-15 minutes. LPN-A had not voiced her concerns to management, however call light audits had been done. Interview on 9/12/24 at 8:59 a.m., with administrator identified his expectation was that call lights would be answered timely, and no resident should have to wait an hour to have their call light answered. Review of the 8/14/21, Call Light, Use Of policy identified staff were to respond promptly to resident call lights. Call lights will signal to the Ariel phones and appear on the marquee. Staff were to answer call lights promptly and never make a resident feel like staff are too busy to give assistance. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of	2 920		

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2 920	Continued From page 29 dependent resident cares to ensure their personal needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21105	MN Rule 4658.0650 Subp. 6 Food Supplies; Prohibited storage Subp. 6. Prohibited storage. The storage of detergents, cleaners, pesticides, and other nonfood items not related to the operation of the dietary service, including employees' personal items, is prohibited in food storage areas. The nursing home may store dry goods and paper products related to the dietary service in the food storage area. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were not co-mingling personal food and effects with resident food. Findings include: Observation on 9/9/24 at 10:45 a.m., during the initial tour of the facility kitchen with the dietary manager present, a reach-in refrigerator in the baking area of the kitchen had two separate compartments. The top compartment contained 5 tumbler style drink cups with straws sticking out of staff's, and 2 Tupperware containers containing staff personal food. The refrigerator also contained food used for residents including butter, frosting, liquid eggs, ice cream topping, and glucerna supplements. The bottom compartment was not cooling and contained staff	21105	Corrected.	10/11/24

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21105	Continued From page 30 effects including shoes, pretzels, clothing, and bags containing unknown items of staff's. Interview on 9/10/24 at 1:17 p.m., with the dietary manager identified she agreed with the above findings and did not know why staff had been storing things in the resident kitchen refrigerator. She would expect staff to follow policy and use the staff break room fridge and lockers to store their food and personal items. Review of the facilities 2017, Personal Hygiene Training Policy identified street clothing, coats, purses, packages, and other personal effects will be stored in employee lockers and not in the kitchen. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs and no staff items are co-migled with resident food, or stored in areas in kitchen or kitchen storage. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21105		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		10/11/24

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21426	Continued From page 31 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete Tuberculosis (TB) symptom screening for 2 of 5 residents (R48 and R49) reviewed for TB testing. In addition, the facility failed to ensure 3 of 5 new employees nursing assistant (NA)-J registered nurse ((RN)-D and RN-E) received a second step Mantoux (a skin test to check for tuberculosis) upon hire to the facility. Findings include: Review of R48's face sheet identified R48 was admitted to the facility on 10/4/23. R48's medical	21426	Corrected.	

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21426	Continued From page 32 record lacked documentation the baseline TB symptom screening had been completed. Review of R49's face sheet identified R49 was admitted to the facility on 3/4/24. R49's medical record lacked documentation the baseline TB symptom screening had been completed. Review of NA-J's employee file revealed a hire date of 7/17/24. File revealed NA-J received a first step Mantoux in her right forearm on 7/17/24 and was read on 7/19/24 with negative results. File lacked evidence NA-J received a second step Mantoux. Review of RN-D's employee file revealed a hire date of 5/31/24. File revealed RN-D received a first step Mantoux in her right forearm on 5/31/2 and was read on 6/3/24 with negative results. File lacked evidence RN-D received a second step Mantoux. Review of RN-E's employee file revealed a hire date of 7/31/24. File revealed RN-E received a first step Mantoux in her left forearm on 7/31/24 and was read on 8/2/24 with negative results. File lacked evidence RN-E received a second step Mantoux. During an interview on 9/11/24 at 9:08 am., infection preventionist (IP) verified R48 and R49 had not received TB symptom screening. Further verified NA-J, RN-D, and RN-E had not received a second step Mantoux. IP stated her expectation was that TB symptom screening was done on all residents and a second Mantoux was performed on all new employees. During an interview on 9/11/24 at 3:08 p.m., director of nursing (DON) stated her expectation	21426		

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21426	Continued From page 33 was that TB symptom screening was done on all residents and a second Mantoux was performed on all new employees. DON stated screening and Mantoux's were important to detect any symptoms or TB infections in residents and staff. Review of a facility policy titled Tuberculosis Prevention and Control -Residents undated, identified each resident admitted to the facility was required to have a written assessment of the residents risk factors along with any current TB symptoms and a two step Mantoux would be initiated within 72 after admission to the facility. Review of a facility policy titled Tuberculosis Prevention and Control -Employees undated, identified all employees having contact with residents for over 5 hours per week, would have a baseline TB screening which consists of two components: assessing for current symptoms of TB disease and testing for the presence of infection by administering a 2-step Tuberculin skin test. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or	21426		

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21426	Continued From page 34 the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to follow their policy and ensure discontinued medications for 5 of 5 residents	21630	Corrected.	10/11/24

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21630	Continued From page 35 (R12, R16, R52, R55, R108) were removed timely and not co-mingled with other current medication supply located in the East and West double locked narcotic medication drawer within the medication cart. Findings include: Observation and interview on 9/10/24 at 2:26 p.m., of the west medication cart narcotic count between registered nurse (RN)-A and licensed practical nurse (LPN)-A. During the controlled substance count it was identified that R12 had 4 bottles of morphine 100 milligrams (mg)/5 milliliter (ml) with 3 of the bottles being partially used and one bottle being unopened who staff reported had passed away on 9/2/24. R108 had 2 bottles of morphine 100 mg/5 ml that were unopened who staff reported had discharged on 9/6/24. R55 also had 2 bottles of morphine 100 mg/5 ml that were unopened in the cart, staff reported she had passed away on 8/27/24. R12's 9/2/24, Physician Order Report identified morphine concentrate 100 mg/5 ml 0.25 ml three times a day for chronic pain. R12's 9/2/24, progress note identified resident passed away at 4:15 a.m., hospice was notified and family. R108's 9/6/24, Physician Order Report identified morphine solution 10 mg/5 ml administer 1.25 ml every 4 hours as needed for shortness of breath. R108's 9/6/24, progress note identified discharge to the U of M for a couple weeks with no bed hold wanted.	21630		

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21630	Continued From page 36 R55's 8/27/24, Physician Order Report identified morphine solution 20 mg/ml administer 0.5 ml every hour as needed for adult failure to thrive. Morphine solution 20 mg/ml administer 0.75 ml every hour as needed for adult failure to thrive. Morphine solution 20 mg/ml administer 1 ml every hour as needed for adult failure to thrive. R55's 8/27/24, progress note identified resident expired at 7:15 a.m., Hospice was notified and family. Observation and interview on 9/10/24 at 2:40 p.m., of the east medication cart narcotic count between LPN-B and LPN-C. During the controlled substance count it was identified that R52 had 5 Fentanyl 25 mcg/hr patches and 9 hydrocodone/APAP 5/325 mg. Staff reported those medications had been discontinued. R16 had 15 oxycodone 5 mg tables, 3 punch cards of hydrocodone/APAP 5/325 mg tablets totaling 86 tablets, and morphine solution 100 mg/5 ml with 18.5 ml remaining. Staff reported that R16 passed away on 9/8/24. LPN-B confirmed that the nurse should be removing the discontinued medications out of the medication cart as soon as possible and destroying. The controlled medications require 2 licensed staff to destroy and with the staffing challenges it has been really hard to get the medication destroyed. LPN-C further confirmed as licensed nurses when someone passes away or discharges the medications should be removed from the medication cart and destroyed. R52's 9/6/24, Physician's Orders identified an order to discontinue Fentanyl patch and start morphine SR 30 mg PO twice a day as needed for break through pain.	21630		

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21630	Continued From page 37 R52's 9/9/24, Physician's Orders identified an order to discontinue Norco. R16's 9/8/24, Physician Order Report identified morphine concentrate 100 mg/5 ml administer 0.5 ml every hour as needed for severe pain or shortness of breath. Physician order report had no mention of Oxycodone 5 mg or hydrocodone 5/325 mg. R16's 7/23/24, label on the Individual Narcotic Record sheet identified hydrocodone/APAP 5 mg/325 mg every 6 hours as needed for severe pain. R16's 9/4/24, individual narcotic record sheet identified oxycodone 5 mg every 6 hours as needed for moderate pain or severe pain. R16's 9/8/24, progress note identified resident passed away at 5:10 p.m., family and hospice notified. Interview on 9/10/24 at 2:48 p.m., with RN-B confirmed discontinued medications should not be kept in with active medications and should be removed and destroyed right away. Interview on 9/10/24 at 2:50 p.m., with director of nursing identified she had not had time to review the medication destruction policy but confirmed that discontinued medications should not be kept in the cart co-mingled with other active medication very long. Review of the 5/26/21, Medication Destruction/Disposal policy identified medication would be destroyed and disposed of in a timely manner that complies with both federal and state guidelines in addition to guidelines set by the Board of Pharmacy and recommended by the pharmacist.	21630		

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21630	Continued From page 38 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21630		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every	21880		10/11/24

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21880	Continued From page 39 facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 grievance policy and procedures were followed. The facility failed to post the grievance policy prominently and throughout the facility and provide forms to submit a grievance anonymously if desired. In addition, the facility also failed to document all grievances, the action taken to resolve grievances and the summary of the resolution to each grievance. This had the ability to affect all 54 residents. Findings include: Interview on 9/9/24 at 12:09 p.m., with R39 who	21880	Corrected.	

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21880	Continued From page 40 reported that he must wait for someone to come help him. He likes to get up around 7:30 a.m., and no one came to help him until 9:00 a.m. and he was so mad he could have "burnt the place up". Interview on 9/9/24 at 1:27 p.m. with R9 who reported the staff are good when they have time. The staff try however, this morning she had put her call light on to get up and had to wait 2 hours before someone came to help her and that is not unusual. Interview on 9/11/24 at 2:43 p.m., with R48's family member identified she had complained about long call light wait times however, nothing had ever occurred related to long wait time. Review of the grievances for the last year provided was a word document that listed dates and concerns and included identified long call light wait times reported on 9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24. Only follow up documentation was on 12/13/23, as the concern identified resident was currently in quarantine due to COVID-19 and family was educated on infection control process and the call light review found that the call light had not been turned on. All other grievances related to long call light times had no action taken or resolution identified. The surveyor requested the investigation and resolution of the reported long call light wait time concerns with no further documentation provided. Interview on 9/11/24 at 1:39 p.m., with licensed social worker (LSW)-A who identified she was unsure of who all the grievances were for the dates that had been requested (9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24,	21880		

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21880	Continued From page 41 4/10/24, 4/11/24, and 8/7/24) however, she was able to figure out some of the residents. She reported the call lights go through the call phone and staff report they do not have enough call phones. She further reported she had no formal grievances it was just residents telling her and she would make a note on the word document that she had provided. She confirmed that she did not fill out a grievance form. Upon admission the facility reviews how to make a grievance and provided a copy of the grievance policy. She revealed there was no form for the residents or families to utilize to make a grievance. She reported families will make concerns known by email or just tell her. She identified the process was for the resident and/or family to go to the source first, if not resolved they could come to her or the administrator, and if still not resolved they may be referred to the ombudsman or to make a state report. Interview on 9/11/24 at 2:07 p.m., with R53 who was unsure how to report a complaint. R53 reported she would just tell her son and contact the attorney downtown. Interview on 9/11/24 at 2:12 p.m., with R5 who identified he did not know what to do or who to tell if he had a complaint or concern. Interview on 9/11/24 at 2:13 with R20 who identified she would not tell anyone if she had a complaint as she did not want to "Russell" up the place. She identified she would tell her family and they would tell her to just keep it to yourself. She reported she did not want to "ruffle any feathers" so she does not complain. Interview on 9/11/24 at 2:19 with R9 who identified she reports to registered nurse (RN)-C	21880		

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21880	Continued From page 42 or the social worker if she has any concerns. She also revealed that other residents will come to her and ask her to report as they do not want to bother the staff. Interview on 9/11/24 at 2:39 p.m., with FM-F reported they were unsure how to make a complaint no one had ever explained that to them. Interview on 9/11/24 at 2:43 p.m., with family member (FM)-E was not sure of a policy or process but would tell the nurse working if had a concern. Review of the blank September 2023, Grievance Form identified the following area's to be documented on: 1) Resident name 2) Date and time of concern 3) Details of concern 4) Statement of witness regarding concern 5) List any contributing factors 6) What immediate action was taken place upon learning of the concern 7) Actions taken 8) Comment or recommendation 9) Signature of individual completing the form There were following pages of the form, that included a place to document by the grievance officer if concern was reportable, the type of concern it was, a place to document investigation findings and summary of investigation. A page to document the resolution or action taken to resolve the grievance, the time and date the resident and/or representative was notified of the resolution, a place to document if the physician was notified of resolution, ombudsman if applicable, the director of nursing and the administrator.	21880		

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21880	Continued From page 43 Interview on 9/11/24 at 4:34 p.m., with director of nursing (DON) identified grievance were handled by the social worker. All grievances should be documented and kept for records. She agreed there should be forms available for residents, families, or staff to assist residents with if they have a complaint, and for anonymous grievances also. The DON stated there needed to be improvement in this area for sure. Interview on 9/12/24 at 8:47 a.m., with administrator identified any time a grievance comes forward it was reported to LSW-A, the DON, or himself. All grievances were overseen by the social worker and reviewed at the daily interdisciplinary team meeting (IDT). He reported during the IDT meeting we come up with an action plan and then the social worker would review that with the resident and family. He reported the facility also reviewed grievances during the QAPI meeting. He would expect that the policy would be followed, and the facility would utilize the forms available to document grievances on. He further agreed that the grievance forms should be available for residents, staff, and representatives to fill out or make an anonymous complaint and kept for records for a minimum of 3 years. He was unaware the facility grievance forms had not been utilized for documenting grievances. Review of the September 2023, Grievance policy and procedure identified the facility encourage residents and/or representatives to communicate grievances verbally or in writing. The facility further, encouraged residents and/or representatives to first discuss their concern informally among themselves. If grievance was not resolved then the grievance should be	21880		

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21880	Continued From page 44 brought to the attention of the grievance officer, the administrator or the designee for assistance to direct the resident or representative to the proper department for resolution. If a resolution has not occurred, the grievance shall be reduced to written form and the grievance officer, administrator or designee would address as soon as possible but no later than five working days when possible. If resident or representative was not satisfied with the decision of the grievance officer, administrator or designee they may contact the Office of Ombudsman or Office of Health Facility Complaints. The policy indicated that the grievance officer would keep on file paper or electronic written grievance documents for 3 years. The policy had no mention that the facility would document grievances, the action taken to resolve the grievance and the summary of the resolution. The policy further had no mention that the policy would be posted throughout the facility and residents or representatives could make anonymous grievances if desired. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to grievances to ensure grievances are acted upon, residents notified and given tools on how and where to submit grievances, and the residents affected given a resolution to the identified grievance. The director of nursing, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure grievances are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs.	21880		

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21880	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	21980		10/11/24

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21980	Continued From page 46 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a fall with injury and potential neglect was reported to the State Agency (SA) for 1 of 3 residents (R11) reviewed for falls. Findings include: R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure. R11's fall report indicated on 8/29/24, R11 had a fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation. In review of Facility Reported Incidents (FRI), it	21980	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00062	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 47 was not evident R11's fall was reported to the State Agency. R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples. R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29. Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff "don't want to switch to the Hoyer [total lift]". R11's annual Minimum Data Set (MDS) dated 7/15/24, identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand related to a recent fall.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

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21980	Continued From page 48 Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. R11's Fall Risk Assessment dated 7/9/24, indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to perform that function. An option for "required the use of assistive devices such as a cane, walker or wheelchair" was left blank. During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell. NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts. During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

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21980	Continued From page 49 sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the verbal reminder to follow care sheet. Her expectation was that all staff would be educated on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being "unpredictable" in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management. During an interview on 9/12/24 at 8:13 a.m., with the administrator identified his expectation was that all staff including agency staff, would have been trained to follow care sheets and care plans and would have followed the care sheets and care plan for R11. Further stated he expected the facility would have reported R11's fall to the SA per facility policy. Review of a facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00062	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 50 of Resident Property revised 7/24, identified Neglect was defined as a failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Further identified it was the facility's policy to report and suspected Abuse, Neglect, Exploitation, Mistreatment, or Misappropriation of Resident Property immediately. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	**1109 EAST HIGHWAY 7** **MONTEVIDEO, MN 56265**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An annual Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/10/2024. At the time of this survey, Luther Haven was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/04/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Luther Haven is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1974, an addition was added that was determined to be of Type II(000) construction. The most recent addition was constructed in 1992 and was determined to be of Type II(000) construction. Because the original building and the two additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system that is monitored for automatic	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 fire department notification. The facility has a capacity of 70 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		10/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 3 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors to hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 7.2.1.15, and 7.2.1.15.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 09/10/2024 between 9:15 and 11:45 AM, it was revealed by observation that the doors to the following hazardous areas did not close and latch properly: Basement Old Generator Room, and Basement Laundry Storage Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 321	This deficient practice had the potential to affect all residents residing in the facility. A medical gas training was compiled to be used for new hire and annual training for employees. A video and power point will be used to train employees, and they will be required to sign an acknowledgement form as part of attendance. This training will be reviewed with new hires during their orientation and annually with employees during annual training/re-education. The Administrator or designee will be responsible for corrective actions and monitoring of compliance. Substantial compliance will be October 11, 2024.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are	K 923		10/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 4 separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of gas cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have an isolated impact on residents within the facliity. Findings include: On 09/10/2024 between 9:15 and 11:45 AM, it was revealed by observation that empty and full oxygen cylinders were stored in the oxygen	K 923	This deficient practice had the potential to affect all residents residing in the facility. The empty oxygen cylinders were separated from the full oxygen cylinders on 9/11/24. Training will be provided to staff regarding the requirements and safety of keeping full and empty cylinders separate. The Maintenance Director or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01** B. WING _____	**09/10/2024**

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K 923	Continued From page 5 storage room without being separated from each other. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	conduct weekly audits for 4 weeks to ensure full and empty tanks remain separated. Results of the audits will be brought to QAPI. Duration of audits will be determined by the QAPI committee. Next QAPI meeting will be 10/15/2024. The Maintenance Director or designee will be responsible for corrective actions and monitoring of compliance. Substantial compliance will be October 11, 2024.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 926	This deficient practice had the potential to affect all residents residing in the facility. A medical gas training was compiled to be used for new hire and annual training for employees. A video and power point will be used to train employees, and they will be required to sign an acknowledgement form as part of attendance.	10/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	**1109 EAST HIGHWAY 7** **MONTEVIDEO, MN 56265**

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K 926	Continued From page 6 On 09/10/2024, between 9:15 and 11:45 AM, it was revealed by review of available documentation and staff interview that the facility could not provide evidence of training provided to personnel on the application and maintenance of medical gases, and the potential risks associated with their handling and use. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 926	This training will be reviewed with new hires during their orientation and annually with employees during annual training/re-education. The Administrator or designee will be responsible for corrective actions and monitoring of compliance. Substantial compliance will be October 11, 2024.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245259	MULTIPLE CONSTRUCTION A. BUILDING: **01** B. WING _____	DATE SURVEY COMPLETE: **9/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	**1109 EAST HIGHWAY 7 MONTEVIDEO, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/10/2024 between 9:15 and 11:45 AM, it was revealed by observation and review of available documentation that the fire sprinkler system was missing the hydraulic design information sign. An interview with the Maintenance Director verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 30, 2024

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: September 12, 2024

Dear Administrator:

On September 25, 2024, we notified you a remedy was imposed. On October 28, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 28, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 10, 2024 be discontinued as of October 28, 2024. (42 CFR 488.417 (b))

In our letter of September 25, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 12, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

October 30, 2024

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: Event ID: 76ZZ13

Dear Administrator:

On October 28, 2024, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $300.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on October 28, 2024 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $300.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $133.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $433.00 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
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Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff