Electronically Delivered

March 21, 2024

Licensee
Luther Haven
801 13th Street North
Montevideo, MN 56265

RE: Project Number(s) SL30465015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30465	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH 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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30465015-0 On February 20, 2024, through February 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 19 residents, all received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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0 680	Continued From page 2 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 3 The findings include: During the initial tour on February 20, 2024, at 1:34 p.m., the facility's layout included one level with 20 apartments. There was no evidence of signage posted or information regarding the licensee's emergency plan. The licensee's EP plan included a multiple page flip chart named "Disaster Preparedness Plan" dated June 2023. The disaster preparedness plan contained header pages which included an introduction, nuclear emergency, natural disaster, bomb emergency, fire emergency, fire zone map, active shooter, tornado emergency, utility emergency procedure, elopement algorithm, elopement, EMAR off-line procedure, and evacuation procedure. In addition, the plan included an outdated, December 28, 2012, Hazard Vulnerability Analysis Tool (HVA). The licensee's plan did not include the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for EP cooperation and collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to	0 680		

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0 680	Continued From page 4 preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On February 22, 2024, at 4:02 p.m., clinical nurse supervisor (CNS)-A stated the licensee had not fully developed and implemented the facility's emergency preparedness plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 5	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On February 21, 2024, at 1:10 p.m., survey staff toured the facility with maintenance manager (MM)-C. During the facility tour, survey staff observed and verified that the fire rated doors for the kitchen, housekeeping, laundry rooms, resident rooms 123, 124, 125, 126, 131, 132, 133, 134,137,138,140,141 and 142 were propped	0 800		

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0 800	Continued From page 6 open with a door wedge. MM-C verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 7 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on February 21, 2024, at 1:45 p.m. with maintenance manager (MM)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the evacuation plan did not include employee actions to be taken in the event of a fire or similar emergency. The current plan uses the	0 810		

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0 810	Continued From page 8 RACE acronym which is very basic and does not show the employees actions in the event of a fire or similar emergency. Record review of the available documentation indicated that the evacuation plan did not include complete procedures for residents' evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan uses the RACE acronym which is very basic and does not show the residents actions in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed evacuation drills being done every six months. During interview, MM-C verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be	01290		

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01290	Continued From page 9 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on November 1, 2016, to provide direct care and services to the facility's residents. On February 21, 2024, at 7:50 a.m., the surveyor observed ULP-B apply R2's compression socks. ULP-B's employee record contained a background study affiliated with another license owned by the same owner dated November 3,	01290		

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01290	Continued From page 10 2016. ULP-B's employee record lacked evidence the licensee affiliated a background study for their current license. On February 20, 2024, at 3:43 p.m., human resources (HR)-D stated ULP-B's background study was not affiliated with the assisted living license. HR-D stated there was some confusion with the changing of licensure, and there was no follow through. This would be the same for all the staff that were employed before August 1, 2021. The licensee's Personnel Records policy, dated July 23, 2019, indicated the personnel record would include documentation of a completed background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 11 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included congestive heart failure. On February 21, 2024, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-B apply	01650		

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01650	Continued From page 12 R2's compression socks. R2's service plan, dated January 23, 2024, indicated services included medication administration, bathing, dressing, grooming, toileting, and compression socks. R3 R3's diagnoses included brain cancer. On February 21, 2024, at 7:58 a.m., the surveyor observed ULP-B administer oral medications to R3. R3's service plan, dated January 23, 2024, indicated services included medication administration, bathing, escorts, dressing and grooming assistance. R2 and R3's service plan lacked the following required content: - a description of the services to be provided; - the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; and - the methods of monitoring assessments of the resident; On February 21, 2024, at 2:43 p.m., clinical nurse supervisor (CNS)-A stated R2 and R3's service plan did not include the information listed above. CNS-A stated the licensee had missed adding the information to the service plan. The licensee's Contents of a Service plan policy, dated November 13, 2014, indicated the service plan would include: - current home care services to be provided;	01650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH 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
01650	Continued From page 13 - frequency of each service; - the identification of the staff or categories of staff who will provide the services; and - methods of monitoring reviews or assessments of the client. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete in the resident's	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30465	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH 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
01910	Continued From page 14 record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 began receiving services on October 3, 2019, with diagnoses including dementia. R1's discharge summary dated February 12, 2024, identified R1 received services which included medication administration. R1 was discharged from the licensee on February 9, 2024. R1's record lacked a completed documentation of a disposition of medications upon discharge. On February 20, 2024, at 2:53 p.m. clinical nurse supervisor (CNS)-A stated the licensee did not complete a disposition of medications upon R1's discharge including medication strength, prescription number as applicable, to whom the medications were given, date of disposition and names of staff or other individuals involved in the disposition. CNS-A stated she forgot to document the disposition of medications upon discharge.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30465	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH 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
01910	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30465	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH MONTEVIDEO, MN 56265

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01940	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included congestive heart failure. On February 21, 2024, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-B apply R2's compression socks. R2's service plan, dated January 23, 2024, indicated services included medication administration, bathing, dressing, grooming, toileting, and compression socks. R2's Service plan/Treatment therapy Management Plan lacked the following content: -identification of the treatment or therapy that will be delegated to unlicensed personnel; and -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services. On February 22, 2024, at 11:34 a.m., clinical	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30465	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH 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
01940	Continued From page 17 nurse supervisor (CNS)-A stated the service and treatment management plan was incomplete and lacked the above listed required content. The licensee's Individualized Treatment or Therapy Management Plan policy, dated November 14, 2014, indicated the RN must develop and maintain a current individualized treatment and therapy management for each tenant which must include the specific content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written prescriber order for a treatment was obtained for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30465	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH 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
01970	Continued From page 18 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on January 10, 2024, and began receiving assisted living services. R2's diagnoses included congestive heart failure. R2's service plan, dated January 23, 2024, indicated services included medication administration, bathing, dressing, grooming, toileting, and compression socks. On February 21, 2024, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-B apply R2's compression socks. R2's record lacked a prescriber order for R2's compression socks. On February 22, 2024, at 2:08 p.m., clinical nurse supervisor (CNS)-A stated the treatment order for compression socks was missing from R2's file and would obtain an order from the provider. The licensee's Individualized Treatment or Therapy Management Plan policy, dated November 19, 2014, indicated there must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. No further information provided.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30465	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	801 13TH STREET NORTH 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
01970	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls
218-332-5150

Type: Full
Date: *02/20/24*
Time: 12:00:00
Report: 1049241042

Food and Beverage Establishment Inspection Report

Location:
Copper Glen
801 13th Street North
Montevideo, MN56265
Chippewa County, 12

Establishment Info:
ID #: 0038982
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202699668
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OPENED MILK LABELED WITH A COMMERCIAL EXPIRATION DATE OF 2/18 WAS IN THE UPRIGHT COOLER. THE PIC DISCARDED THE EXPIRED MILK DURING THE INSPECTION. VIOLATION CORRECTED ON SITE.

Corrected on Site

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

THE ESTABLISHMENT'S DISH MACHINE IS NON-DETECT FOR CHLORINE SANITIZER. ESTABLISHMENT WILL USE PAPER PLATES UNTIL THE DISH MACHINE IS REPAIRED.

Comply By: 02/23/24

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

THE OPENED MILK IN THE UPRIGHT COOLER WAS NOT LABELED WITH A DATE TO INDICATE WHEN THE FOOD MUST BE CONSUMED BY OR DISCARDED. PIC INSTRUCTED TO DATE MARK OPENED TCS FOODS.

Comply By: 02/23/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

THE POSTED CFPM CERTIFICATE IS EXPIRED. AN EMPLOYEE HAS COMPLETED A FOOD SAFETY COURSE. PIC IS INSTRUCTED TO SUBMIT THE INITIAL APPLICATION TO THE STATE TO RECEIVE THE CFPM CERTIFICATE. APPLICATION PROVIDED VIA EMAIL.

Comply By: 02/23/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE KITCHEN DISH MACHINE IS NON-DETECT FOR CHLORINE SANITIZER. PIC IS INSTRUCTED TO REPAIR THE DISH MACHINE ACCORDINGLY.

Comply By: 02/23/24

Surface and Equipment Sanitizers

Chlorine: = 0 ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: Yes

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Sanitizer Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 162 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 190 Degrees Fahrenheit - Location: Hash Brown Casserole
Violation Issued: No

Process/Item: Hot Holding
Temperature: 181 Degrees Fahrenheit - Location: Mashed Potatoes
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 14.5 Degrees Fahrenheit - Location: Orange Juice
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 20 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Type: Full
Date: *02/20/24*
Time: 12:00:00
Report: 1049241042
Copper Glen

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 21.5 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	2

MET WITH MDH NURSE SURVEYOR JENN PANITZKE AND ESTABLISHMENT REPRESENTATIVE.

KITCHEN HAS LINOLEUM FLOORING, WOOD CABINETS, LAMINATE COUNTERTOPS AND SMOOTH DROP DOWN CEILING PANELS.

THE DISH MACHINE WAS NON-DETECT FOR CHORINE SANITIZER. ESTABLISHMENT WAS INSTRUCTED TO REPAIR THE DISH MACHINE ACCORDINGLY. THE ESTABLISHMENT WILL USE PAPER PLATES UNTIL THE DISH MACHINE IS REPAIRED.

A FOLLOW-UP INSPECTION WILL BE SCHEDULED AFTER THE DISH MACHINE IS REPAIRED.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Full
Date: *02/20/24*
Time: 12:00:00
Report: 1049241042
Copper Glen

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1049241042 of 02/20/24.

Certified Food Protection Manager: NEED

Certification Number: _____ Expires: / /

Signed: _____
Establishment Representative

Signed: *Stephanie Reynolds*
Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us

Report #: 1049241042

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls

No. of RF/PHI Categories Out	3
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/20/24
Time In 12:00:00
Time Out

	Address	City/State	Zip Code	Telephone
Copper Glen	801 13th Street North	Montevideo, MN	56265	3202699668

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038982		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT N/A	Certified food protection manager, duties	
Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting	
4	IN OUT	Proper use of reporting, restriction & exclusion	
5	IN OUT	Procedures for responding to vomiting & diarrheal events	
Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use	
7	IN OUT N/O	No discharge from eyes, nose, & mouth	
Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed	
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed	
10	IN OUT	Adequate handwashing sinks supplied/accessible	
Approved Source			
11	IN OUT	Food obtained from approved source	
12	IN OUT N/A N/O	Food received at proper temperature	
13	IN OUT	Food in good condition, safe, & unadulterated	
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction	
Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized	
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food	

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature	
19	IN OUT N/A N/O	Proper reheating procedures for hot holding	
20	IN OUT N/A N/O	Proper cooling time & temperature	
21	IN OUT N/A N/O	Proper hot holding temperatures	
22	IN OUT N/A	Proper cold holding temperatures	
23	IN OUT N/A N/O	Proper date marking & disposition	
24	IN OUT N/A N/O	Time as a public health control: procedures & records	
Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food	
Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered	
Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used	
28	IN OUT	Toxic substances properly identified, stored, & used	
Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP	

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/23/24

Inspector (Signature) Stephanie Reynolds