DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: Reinspection Results
Event ID: IZ8M12

Dear Administrator:

On February 4, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 13, 2025. At this time these correction orders were found corrected.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: January 13, 2025

Dear Administrator:

On January 24, 2025, we notified you a remedy was imposed. On February 4, 2025 the Minnesota Department of Health 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 January 28, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 8, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 24, 2025, 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 February 8, 2025. 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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
January 24, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: January 13, 2025

Dear Administrator:

On January 13, 2025, 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 January 10, 2025, 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 February 8, 2025.

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 February 8, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 8, 2025, (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 January 13, 2025. 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 January 13, 2025. 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 July 13, 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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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
January 24, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: State Nursing Home Licensing Orders
Event ID: IZ8M11

Dear Administrator:

The above facility was surveyed on January 8, 2025 through January 13, 2025 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 01/13/2025

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
F 000	INITIAL COMMENTS On 1/8/25, 1/9/25, and 1/13/25, a standard abbreviated 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 (F689) began on 12/28/24, when the facility failed to complete a timely comprehensive elopement risk assessment that addressed window type as a possible exit for mobile which resulted in R1 eloping through a window. The administrator, and interim director of nursing (IDON) were notified of the IJ on 1/9/25 at 4:40 p.m. The IJ was removed on 1/10/25. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 1/13/25. The following complaints were reviewed: H52593703C (MN00109606) with a deficiency cited at (F689). 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/2025

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 _____ B. WING _____	C 01/13/2025

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

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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
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 complete a timely comprehensive elopement risk assessment that addressed window type as a possible exit for mobile residents who were at risk for elopement for 1 of 3 residents (R1) who had a history of exit seeking. This resulted in immediate jeopardy (IJ) when R1 eloped from a window in her room and was found ½ mile from the facility approximately an hour later by the police and family member. The immediate jeopardy began on 12/28/24, when R1 eloped from the facility by exiting through the window in her room and was found an hour later 1/2 mile from the facility. The immediate jeopardy was identified on 1/9/25, and the assistant administrator was notified on 1/9/25, at 4:40 p.m. The immediate jeopardy was removed on 1/10/25, but noncompliance remained a lower scope and severity of a D with no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 689	Resident R1 has been reassessed for their elopement risk to elope through a window. Their care plan was reviewed and updated to assist in the prevention of elopement. In addition, window cranks were removed from their windows to prevent them from being able to open without supervision. This was completed on 1/10/2025. The remaining residents identified as elopement risks had a new comprehensive assessment completed and were assessed for their risk of eloping through a window. This was completed on 1/9/2025 and 1/10/2025. New admissions from 12/23/2024 through 1/9/2025 have also been assessed for their elopement risk and for their risk of eloping through a window. The facility elopement policy has been	1/28/25

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

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F 689	Continued From page 2 Finding include: R1's Face Sheet dated 1/8/25, indicated R1 had diagnoses of encephalopathy (disease of the brain that causes altered mental state and confusion), hallucinations, tremors, and insomnia (inability to sleep). R1's hospital Discharge Summary dated 12/23/24, identified R1 did attempt to elope from the hospital during her stay. The report also noted that upon discharge to the nursing home, R1 was exhibiting signs of paranoia and not wanting to go to the facility. R1's admission minimum data set (MDS) dated 12/29/24, identified R1 was admitted to the facility on 12/23/24, had moderate cognitive impairment with delusions. The MDS further indicated R1 had a history of wandering. R1 required supervision with walking but was independent with transferring and bed mobility. R1's progress noted dated 12/28/24 at 3:48 a.m., noted nursing assistant (NA)-B redirected R1 back to her room but was very difficult to redirect and had been restless most of the night. At 3:00 a.m. NA-B noted a cold breeze coming from R1's bedroom door and upon entering R1's room, noted R1 was not in the room, the window was open, and the screen was off the window. The administrator and law enforcement were notified. A Police Department Incident Report dated 12/28/24, indicated the police department received a report on 12/28/24 at 3:23 a.m. that R1 had left the facility through a window. R1 was located with a law enforcement drone and transported by ambulance to the ED to be	F 689	updated to include assessing all residents on the elopement risk list after an elopement occurs. The policy was also updated to include assessing the day of admission or re-admission, change of condition, or as needed. The facility elopement assessment was updated to include a window mobility section. Education was provided to staff beginning on 1/10/2025. Education included: residents who are at risk for eloping, education on window cranks, and how to identify possible elopement hazards, opportunities, or risks. The facility nursing assistant orientation checklist and agency staff orientation checklist have been updated to include where to find the pictures of the elopement risk residents and information regarding window cranks. The facility will be completing an elopement observation audit weekly for four weeks, then bi-weekly for four weeks, and monthly thereafter. Audit results will be brought to QAPI for review. Audits will be completed by DON or designee. Next QAPI is 2/11/2025.	

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 01/13/2025

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

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F 689	Continued From page 3 evaluated after being in the elements for about an hour. R1's ED Provider Note dated 12/28/24 at 4:19 a.m., indicated R1 arrived at the ED with agitation, confusion, hallucinations, limited exposure to the cold, and evidence of falling onto her knees. R1's Baseline Care Plan dated 12/23/24, did not include wandering or elopement risks with individualized intervention to prevent/mitigate risk for elopement. The care plan identified R1 was admitted with weakness and confusion, disoriented to time and place along with communication was clear. She understood along with at times understanding others. She required supervision with transferring walking throughout the facility, used a walker, and needed staff assistance with toileting and dressing. R1's record reviewed between 12/23/24 through 12/27/24, had not identified risk for elopement even though the hospital discharge summary dated 12/23/24 identified R1 attempted to elope from the hospital. The MDS also identified R1 had a history of wandering. There was no indication the facility had completed a comprehensive risk assessment for elopement/wandering. R1's progress note dated 12/23/24 at 10:46 p.m., noted R1 wanted to go home and was not accepting staff's redirection, wandered into other resident's rooms, and was aggressive with staff. Staff placed a wander guard bracelet on R1's left wrist and increased staff supervision. R1's progress note dated 12/24/24 at 9:28 p.m.,	F 689		

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	245259	A. BUILDING _____ B. WING _____	C 01/13/2025

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F 689	Continued From page 4 noted R1 had cut the wander guard off and threw it in the garbage. No extra wander guards were available so R1 was placed on hourly checks. R1's baseline care plan was not revised to include hourly checks. R1's progress note dated 12/25/24 at 11:32 p.m., noted R1 was found in another resident's bathroom with no wander guard on. R1 was also noted to be impulsive, hard to redirect, trying to open the exit doors and wandering the hallways. R1 had a coat, shoes, and head band and told staff she was going for a walk. Staff placed a new wander guard bracelet on R1 at 6:30 p.m. R1's progress note dated 12/26/24 at 12:52 p.m., noted staff found R1 with some of her belongings wanted to leave and was redirected by staff. R1's progress noted dated 12/26/24 at 9:01 p.m., noted R1 presented at the nursing station, requested to go home, and staff redirected R1 back to her room. R1's progress note dated 12/28/24 at 1:29 a.m., noted R1 was restless and wandering in and out of her room. R1 was given Melatonin (a sleep aide). During an interview on 1/9/25 at 12:20 p.m., NA-A indicated she worked the 10 p.m.-6 a.m. shift on 12/27/24, and R1 was "very exit seeking" from 10:00 p.m. to 2:00 a.m. Further indicated R1 wanted to go to the store, wanted her family to pick her up, and needed constant redirection but the redirection was not working. NA-A then identified her co-worker (NA-B) toileted R1 at 2:30 a.m. and encouraged R1 to lay down in bed. At 3:15 a.m., NA-A noticed R1's door was closed	F 689		

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F 689	Continued From page 5 so opened it but could not find R1, then noticed the room was cold, the right crank window was open, and the screen was pushed out. NA-A immediately told the charge nurse and started searching for R1. During an interview on 1/9/25 at 12:45 p.m., NA-B indicated she worked the 10pm-6am shift on 12/27/24, R1 was wanting to leave, was getting more "antsy", and was not responding to redirection. NA-B requested a Melatonin for R1 at 1:00 a.m. and redirected R1 back to her room "at least a couple more times". NA-B convinced R1 to lay down in bed at 2:30 a.m. but R1 insisted on staying in her clothes and had a pair of shoes by her. NA-B was in another resident room about 3:15 a.m. and heard other staff yelling for R1 and she helped search for her. NA-B indicated the facility protocol was to check on every resident every hour at night. During an interview on 1/8/25 at 3:15 p.m., registered nurse (RN)-A indicated she began her work shift at 2:00 a.m. on 12/28/24 and was aware R1 was an elopement risk. RN-A observed R1 in the recliner in her room at 2:00 a.m. and was notified at approximately 3:15 a.m. R1 had eloped out of the window in her room. RN-A immediately contacted the administrator and implemented the elopement policy. During an interview on 1/8/25 at 2:50 p.m., family member (FM)-A indicated she was notified on 12/28/24 during the early morning hours that R1 had "gotten out of a window" at the facility and went out to look for her. FM-A found R1 walking through the Subway sandwich parking lot wearing jeans, slippers, short sleeve shirt, and a sweatshirt coat. FM-A noted R1 "wrapped in	F 689		

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F 689	Continued From page 6 herself, shivering" and got her into the vehicle further identifying R1 appeared "cold but not freezing". R1 had mud on both knees of her jeans and told FM-A that she had "crawled across the highway". FM-A indicated she had accompanied R1 to the ED. R1 was "really confused" and had a couple of bruises on her knees but no other noted injuries. During an interview on 1/8/25 at 3:45 p.m., the social worker (SW) reported she completes the elopement risk assessments on the residents upon admission but completes them within the assessment reference date (ARD) with the MDS and not always the first admission day. The SW indicated upon admission, R1 did not appear to be an elopement risk as there was not a history of wandering or elopement. R1's Elopement Risk Observation on 12/30/24 (two days after R1's elopement), indicated reason for R1's admission was dementia care and cognition was severely impaired. Further identified R1 was independent with mobility and was at risk for elopement due to the following risk factors: elopement success in the past, removing device, verbalizing statements about leaving, changes in medications, history of leaving facility, recent move to the facility, wandering in the past 60 days, depression, hallucinations, and other symptoms and signs involving cognitive functions and awareness. Interventions included: activities, door alarm band (wander guard), photograph posted, physician update, redirection, frequent checks, med changes, and window cranks removed from windows (R1s). Observations of the facility on 1/8/25 and 1/9/25 at various times throughout both days, revealed	F 689		

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F 689	Continued From page 7 handle cranks on common area windows. Although the elopement risk assessment identified the cranks were removed from R1's windows, it did not identify the risk and interventions for other windows in the facility that R1 would have access to. An observation and interview 1/9/25 at 10:25 a.m., the administrator took the screen off in R1's room and measured the crank window opening to reveal a 16-17 inch wide opening and the bottom sill to be approximately 32 inches to the ground. The administrator verified the windows were all the same operationally and size throughout the facility. Administrator indicated he had not considered evaluating other residents at risk for elopment that had the physical abillity to exit through a window as part of their assessment. During a follow up interview on 1/9/25 at 10:40 a.m., SW indicated the facility was aware the windows were a way to elope from the facility because a resident who no longer resided at there had eloped out of windows "several times." Further indicated, the other residents that were at risk for elopement and new admission residents were not assessed for their ability to elope out the windows. During observation and interview on 1/8/25 at 2:50p.m., R1's windows were without the cranks. R1 was sitting in recliner, mumbling, and difficult to understand. R1 declined interview and stated she was "not doing good". During a follow up interview on 1/9/25 at 4:10 p.m., R1 was sitting in the recliner in her room with legs over the side of the arms of the chair. R1 stated she was adjusting to staying at the facility because she had no choice and that her biggest problem was	F 689		

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F 689	Continued From page 8 that she loved to be outdoors even in the coldest weather. R1 loved to go for walks, get fresh air, and go to the store which no one at the facility would allow her to do. R1 then indicated she was upset because of her stroke, dementia, and the need to stay in the facility. R1 did not mention the elopement from the facility. The facilities undated Admission Assessment Form indicates Elopement Risk Assessment was completed on admission day and then reviewed quarterly, annually, and significant change. The facility policy titled Elopement dated 12/28/24, indicated the purpose was to ensure the safety of all residents, protect any residents who are at risk for elopement, and to provide staff an organized plan for searching for an eloped resident. Procedure was to attempt to prevent departure, obtain assistance and detailed steps to take following an elopement but did not address prevention of elopement. The immediate jeopardy that began on 12/28/24, and removed on 1/10/25 and was verified through observation, interview, and document review, when the facility implemented the following interventions: -Updated the Elopement Risk Assessment tool to include assessment of physical ability to elope from the windows. -Updated the Facility Elopement policy to include to complete the elopement assessment the day of admission, readmission, change of condition, or as needed. -Removed all window cranks in common areas. -Reassessed all residents at risk for elopement for their physical ability to elope out the windows.	F 689		

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F 689	Continued From page 9 -Reviewed elopement policy and educated staff on recognizing elopement hazards, opportunities, window cranks all interventions	F 689		

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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 1/8/25, 1/9/25, and 1/13/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed: H52593703C (MN00109606), NO licensing	2 000		

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2 000	Continued From page 1 orders were issued. 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		
2 830	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete a timely comprehensive elopement risk assessment that addressed window type as a possible exit for mobile residents who were at risk for elopement for 1 of 3 residents (R1) who had a history of exit seeking. This resulted in immediate jeopardy (IJ)	2 830	Corrected.	1/28/25

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2 830	Continued From page 2 when R1 eloped from a window in her room and was found ½ mile from the facility approximately an hour later by the police and family member. The immediate jeopardy began on 12/28/24, when R1 eloped from the facility by exiting through the window in her room and was found an hour later 1/2 mile from the facility. The immediate jeopardy was identified on 1/9/25, and the assistant administrator was notified on 1/9/25, at 4:40 p.m. The immediate jeopardy was removed on 1/10/25, but noncompliance remained a lower scope and severity of a D with no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding include: R1's Face Sheet dated 1/8/25, indicated R1 had diagnoses of encephalopathy (disease of the brain that causes altered mental state and confusion), hallucinations, tremors, and insomnia (inability to sleep). R1's hospital Discharge Summary dated 12/23/24, identified R1 did attempt to elope from the hospital during her stay. The report also noted that upon discharge to the nursing home, R1 was exhibiting signs of paranoia and not wanting to go to the facility. R1's admission minimum data set (MDS) dated 12/29/24, identified R1 was admitted to the facility on 12/23/24, had moderate cognitive impairment with delusions. The MDS further indicated R1 had a history of wandering. R1 required supervision with walking but was independent with transferring and bed mobility. R1's progress noted dated 12/28/24 at 3:48 a.m.,	2 830		

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2 830	Continued From page 3 noted nursing assistant (NA)-B redirected R1 back to her room but was very difficult to redirect and had been restless most of the night. At 3:00 a.m. NA-B noted a cold breeze coming from R1's bedroom door and upon entering R1's room, noted R1 was not in the room, the window was open, and the screen was off the window. The administrator and law enforcement were notified. A Police Department Incident Report dated 12/28/24, indicated the police department received a report on 12/28/24 at 3:23 a.m. that R1 had left the facility through a window. R1 was located with a law enforcement drone and transported by ambulance to the ED to be evaluated after being in the elements for about an hour. R1's ED Provider Note dated 12/28/24 at 4:19 a.m., indicated R1 arrived at the ED with agitation, confusion, hallucinations, limited exposure to the cold, and evidence of falling onto her knees. R1's Baseline Care Plan dated 12/23/24, did not include wandering or elopement risks with individualized intervention to prevent/mitigate risk for elopement. The care plan identified R1 was admitted with weakness and confusion, disoriented to time and place along with communication was clear. She understood along with at times understanding others. She required supervision with transferring walking throughout the facility, used a walker, and needed staff assistance with toileting and dressing. R1's record reviewed between 12/23/24 through 12/27/24, had not identified risk for elopement even though the hospital discharge summary dated 12/23/24 identified R1 attempted to elope	2 830		

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2 830	Continued From page 4 from the hospital. The MDS also identified R1 had a history of wandering. There was no indication the facility had completed a comprehensive risk assessment for elopement/wandering. R1's progress note dated 12/23/24 at 10:46 p.m., noted R1 wanted to go home and was not accepting staff's redirection, wandered into other resident's rooms, and was aggressive with staff. Staff placed a wander guard bracelet on R1's left wrist and increased staff supervision. R1's progress note dated 12/24/24 at 9:28 p.m., noted R1 had cut the wander guard off and threw it in the garbage. No extra wander guards were available so R1 was placed on hourly checks. R1's baseline care plan was not revised to include hourly checks. R1's progress note dated 12/25/24 at 11:32 p.m., noted R1 was found in another resident's bathroom with no wander guard on. R1 was also noted to be impulsive, hard to redirect, trying to open the exit doors and wandering the hallways. R1 had a coat, shoes, and head band and told staff she was going for a walk. Staff placed a new wander guard bracelet on R1 at 6:30 p.m. R1's progress note dated 12/26/24 at 12:52 p.m., noted staff found R1 with some of her belongings wanted to leave and was redirected by staff. R1's progress noted dated 12/26/24 at 9:01 p.m., noted R1 presented at the nursing station, requested to go home, and staff redirected R1 back to her room. R1's progress note dated 12/28/24 at 1:29 a.m., noted R1 was restless and wandering in and out	2 830		

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2 830	Continued From page 5 of her room. R1 was given Melatonin (a sleep aide). During an interview on 1/9/25 at 12:20 p.m., NA-A indicated she worked the 10 p.m.-6 a.m. shift on 12/27/24, and R1 was "very exit seeking" from 10:00 p.m. to 2:00 a.m. Further indicated R1 wanted to go to the store, wanted her family to pick her up, and needed constant redirection but the redirection was not working. NA-A then identified her co-worker (NA-B) toileted R1 at 2:30 a.m. and encouraged R1 to lay down in bed. At 3:15 a.m., NA-A noticed R1's door was closed so opened it but could not find R1, then noticed the room was cold, the right crank window was open, and the screen was pushed out. NA-A immediately told the charge nurse and started searching for R1. During an interview on 1/9/25 at 12:45 p.m., NA-B indicated she worked the 10pm-6am shift on 12/27/24, R1 was wanting to leave, was getting more "antsy", and was not responding to redirection. NA-B requested a Melatonin for R1 at 1:00 a.m. and redirected R1 back to her room "at least a couple more times". NA-B convinced R1 to lay down in bed at 2:30 a.m. but R1 insisted on staying in her clothes and had a pair of shoes by her. NA-B was in another resident room about 3:15 a.m. and heard other staff yelling for R1 and she helped search for her. NA-B indicated the facility protocol was to check on every resident every hour at night. During an interview on 1/8/25 at 3:15 p.m., registered nurse (RN)-A indicated she began her work shift at 2:00 a.m. on 12/28/24 and was aware R1 was an elopement risk. RN-A observed R1 in the recliner in her room at 2:00 a.m. and was notified at approximately 3:15 a.m.	2 830		

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2 830	Continued From page 6 R1 had eloped out of the window in her room. RN-A immediately contacted the administrator and implemented the elopement policy. During an interview on 1/8/25 at 2:50 p.m., family member (FM)-A indicated she was notified on 12/28/24 during the early morning hours that R1 had "gotten out of a window" at the facility and went out to look for her. FM-A found R1 walking through the Subway sandwich parking lot wearing jeans, slippers, short sleeve shirt, and a sweatshirt coat. FM-A noted R1 "wrapped in herself, shivering" and got her into the vehicle further identifying R1 appeared "cold but not freezing". R1 had mud on both knees of her jeans and told FM-A that she had "crawled across the highway". FM-A indicated she had accompanied R1 to the ED. R1 was "really confused" and had a couple of bruises on her knees but no other noted injuries. During an interview on 1/8/25 at 3:45 p.m., the social worker (SW) reported she completes the elopement risk assessments on the residents upon admission but completes them within the assessment reference date (ARD) with the MDS and not always the first admission day. The SW indicated upon admission, R1 did not appear to be an elopement risk as there was not a history of wandering or elopement. R1's Elopement Risk Observation on 12/30/24 (two days after R1's elopement), indicated reason for R1's admission was dementia care and cognition was severely impaired. Further identified R1 was independent with mobility and was at risk for elopement due to the following risk factors: elopement success in the past, removing device, verbalizing statements about leaving, changes in medications, history of leaving facility,	2 830		

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 _____	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 7 recent move to the facility, wandering in the past 60 days, depression, hallucinations, and other symptoms and signs involving cognitive functions and awareness. Interventions included: activities, door alarm band (wander guard), photograph posted, physician update, redirection, frequent checks, med changes, and window cranks removed from windows (R1s). Observations of the facility on 1/8/25 and 1/9/25 at various times throughout both days, revealed handle cranks on common area windows. Although the elopement risk assessment identified the cranks were removed from R1's windows, it did not identify the risk and interventions for other windows in the facility that R1 would have access to. An observation and interview 1/9/25 at 10:25 a.m., the administrator took the screen off in R1's room and measured the crank window opening to reveal a 16-17 inch wide opening and the bottom sill to be approximately 32 inches to the ground. The administrator verified the windows were all the same operationally and size throughout the facility. Administrator indicated he had not considered evaluating other residents at risk for elopment that had the physical abillity to exit through a window as part of their assessment. During a follow up interview on 1/9/25 at 10:40 a.m., SW indicated the facility was aware the windows were a way to elope from the facility because a resident who no longer resided at there had eloped out of windows "several times." Further indicated, the other residents that were at risk for elopement and new admission residents were not assessed for their ability to elope out the windows.	2 830		

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2 830	Continued From page 8 During observation and interview on 1/8/25 at 2:50p.m., R1's windows were without the cranks. R1 was sitting in recliner, mumbling, and difficult to understand. R1 declined interview and stated she was "not doing good". During a follow up interview on 1/9/25 at 4:10 p.m., R1 was sitting in the recliner in her room with legs over the side of the arms of the chair. R1 stated she was adjusting to staying at the facility because she had no choice and that her biggest problem was that she loved to be outdoors even in the coldest weather. R1 loved to go for walks, get fresh air, and go to the store which no one at the facility would allow her to do. R1 then indicated she was upset because of her stroke, dementia, and the need to stay in the facility. R1 did not mention the elopement from the facility. The facilities undated Admission Assessment Form indicates Elopement Risk Assessment was completed on admission day and then reviewed quarterly, annually, and significant change. The facility policy titled Elopement dated 12/28/24, indicated the purpose was to ensure the safety of all residents, protect any residents who are at risk for elopement, and to provide staff an organized plan for searching for an eloped resident. Procedure was to attempt to prevent departure, obtain assistance and detailed steps to take following an elopement but did not address prevention of elopement. The immediate jeopardy that began on 12/28/24, and removed on 1/10/25 and was verified through observation, interview, and document review, when the facility implemented the following interventions: -Updated the Elopement Risk Assessment tool to	2 830		

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2 830	Continued From page 9 include assessment of physical ability to elope from the windows. -Updated the Facility Elopement policy to include to complete the elopement assessment the day of admission, readmission, change of condition, or as needed. -Removed all window cranks in common areas. -Reassessed all residents at risk for elopement for their physical ability to elope out the windows. -Reviewed elopement policy and educated staff on recognizing elopement hazards, opportunities, window cranks all interventions SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to elopement assessment timelyness and environmental risk assessments.The DON or designee could also and ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopement. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		