



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 21, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: March 19, 2025

Dear Administrator:

On April 14, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 21, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: Reinspection Results
Event ID: PJNH12

Dear Administrator:

On April 14, 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 March 19, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: March 19, 2025

Dear Administrator:

On March 19, 2025, a survey was completed at your facility by the Minnesota Department of Health 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

Luther Haven

April 1, 2025

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the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 19, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 19, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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>

Luther Haven

April 1, 2025

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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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: State Nursing Home Licensing Orders
Event ID: PJNH11

Dear Administrator:

The above facility was surveyed on March 18, 2025 through March 19, 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.

Luther Haven

April 1, 2025

Page 2

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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245259		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2025	
NAME OF PROVIDER OR SUPPLIER LUTHER HAVEN				STREET ADDRESS, CITY, STATE, ZIP CODE 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 3/18/25 and 3/19/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52599181C (MN00111027), with an incidnetal deficiency cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F 000			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			F 880			4/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/07/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 880	Continued From page 1 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			F 880			

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F 880	Continued From page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate transmission based precautions used for 1 of 1 resident (R4) with diagnosis of Respiratory Syncytial Virus (RSV). Findings include: R4's quarterly Minimum Data Set (MDS) dated 2/28/25, indicated severe impaired cognition with diagnosis of dementia. R4's progress note dated 3/14/25 at 9:39 a.m., indicated R4 continued to have a runny nose and wet cough and complained of not feeling well. 4-plex (nasal swab allowing staff to quickly identify whether a person is infected with Influenza A, Influenza B, Respiratory syncytial virus (RSV), or COVID-19) and placed on precautions. R4's progress notes dated 3/14/25 at 11:12 a.m., indicated call from physician that R4 had RSV, and R4 was placed on droplet precautions.			F 880	The contact precaution sign was placed by the R4's room and additional gowns were placed in the PPE bin outside R4's room. This was completed on 3/18/25. R4's care sheet was updated as well. The Infection Preventionist (ICP) checked all other residents for signs and symptoms of transmittable disease to ensure TBP were in place or needed. ICP and Nurse Managers make daily rounds and review medication orders and lab orders. Information is entered into the infection control log and infection control map. Luther Haven follows CDC guidelines related to TBP. TBP policy and procedure were reviewed and revised. Luther Haven's policies related to Infection Prevention and Control were reviewed and revised to ensure that each policy contained all components of an infection control program to mitigate transmission of potential infections. The policies included: Antibiotic Stewardship Program;		

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F 880	Continued From page 3 During an observation on 3/18/25 at 12:36 p.m., R4's room door was open, and there was a droplet precaution sign outside door with a 3-drawer isolation bin with gloves, goggles, and face shields. During an observation on 3/18/25 at 1:16 p.m., R4 wheeled himself in wheelchair out into the hall without a mask on and moved towards the nurse's station. Nursing assistant (NA)-D returned R4 to room at 1:20 p.m. During an observation on 3/18/25 at 1:33 p.m., NA-D and NA-A entered R4's room with gloves, mask and goggles on. No gown was applied. During an observation and interview on 3/18/25 at 1:54 p.m., NA-D indicated R4 had RSV and staff were supposed to apply gloves, goggles and masks, but no gown. R4 continued to have a cough as well. During an interview on 3/18/25 at 1:59 p.m., licensed practical nurse (LPN)-H indicated for RSV staff should be wearing mask, goggles or face shield, gloves, and gown. LPN-H confirmed there were no gowns in the isolation cart outside of R4's room. During an interview on 3/18/25 at 2:01 p.m., infection control preventionist (ICP), indicated R4 had RSV and was to be on contact and droplet precautions. ICP further stated the center for disease control (CDC) sign posted outside R4's room was for only droplet precautions. ICP walked to R4's room and placed the contact precautions sign and gowns in the cart outside of R4's room.	F 880	Infection Control Surveillance; Standard Precautions; Transmission-Based Precautions (Contact, Droplet, Airborne); Enhanced Barrier Precautions; Prevention and Control of Seasonal Influenza; Prevention and Control of Pneumonia/Pneumococcal Infections. The reviewed and revised Infection Control policies have been presented to QAPI/QAA Committee on 4/8/25. All staff were educated on TBP and use of PPE. The ICP follows the CDC guidelines regarding TBP implementation. Staff education began on 3/18/25 as well as 4/8/25. Audits are completed 3x/week for month 1, 2x/week for month 2, and 1x/week for month 3. The audits will be completed across all shifts by the ICP or designee. The Administrator and/or DON will audit the timely implementation of TBP. These audits will be completed 1x/week for a month, bi-weekly for a month, and then monthly. Results of the infection control audits will be brought to QAPI/QAA for review and duration of the audits will be determined by our QAPI/QAA committee. Responsible Person(s): Administrator, Interim Director of Nursing, Infection Preventionist Date Certain: Friday, April 11, 2025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245259		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2025	
NAME OF PROVIDER OR SUPPLIER LUTHER HAVEN				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265			
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F 880	Continued From page 4 During an interview on 3/19/25 at 2:01 p.m., interim director of nursing (DON) stated it was her expectation staff follow the CDC guideline for all infection control measures. Review of undated facility policy titled, Isolation Precautions, indicated strict isolation may be utilized: A.a. when a resident is identified to have an active infection with a highly transmissible or epidemiologically significant pathogen. A.d. Transmission based precautions (TBP) may be utilized with or without strict isolation. When the resident requires TBPs, over and above standard precautions, one or more of the following may be put into place: - i: Contact precautions - ii: Airborne precautions - iii: Droplet precautions - iv: Enhanced barrier precautions			F 880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER LUTHER HAVEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
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 3/18/25 and 3/19/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/07/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER LUTHER HAVEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52599181C (MN00111027), with a licensing order issued at 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER LUTHER HAVEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 2 state form. 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.	2 000			
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390			4/11/25

Minnesota Department of Health

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21390	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate transmission based precautions used for 1 of 1 resident (R4) with diagnosis of Respiratory Syncytial Virus (RSV). Findings include: R4's quarterly Minimum Data Set (MDS) dated 2/28/25, indicated severe impaired cognition with diagnosis of dementia. R4's progress note dated 3/14/25 at 9:39 a.m., indicated R4 continued to have a runny nose and wet cough and complained of not feeling well. 4-plex (nasal swab allowing staff to quickly identify whether a person is infected with Influenza A, Influenza B, Respiratory syncytial virus (RSV), or COVID-19) and placed on precautions. R4's progress notes dated 3/14/25 at 11:12 a.m., indicated call from physician that R4 had RSV, and R4 was placed on droplet precautions. During an observation on 3/18/25 at 12:36 p.m., R4's room door was open, and there was a droplet precaution sign outside door with a 3-drawer isolation bin with gloves, goggles, and face shields. During an observation on 3/18/25 at 1:16 p.m., R4 wheeled himself in wheelchair out into the hall without a mask on and moved towards the nurse's station. Nursing assistant (NA)-D returned R4 to room at 1:20 p.m.	21390	Corrected.		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER LUTHER HAVEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265		
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21390	Continued From page 4 During an observation on 3/18/25 at 1:33 p.m., NA-D and NA-A entered R4's room with gloves, mask and goggles on. No gown was applied. During an observation and interview on 3/18/25 at 1:54 p.m., NA-D indicated R4 had RSV and staff were supposed to apply gloves, goggles and masks, but no gown. R4 continued to have a cough as well. During an interview on 3/18/25 at 1:59 p.m., licensed practical nurse (LPN)-H indicated for RSV staff should be wearing mask, goggles or face shield, gloves, and gown. LPN-H confirmed there were no gowns in the isolation cart outside of R4's room. During an interview on 3/18/25 at 2:01 p.m., infection control preventionist (ICP), indicated R4 had RSV and was to be on contact and droplet precautions. ICP further stated the center for disease control (CDC) sign posted outside R4's room was for only droplet precautions. ICP walked to R4's room and placed the contact precautions sign and gowns in the cart outside of R4's room. During an interview on 3/19/25 at 2:01 p.m., interim director of nursing (DON) stated it was her expectation staff follow the CDC guideline for all infection control measures. Review of undated facility policy titled, Isolation Precautions, indicated strict isolation may be utilized: A.a. when a resident is identified to have an active infection with a highly transmissible or epidemiologically significant pathogen. A.d. Transmission based precautions (TBP) may be utilized with or without strict isolation. When	21390			

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21390	Continued From page 5 the resident requires TBPs, over and above standard precautions, one or more of the following may be put into place: - i: Contact precautions - ii: Airborne precautions - iii: Droplet precautions - iv: Enhanced barrier precautions SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390			