



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 12, 2024

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: February 7, 2024

Dear Administrator:

On March 4, 2024, 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.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2024

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: February 7, 2024

Dear Administrator:

On February 7, 2024, 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

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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 May 7, 2024 (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 August 7, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Luther Haven
February 15, 2024
Page 4

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 style with a loop at the end of the last name.

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



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February 15, 2024

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: Event ID: HWCP11

Dear Administrator:

The above facility survey was completed on February 7, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

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 02/07/2024
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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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(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
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/6/24 and 2/7/24, 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.</p> <p>The following complaints were reviewed</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/23/24
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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 02/07/2024
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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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2 000	<p>Continued From page 1</p> <p>H52599562C (MN00100481). NO licensing orders were issued.</p> <p>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.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		

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

PRINTED: 03/04/2024
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 02/07/2024
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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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F 000	<p>INITIAL COMMENTS</p> <p>On 2/6/24 and 2/7/24, 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.</p> <p>The following complaint was reviewed: H52599562C (MN00100481) with a deficiency cited at F607 and F609. .</p> <p>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.</p> <p>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.</p>	F 000		
F 607 SS=D	<p>Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95,</p>	F 607		2/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/23/2024
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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.

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F 607	<p>Continued From page 1</p> <p>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to implement the reporting and investigation of injury of unknown origin according to their abuse policy for 1 of 3 residents (R1) reviewed for abuse. In addition, the facility failed to ensure the abuse policy identified reporting requirements to the State Agency (SA) according to the regulation.</p> <p>Finding include:</p> <p>A Vulnerable Adult Maltreatment report submitted to the State Agency (SA) on 2/1/24 at 12:45 p.m., alleged potential neglect when R1 was hospitalized with large bruises to ribs, breast, and inner thigh areas. The report also indicated R1 has dementia and did not know how the bruising occurred.</p> <p>R1's annual Minimum Data Set (MDS) dated</p>	F 607	<p>F607 Develop/Implement Abuse/Neglect policies:</p> <p>State agency investigated and determined that the facility did not do an immediate investigation and report of an injury of unknown origin that was present on 01/28/2024 that was on residents trunk and inner leg without a consistent answer of how bruising occurred. Licensed staff did document the bruising on the trunk and referral was sent to NP who examined resident on 01/29/24 and did not feel that bruising was out of the ordinary for resident's disease process. Through the investigation by the SA it was brought to our attention that even if the bruising was ordinary for this particular resident with the bruising on the inner leg we should have become aware that is could have been determined as</p>	

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F 607	<p>Continued From page 2</p> <p>11/3/23, indicated R1 had moderately impaired cognition and no behaviors. The MDS further indicated R1 was independent but needed staff set up for eating and dressing upper body. R1's diagnoses included dementia, depression, anxiety disorder, and myelodysplastic syndrome (disorder of the blood that can cause easy bruising, infections, and tiredness).</p> <p>R1's progress note dated 1/28/24 at 10:10 a.m., indicated R1 woke up with a large bruise to her right ribcage measuring 157 mm (millimeters) x 130 mm; area above measures 40 mm x 25 mm; area near right breast measure 30mm x 85mm; area to back measures 70mm x 10mm. All bruises are dark blue/purple in color. R1 complains of mild pain with pressure or movement. Family, nurse manager, and primary care provider notified.</p> <p>R1's Skilled Nursing Facility Note dated 1/29/24, Certified Nurse Practitioner indicated R1 woke up that morning with a large new bruise to right rib cage that measured 175 cm (centimeters) x 130 cm. Also noted was a bruise to the inner left thigh. Bruises noted to be dark purple and tender. R1 has an area of edema noted to right upper back with tenderness and was concerned about a possible rib fracture. X-rays were ordered. R1 has dementia and denied any falls or injuries but reported maybe hitting her ribs on the side of her bed.</p> <p>R1's Progress Note dated 1/29/24 at 10:44 p.m., indicated R1 was transferred to the ER (emergency room) at approximately 7:30 p.m. and would be transferred to a higher-level care hospital for possible internal bleeding and need for blood transfusions.</p>	F 607	<p>suspicious. Since the DON was not contacted immediately she was unable to question staff for an immediate determination of reportability.</p> <p>Nursing staff has been directed to call DON or designee with any bruising and/or injury of unknown origin so the immediate determination can occur timely going forward.</p> <p>All bruising events are reviewed in IDT and checked for accuracy, follow up and resolution.</p> <p>All staff are updated to notify the charge nurse of any bruising present. Charge Nurses are aware of the need for bruising events to be entered into Matrix for any new bruising &/or bruising discovered during routine weekly skin checks on bath day.</p> <p>The completion of weekly skin checks on bath day are done to be sure we do not miss any changes in alteration in skin integrity, open areas & or Bruising.</p> <p>Auditing will be completed weekly of all new skin events including bruising for healing and or resolution and to assure all skin concerns are identified timely.</p> <p>Audits will also be completed by DON or designee of weekly skin checks in the bath book to assure they are completed and areas of concern do not get missed.</p> <p>Audits will be completed weekly X 8 and</p>	

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F 607	<p>Continued From page 3</p> <p>During an interview on 2/6/24 at 2:45 p.m. registered nurse (RN)-A stated an injury of unknown origin is when the resident can not tell you what happened. We would then notify the director of nursing (DON) and she would tell us if it was reportable to the SA or not. Indicated R1 has a history of bruising and told us she thought she may have bumped it on the side rail. RN-A did not know about the large bruise on the inner thigh and did not call the DON regarding R1's bruising.</p> <p>During an interview on 2/7/24 at 11:11 a.m., RN-B indicated R1 showed her the bruising but was not able to remember what happened to cause the bruising. Further stated R1's bruising was very large, but she bruised easily. RN-B indicated staff were directed to leave the nurse manager a voicemail if there was a fall with a minor injury but if it was a fall with a major injury, staff need to call the DON right away for further guidance. RN-B stated that despite the size of the bruising and unknown origin, she did not call the DON to report the bruising because bruising was not unusual for R1.</p> <p>During an interview on 2/6/24 at 4:10 p.m., the DON stated R1 will make up the answers that she thinks you want to hear at the time you are talking to her. Further stated that although the injury and bruising was identified on 1/28/24, with hospitalization on 1/29/24, she was not notified of the significant injury or the hospitalization until Monday 1/20/24, during their scheduled interdisciplinary team meeting (IDT).</p> <p>During a follow up interview on 2/7/24 at 10:50 a.m., the DON indicated they did not investigate</p>	F 607	then biweekly x 4 and monthly there after.	

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F 607	<p>Continued From page 4</p> <p>R1's bruising because "that [bruising] is just what she does. The DON verified she was unaware of the bruise on R1's inner thigh and that would not be consistent with their theory of the bed grab rail as the cause. Verified a vulnerable adult report was not submitted to the SA.</p> <p>During an interview on 2/7/24 at 11:30 a.m., the administrator denied being notified of R1's bruising and hospitalization immediately.</p> <p>The undated facility policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property provides the following definitions: Abuse allegations: abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. Injury of unknown origin: when both of the following conditions are met: the source of injury was not observed by another person, or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of injuries over time. Serous bodily injury: an injury involving extreme physical pain; involving substantial risk of death or requiring medical interventions such as surgery, hospitalization, or physical rehabilitation. The policy further indicates investigation of injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse: injuries include, but are not limited to, bruising of the inner thigh, chest, face, and breast; bruises of an unusual size, multiple unexplained bruises, and/or in an area not typically vulnerable to trauma. If the events that cause the reasonable suspicion result in serious</p>	F 607		

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F 607	Continued From page 5 bodily injury to a resident, the covered individual shall report the suspicion immediately. Internal reporting: an employee must always report an abuse or suspicion of abuse immediately to the administrator or designee. The administrator will involve key leadership personnel as necessary to assist with reporting, investigation, and follow up. The administrator will report to the medical director. If an incident or allegation is considered reportable, the administrator or designee will make an initial (immediate or within 24 hours) report to the state agency.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		2/28/24

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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 02/07/2024
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 609	<p>Continued From page 6</p> <p>investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to report allegations of physical abuse (bruising of unknown origin) timely to the State Agency (SA) for 1 of 3 residents (R1)) reviewed for allegations of abuse.</p> <p>Findings include:</p> <p>A Vulnerable Adult Maltreatment report submitted to the State Agency (SA) on 2/1/24 at 12:45 p.m., alleged potential neglect when R1 was hospitalized with large bruises to ribs, breast, and inner thigh areas. The report also indicated R1 has dementia and did not know how the bruising occurred.</p> <p>R1's annual Minimum Data Set (MDS) dated 11/3/23, indicated R1 had moderately impaired cognition and no behaviors. The MDS further indicated R1 was independent but needed staff set up for eating and dressing upper body. R1's diagnoses included dementia, depression, anxiety disorder, and myelodysplastic syndrome (disorder of the blood that can cause easy bruising, infections, and tiredness).</p> <p>R1's Progress Note dated 1/28/24 at 10:10 a.m., indicated R1 woke up with a large bruised to her right ribcage measuring 157 mm (millimeters) x 130 mm; area above measures 40mm x 25 mm; area near right breast measure 30mm x 85mm;</p>	F 609	<p>F609 Reporting of alleged violations The Abuse policy was updated and clarified to reflect clearly the immediate but not > 2 hours definition and all staff were educated to contact the administrator/DON or designee with all bruising and injury of unknown origin. This should ensure that going forward all abuse/bruising or injury of unknown origin will immediately be investigated by Administrator/DON or designee.</p> <p>All bruising events are reviewed in IDT and checked for accuracy, follow up and resolution.</p> <p>All staff are updated to notify the charge nurse of any bruising present. Charge Nurses are aware of the need for bruising events to be entered into Matrix for any new bruising &/or bruising discovered during routine weekly skin checks on bath day and new bruising is reported to DON or Designee immediately (not greater than 2 hours after discovery.)</p> <p>The completion of weekly skin checks on bath day are done to be sure we do not miss any changes in alteration in skin integrity, open areas & or Bruising.</p>	

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F 609	<p>Continued From page 7</p> <p>area to back measures 70mm x 10mm. All bruises are dark blue/purple in color. R1 complains of mild pain with pressure or movement. Family, nurse manager, and primary care provider notified.</p> <p>R1's Skilled Nursing Facility Note dated 1/29/24, Certified Nurse Practitioner indicates R1 woke up that morning with a large new bruise to right rib cage that measured 175 cm (centimeters) x 130 cm. Also noted was a bruise to the inner left thigh. Bruises noted to be dark purple and tender. R1 has an area of edema noted to right upper back with tenderness and was concerned about a possible rib fracture. X-rays were ordered. R1 has dementia and denied any falls or injuries but reported maybe hitting her ribs on the side of her bed.</p> <p>R1's Progress Note dated 1/29/24 at 10:44 p.m., indicated R1 was transferred to the ER (emergency room) at approximately 7:30 p.m. and would be transferred to a higher-level care hospital for possible internal bleeding and need for blood transfusions.</p> <p>During an interview on 2/6/24 at 2:45 p.m. registered nurse (RN)-A stated an injury of unknown origin is when the resident cannot tell you what happened. We would then notify the director of nursing (DON) and she would tell us if it was reportable to the SA or not. RN-A indicated R1 has a history of bruising and told us she thought she may have bumped it on the side rail. RN-A did not know about the large bruise on the inner thigh, did not call the DON regarding R1's bruising, and did not submit a VA (vulnerable adult) report to the SA.</p>	F 609	<p>Auditing will be completed weekly of all new skin events including bruising for healing and or resolution and to assure all skin concerns are identified timely.</p> <p>Audits will also be completed by DON or designee of weekly skin checks in the bath book to assure they are completed and areas of concern do not get missed.</p> <p>Audits will be completed weekly X 8 and then biweekly x 4 and monthly there after.</p>	

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F 609	<p>Continued From page 8</p> <p>During an interview on 2/7/24 at 11:11 a.m., RN-B indicated R1 showed her the bruising but was not able to remember what happened to cause the bruising. Further stated R1's bruising was very large, but she bruises easily. RN-B stated staff were directed to leave the nurse manager a voicemail if there was a fall with a minor injury but if it was a fall with a major injury, staff need to call the DON right away for further guidance. RN-B stated that despite the size of the bruising and unknown origin, she did not call the DON and report the bruising to the DON because bruising was not unusual for R1.</p> <p>During an interview on 2/7/24 at 10:50 a.m., DON indicated they did not investigate or report R1's bruising because "that [bruising] is just what she does." The DON verified she was unaware of the bruise on R1's inner thigh. Verified a vulnerable adult report was not submitted to the SA.</p> <p>During an interview on 2/7/24 at 11:30 a.m., the administrator denied being notified of R1's bruising and hospitalization immediately and verified a VA report was not submitted to the SA.</p> <p>The undated facility policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property provides the following definitions: Abuse allegations: abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. Injury of unknown origin: when both of the following conditions are met: the source of injury was not observed by another person, or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury</p>	F 609		

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F 609	<p>Continued From page 9</p> <p>or the number of injuries observed at one point in time or the incidence of injuries over time.</p> <p>Serous bodily injury: an injury involving extreme physical pain; involving substantial risk of death or requiring medical interventions such as surgery, hospitalization, or physical rehabilitation. The policy further indicates investigation of injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse: injuries include, but are not limited to, bruising of the inner thigh, chest, face, and breast; bruises of an unusual size, multiple unexplained bruises, and/or in an area not typically vulnerable to trauma. If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately.</p> <p>Internal reporting: an employee must always report an abuse or suspicion of abuse immediately to the administrator or designee. The administrator will involve key leadership personnel as necessary to assist with reporting, investigation, and follow up. The administrator will report to the medical director.</p> <p>If an incident or allegation is considered reportable, the administrator or designee will make an initial (immediate or within 24 hours) report to the state agency.</p> <p>The policy lacks the immediate but not greater than two-hour reporting language per regulation.</p>	F 609		