

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 5, 2021

Administrator Mn Veterans Home - Luverne 1300 North Kniss, Po Box 539 Luverne, MN 56156

RE: CCN: 245631

Cycle Start Date: March 17, 2021

Dear Administrator:

On March 17, 2021, a survey was completed at your facility by the Minnesota Departments 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.

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:

Mn Veterans Home - Luverne April 5, 2021 Page 2

- 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" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 17, 2021 (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).

Mn Veterans Home - Luverne April 5, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by September 17, 2021 (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/ltc 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. Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/20/2021 FORM APPROVED OMB NO. 0938-0391

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245631	B. WING		03	C 5/ 17/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156	_ 03	717/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	гѕ	F 00	00		
	completed at your finvestigation. Your compliance with 42 for Long Term Care The following comp	plaints were found to be				
	F600, F609 and F6	'041) with a deficiency cited at				
F 600 SS=D	signature is not req page of the CMS-2 correction is require acknowledge receip	<u> </u>	F 60	00		5/17/21
	Exploitation The resident has the neglect, misapproper and exploitation as includes but is not leading to corporal punishment any physical or che	rom Abuse, Neglect, and re right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.				
	§483.12(a) The fac	•				
	physical abuse, cor involuntary seclusion	use verbal, mental, sexual, or poral punishment, or on; NT is not met as evidenced				
L ABORATORY	 / DIRECTOR'S OR PROVIC	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed 04/12/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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:	` '	LE CONSTRUCTION	(X3) DATE S COMPLE	
		245631	B. WING		03/17	/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/17/	/2021
MN VETE	ERANS HOME - LUVE	ERNE		LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE C	(X5) COMPLETION DATE
F 600	review, the facility f	tion, interview, and document ailed to prevent sexual	F 600	F600 □ Free from Abuse and Neg		
	behaviors and implined resident (R2) with a inappropriately tout of sexual abuse. A identify R1 was at iby another resident inappropriately and Findings include:	ement interventions for 1 of 1 known sexual behaviors who ched R1 during 2 of 2 incidents dditionally, the facility failed to ncreased risk for further abuse t (R3) who also touched R1 I had known sexual behaviors.		1. R2 was moved off the Special C Unit (SCU) on 1/25/2021 and R3 w moved off of the SCU on 3/22/202 order to further protect R1. R1 has been involved in any further similar since the last event that occurred k R1 and R3 on 3/13/2021. All reside be reviewed to determine if they ar higher risk of receiving sexual abus and/or determine if they have a his	vas 1 in not r events between ents will re at a se	
	state agency (SA) is walking up the hall (SCU) and observe hand in her shirt. Re he was doing and NA-A noticed the re	20 at 11:37 a.m., report to the dentified the NA-A was way of the special care united R2 sitting next to R1 with his 2 was unable to verbalize what was removed from the area. egistered nurse (RN) on duty. To remain separated from 0/21 at 11:37 a.m.,		sexual behaviors towards others. I identified as being at a higher risk receiving sexual abuse, which inclu R1, will have a new vulnerability assessment completed and will be planned to be observed for signs of sexual abuse. Residents identified a history of sexual behaviors toward others, including R2 and R3, will have vulnerability assessment compand will be care planned to be observed.	of udes care of to have rds ave a pleted	
	investigation summidentified NA-A was observed R2 sitting her shirt. Staff imm residents and notifilast seen in the hal incident. R2 had deverbalize details of prior incidents between the incident. R2's of supervised interact remove resident from	pary submitted to the SA swalking up the hallway and prext to R1 with his hand in ediately separated the ed the RN on duty. R2 was lway a few minutes prior to the ementia and was unable to the incident. There were no ween the R1 and R2, all parties ied appropriately. There were a from either resident following are plan was updated to keep ions with female residents to the incidents if inappropriate 2 was to be offered		for signs of sexual aggression or s behaviors towards others. 2. All residents have the potential t affected. 3. Director of Nursing and Adminis reviewed policy titled Vulnerable Adult/Resident Protection Plan on 4/6/2021. Facility staff will be educ the Administrator or Designee regathe Vulnerable Adult/Resident Prot Plan Policy by 5/17/2021. Specifical staff will be educated regarding monitoring residents for signs of se	exual o be trator ated by arding ection ally,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245631	B. WING			C 1 7/2021
	PROVIDER OR SUPPLIER	ERNE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	Review of the 1/23, SA identified licens was providing super R1 was seated in a front of her and R2 adjacent to R1. LPI wake another resided LPN-C's return, R2 his right hand on R reaching with his less breast. LPN-C was occurred. Neither roof the incident. R2 from the area. Both distress and neither related to diagnose to another area in treated to diagnose to	tivity when behaviors occurred. 21 at 2:03 p.m., report to the ed practical nurse (LPN)-C exision in the SCU dining area. Chair with an over-bed table in was seated at a table N-C left the dining area to ent for the noon meal. Upon was sitting in front of R1 with 1's knee and his left hand was ft hand was reaching for R1's unsure if R2 actual contact esident was upset at the time was immediately removed a residents had no signs of residents had no signs of revere able to be interviewed as of dementia. R2 was moved he facility for meals. R1 and separate from one another. 21 at 3:32 p.m., 5-day submitted to the SA identified a separated at the time of the nave been separated further. It d symptoms of distress nt, and neither were able to mediate interventions included on of R2 from R1. R2 was the solarium out of sight of R1 was placed on frequent visual	F 600	abuse and sexual behaviors toward others. 4. Audits will be conducted weekly weeks by the Administrator or Defor 5 random residents to determ resident should be identified as brisk for receiving sexual abuse or of sexually abusing others. If any residents are identified, resident plan will be audited to ensure interventions are in place and defa vulnerability assessment may response to the Quality Assurance Committee for review at the next Assurance meeting. 5. 5/17/2021	ly for 4 esignee ine if the eing high high risk of the 5 s care termine if eed to e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	IPLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		245631	B. WING _			C / 17/2021	
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	ERNE		STREET ADDRESS, CITY, STATE, ZIP CO 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	reviewed and intern further abuse from R2's 1/24/21, quart identified he had mphysical behaviors occurred 1 to three assistance of 1 stamove independent wheelchair. R2's diwith and without be weakness, and a hR2's 1/26/21, care impaired cognitive a benign brain tuminappropriate sexuadmission. Staff we snacks, and other R2 for behaviors at R2 was sexually in seeking. Staff were female residents at behaviors occurred 6:30 a.m., and staff consistent.	f whether R1's care plan was ventions added to prevent	F 60				
	1) 12/20/20, R2 was attempted to grab sassistance to trans 2) 1/23/21, R2 was towards staff and gduring morning car 3) 1/28/21, R2 atte because his believe 4) 1/31/21 R2 was	is sexually inappropriate and staff's breasts during fer. sexually inappropriate grabbed staff in the groin area					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		245631	B. WING _			C / 17/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	buttocks. 5) 2/11/21, R2 put hand made sexually redirected R2. 6) 3/3/21, R2's beh R2 continued to hat behaviors. R2 had documented over 5 sexual comments a member. During an interview RN-A identified R2 R2 used to reside a moving to the SCU sexually inappropriahistory of exit seeki until he was sexual resident. He was the (all male) and has had been been been been been been been bee	nis hand between an NA's legs inappropriate comments. Staff avior review charting identified we occasional sexual 11 shifts with behavior weeks. Three shifts included and grabbing at a staff on 3/17/21 at 9:50 a.m. with had poor cognition and insight. In the Red wing prior to the Red wing prior to the Red wing prior to the Red wing are with staff. R2 also had a ng and was moved to the SCU ly inappropriate with another ten moved to the Green Wing	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245631	B. WING			C 3/17/2021	
	PROVIDER OR SUPPLIER	A BUILDING 245631 B. WING OR SUPPLIER OME - LUVERNE STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES CHOPPICIENCY MUST BE PRECEDED BY FULL DULATORY OR LSC IDENTIFYING INFORMATION) THE DEFICIENCY MUST BE PRECEDED BY FULL DULATORY OR LSC IDENTIFYING INFORMATION) THE DEFICIENCY TAG F 600 F 600		3/11/2021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE	
F 600	with his hand up Raresidents and reporting immediately. After the supervise R2 when residents. Staff wer from R2, and provide puzzles, and other immore recent encour meal. R2 was transfollowing the incide. During an interview the director of nursi R2 had a history of inappropriateness. unattended by staff providing a.m. care 1/23/21, R2 was left dining area. R2 approbserved being sex sexually inappropriateness the R2 was able to mot and at times attemprooms. Staff were thim around female to redirect him whe second encounter with the action took place. Neither resident has after the encounter separate male unit to the SCU or to fin	I's shirt. She separated the ted the incident to the nurse he incident staff were to he was around other female e to also keep R1 separated de R2 with distractions, activities. R2 had another neer with R1 during the noon ferred to the Green wing at as that was an all male unit. on 3/17/21 at 3:21 p.m., with ng (DON) identified R1 and encounters involving sexual On 11/6/21, R1 was left during while they were s to other residents. On the unattended in the SCU proached R1 and was staff only prior to be to "on the radar" for sexual owards residents until 11/6/21, ivate independently in the unit of the other other resident's to redirect him and supervise residents. Staff were trained in he had behaviors. R2's was less than one minute, and the outside of R1's clothing. It is disparately as transferred to a and had no attempts to return d R1.	F6	500			
		21, report to the SA identified R1 who was sitting in recliner					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245631	B. WING _		03	C / 17/2021	
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 245631 IAME OF PROVIDER OR SUPPLIER IN VETERANS HOME - LUVERNE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP COI 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		, , = v= .	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	and placed one hat to be reaching to ghand. Staff had taked dining area and haminute before returned and and initiated an act no signs of distress laughed and smiled Both residents lack consent/understant R1's 3/3/21, quarted severe cognitive imbehaviors during a extensive assist win mobility, total assistance with am diagnoses of Alzhed R1's undated care impaired cognitive related to dementiatime, or situation. Frommunicate her intervention was act away from R1. On added that identified R2 apart from each interaction between 3/15/21, an intervention was act away from R3 away from interactions between R1's progress note sexual abuse perpoto keep R1 and R2 supervision. Staff for the sexual staf	and on her breast and appeared et under R1's shirt with other ten another resident to the deen gone approximately 1 ring to find R3 next to R1. It depends a next to R1. It	F 60				

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245631	B. WING		05	C 3/ 17/2021
	PROVIDER OR SUPPLIER	RNE		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156	1 00	9/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	another resident R3 facility identified R1 abuse related to he increased supervis from occurring, nor known sexual beha increased risk to fo other residents. Review of R1's 3/1 identified she had climitation, and sens The assessment in maltreatment prevenention she was a following the 11/6/2 R3's 1/25/21, quart severe impairment during the assessmindependently, was once in his wheelch assist with Activities diagnoses included dementia, and anxi R3's current, undat impaired cognitive and impaired though of a motor vehicle a R3 also had mood anxiety disorders. Fand comments that On 7/27/18, staff we was being sexually continued, staff we place and re-appropriate and re-a	alted on 3/13/21 a third time by 3. There was no mention the was at increased risk for a dementia and required ion to prevent further abuse identified residents with aviors towards staff were at cus those behaviors towards 21, vulnerability assessment cognitive impairment, physical cory/communication limitations. dicated to see care plan for ention plan. There was no trincreased risk for abuse increased risk for abuse incident. erly MDS identified he had and behaviors were noted and period. R3 ate independent with locomotion hair, and required extensive of Daily Living (ADL). R3's traumatic brain injury (TBI),	F 6			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245631	B. WING		03	C / 17/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP COI 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	3/13/21, an interverto supervise interaction and remove R3 from behaviors occurred an activity in a separate present. The facility risk for potential interesidents knowing in 2018.	ge 8 opropriate behaviors. On ation was added that staff were ctions with female residents in situation if inappropriate. Staff were to distract R3 with a rate area if behaviors were a failed to identify R3 was at appropriate behaviors with the had the behaviors with staff 5/21, vulnerability assessment	F 6	00		
	identified he had in cognitive impairme sensory and comm assessed to have r of maltreatment tow was no indication s for known sexual in beginning in 2018,	appropriate sexual comments, nt, physical limitations, unication limitation. He was to indicators for increased risk wards other residents. There taff accurately assessed R2 appropriate behaviors and was therefore at otential abuse of other				
	R3 had special nee all interactions with staff were to redired There was no indic ensure R3 was dist	Resident Care Sheet identified ds as staff were to supervise female residents. If sexual, at behavior or comments. ation staff were alerted to anced and appropriately round female residents prior.				
	through 3/16/21 ide 1) 1/7/21, R3 made staff inappropriately 2) 1/10/21, R3 made during cares.	avior notes from 1/1/21 entified the following. On: e several attempts to grab at e and made sexual comments. e sexual comments to staff making sexual comments to es.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245631	B. WING				C 17/2021
NAME OF F	PROVIDER OR SUPPLIER	240001			TREET ADDRESS, CITY, STATE, ZIP CODE	03/	17/2021
					300 NORTH KNISS, PO BOX 539		
MN VETE	ERANS HOME - LUVE	RNE		L	UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
		,			DEFICIENCY)		
F 600	the staff. 5) 1/27/21, R3 had during the evening 6) 2/1/21, R3 asked could squeeze staff 7) 2/2/21, R3 made statements towards 8) 2/3/21, R3 making grabbing at staff du longer in R3 reach stopped. 9) 2/4/21, R3 made comments towards 10) 2/6/21, R3 made during cares. 11) 2/22/21, R3 trie 2 times this shift. 12) 2/23/21, R3 had attempts to inappro 13) 3/7/21, R3 called "pull down their par 14) 3/13/21 (1:58 president's breast the 15) 3/13/21 (10:04) approach another for fredirected to another for edirected to another	making sexual comments to many sexual comments shift. d staff to come over so he foreast. e sexual comments and staff during cares. In sexual comments and uring cares. When staff no comments and advancements as several sexually inappropriate staff. It is esexual remarks to staff d to touch staff inappropriately d sexual comments and epriately touch staff 2 times. In the sexual comments and epriately touch staff 2 times. In the sexual comments and epriately touch staff 2 times. In the sexual comments and epriately touch staff 2 times. In the sexual comments and told staff to example at day. In the sexual comment sexually. Staff er unit to watch TV. R3 would example a sexual to grab at a sext during transfer. In the sexual comments are resident. In the sexual comments are residen	F	600			
	assistant (NA)-A ide	entified she was the one who t between R1 and R3 that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COV	(X3) DATE SURVEY COMPLETED	
		245631	B. WING _			C / 17/2021	
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		717/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 600	occurred in the comunit (SCU). R1 was common area and wheelchair parked had taken another upon returning to the R3 with his hand or breast. She cued R towards them. R3 r confirmed R1 was r she approached he A nurse, LPN-A was back towards R1 ar another resident at NA-A's verbal cues with intervening. The a close eye" on R3 had a history of ma trying to touch staff approached a resid She confirmed R3 varound in his wheel. Observation on 3/1 identified she was sin the common area were noted at that the common area where an active female residents we immediate area. Interview on 3/17/2 practical nurse (LPI the common area of the comm	mmon area of the Special Care is sitting in the recliner in the R3 was sitting in his by wall in front by R1. NA-A resident to the dining area and the common area, witnessed in top of R1's shirt over her area to stop as she walked eplied "she likes me". She monverbal and smiled when in the area but had her ind R3, as she was assisting the time. LPN-A did hear directed at R3 and assisted the nurse instructed us to "keep after that. NA-A revealed R3 king sexual comments or however, R3 had never ent before to her knowledge. Was able to wheel his self chair. 7/21 at 9:35 a.m., of R1 sleeping in the recliner located a on the SCU. No concerns	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245631	B. WING				C 1 7/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH KNISS, PO BOX 539 .UVERNE, MN 56156		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	residents at the tim comment to R3 "yo that" and turned to two. She revealed to separated the rest R3 in eyesight. Observation on 3/1 1:00 p.m., of the considering in a recline table behind R3. St walking through the of R3, however, state area. Interview on 3/17/2 identified the only reany sexual behaviounless he is resting does not attempt to could assist others area consistently. Observation on 3/1 was sleeping in a reand R3 was seated an one-to-one active. Interview on 3/17/2 nurse (RN)-B identification on 3/13/2 an incident with R1 breast. Later on that LPN had reported to making comments at R1 so the staff my watch a game on T	d her back towards the two e but had heard NA-A u cannot touch women like go assist with separating the the staff then kept R1 and R3 of the weekend and staff kept 7/21 at 12:42 p.m. through mmon area identified R3 was er. R1 was sitting at a small aff were observed frequently e common area for supervision off were not consistently in the 1 at 12:50 p.m., with NA-A esident on the SCU that had rs was R3. Staff supervise R3 in a stationary chair as he get out. During that time, staff and not be in the common 7/21 at 2:00 p.m., identified R1 ecliner in the common area I in a recliner with staff doing	F	600			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245631	B. WING		03	C 3/ 17/2021	
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP CO 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156	<u> </u>	717/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 600	one person in the c supervision of R3 d confirmed that R3 v supervised while he to ensure R1's safe. Review of memo to staff were to supervand female residen report to the RN im discussion or action. Interview on 3/17/2 administrator reveasexual abuse he wo put into place to ensinvolved to prevent interventions into plincident of the same the unit. He agreed followed for R1 and the second incident they were not to be been left alone at the occurred. He identified involving R3 "could facility could not presidents and we do the beneficial SCU stated R1 had no signable to recall the facility did not protereoccurrence. "You resident and predict there was nothing at the first incident with already a victim of a supervision of a supe	ommon area for constant uring the evening shift. RN-A was now to be appropriately was around other residents ty and any other resident's. staff dated 3/13/21, identified rise all interactions with R3 ts. Staff are to remove R3 and mediately if any inappropriate is are witnessed. 1 at 4:17 p.m., with led if a resident had identified ould expect interventions to be sure the safety of the resident reoccurrence. Staff put ace for R2. After the second enature, R2 was moved off of the care plan had not been R2 immediately preceding. The intervention identified together. R1 and R2 had be table and the second event fied the third incident with R1 not of been predicted" as the edict that kind of behavior. icies in place to protect the onot want to move them off of unit if we do not need to". He gns of fear and R3 was event. He disagreed that the	F6	500			

AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	,		(X3) DATE SURVEY COMPLETED
		245631	B. WING			C 03/17/2021
NAME OF PROVID		ERNE		STREET ADDRESS, CITY, STATE, 2 1300 NORTH KNISS, PO BOX 5 LUVERNE, MN 56156		03/11/2021
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE COMPLÉTION
plans preve R2 b thoughen The A the S beha Revie Resid abus with a an in to inf empl they supe imme made per s comp staff were were moni facto and s beha room inapp comr resid depe were resid preve	ented the second telt there was gh staff documents to staff part of the 11/19 dent Protection e was any nor a resident. Will dividual, not where to report rivisor or office ediately ensure to the facility tate and feder to the facility tate and feder onents were in were responsively educated on late assess, platter residents were in the sensory deficit viors such as as, wandering, propriate. Addimunication dispents requiring andent on staff to be identified ent involved a cent future occurrence.	nge 13 ne facility should have and incident between R1 and as no way to predict R3, even mented R3 had known sexual arior to the incident with R3. dentified the only resident on any inappropriate sexual 2/19, Vulnerable Adult and a Plan policy identified sexual a-consensual sexual contact lful meant deliberate actions of thether an individual intended arm. When any nursing home eer became aware of abuse, it immediately to the are of the day. That staff was to be the proper notifications were leadership and state agency al requirements. Seven an place to prevent abuse. All ble for preventing abuse and how to report abuse. Staff an care and services, and with needs and behaviors. Risk actuded a history of cognitive and saggressive behaviors, entering other residents' and being socially tional risk factors included orders, nonverbal, and heavy care or are totally appropriate interventions d and implemented for the and all other residents were to be alleged offenders. Additional		500		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E SURVEY IPLETED	
		045004					С
		245631	B. WING			03/	17/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		1300 N	ET ADDRESS, CITY, STATE, ZIP CODE NORTH KNISS, PO BOX 539 ERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	resident could be a environment, consideranges in location	dents as appropriate. If the	F €	500			
F 609 SS=D	Reporting of Alleger CFR(s): 483.12(c)(§483.12(c) In response		F 6	609			5/17/21
	involving abuse, ne mistreatment, inclus source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cause abuse and do not rethe administrator of officials (including the adult protective serfor jurisdiction in lor accordance with St. procedures.						
	investigations to the designated represe accordance with St. Survey Agency, with incident, and if the appropriate corrections.	e administrator or his or her ntative and to other officials in ate law, including to the State nin 5 working days of the alleged violation is verified ive action must be taken.					

PRINTED: 04/20/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (COMI		(X3) DATE SURVEY COMPLETED		
	245631	B. WING		C 03/17/2021
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME - LUVE	ERNE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156	,
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION
facility failed to ensallegation of abuse the State Agency (SFindings include) Review of the 11/6/state agency (SA) in NA-A was walking a care unit (SCU) and R1 with his hand in verbalize what he was from the area. NA-A (RN) on duty. The assparated from each of the incident of the incident of the incident of the incident of the work. The SA report occurred at 7:00 at the person submitting identified she had was quite some time be to the SA at 11:37 at incident of abuse the incident on the work. The SA report occurred at 7:00 at the person submitting identified she had way the same time be to the SA at 11:37 at incident of abuse the same time be to the SA at 11:37 at incident of abuse the same time be to the SA at 11:37 at incident of abuse the same time be to the SA at 11:37 at incident of abuse the same time be to the SA at 11:37 at incident of abuse the same time in the same time be to the SA at 11:37 at incident of abuse the same time in the same time be to the SA at 11:37 at incident of abuse the same time in the same time be to the SA at 11:37 at incident in the same time in the same time to the SA at 11:37 at incident in the same time to the SA at 11:37 at incident in the same time to the SA at 11:37 at incident in the same time to the same time time time time time time time ti	v and document review the ture 1 of 2 resident (R1)'s was reported within 2 hours to SA). (20 at 11:37 a.m., report to the dentified at 7:00 a.m., the up the hallway of the special d observed R2 sitting next to her shirt. R2 was unable to was doing and was removed A notified the registered nurse residents were to remain ch other. (1 at 10:31 a.m., with NA-A 0, she observed the interaction 2. The charge nurse was y after the residents were ment review, on 3/17/21 at social worker (SW) identified complete the investigation of S/21 by either the administrator ursing (DON). She was notified a morning after she arrived to retidentified the incident m. and indicted the SW was ing the SA report. The SW worked on the investigation for afore she reported the incident	F 609	1. R2 was moved off the Special CUnit (SCU) on 1/25/2021 and R3 we moved off the SCU on 3/22/2021 it of further protect R1. R1 has not be involved in any further similar every the last event that occurred between and R3 on 3/13/2021. Facility has reported and will report other reported and will report of Nursing and Administrator of Designeer and Protection Plan on 4/6/2021. Facility staff will be educated by the Administrator of Designeer regarding the Vulnerable Adult/Resident Protection Plan Po 5/17/2021. Specifically, staff will be educated regarding reporting time incidents of potential abuse. 4. Audits will be conducted weekly weeks by the Administrator or Desfor 10 random staff to ensure each member has a good understandin reporting timelines for incidents of potential abuse as well as the Vulnerable and the vulnerable	care vas n order een nts since en R1 rtable trator ated by arding ection staff will or elicy by elines for for 4 ignee n staff g of the nerable icy.

Facility ID: 00411

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		. ,		E SURVEY PLETED
		245631	B. WING				C 17/2021
	PROVIDER OR SUPPLIER	RNE		13	TREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH KNISS, PO BOX 539 UVERNE, MN 56156		11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	unable to recall who incident on 11/6/21. identified she was r SW reported the incagreed the report was Interview on 3/17/2 administrator identified the facility at the time any allegation of abimmediately but no notification for abuse. Review of the 11/19 Resident Protection as nonconsensuals. The policy was to permitted the policy was	en she was notified of the The incident report provided notified at 12:25 p.m., after the cident to the SA. The DON ras not made within 2 hours. I at 4:18 p.m., with the fied he was not employed with ne of the incident but expected later than 2 hours of se. I at 4:18 p.m., with the fied he was not employed with ne of the incident but expected later than 2 hours of se. I at 4:18 p.m., with the fied he was not employed with ne of the incident but expected later than 2 hours of se. I at 4:18 p.m., with the fied he was not employed with ne reported later than 2 hours of se. I at 4:18 p.m., with the fied he was not employed with expected later than 2 hours of se. I at 4:18 p.m., with the fied he was not employed with expected later than 2 hours of sexual abuse, and preventing was later than 2 hours of sexual abuse, and prevention. The sexual abuse, and prevention employee or volunteer who abuse, mistreatment, neglect, appropriation shall the incident to their supervisor day. Staff were to report experiment and sexual abuse administrator or designee. The signee with training and access for reporting was to find abuse to the SA within two	F 6		next Quality Assurance meeting. 5. 5/17/2021		E/17/01
F 610 SS=D	CFR(s): 483.12(c)(2 §483.12(c) In response	/Correct Alleged Violation 2)-(4) onse to allegations of abuse, n, or mistreatment, the facility	F6	10			5/17/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE COMF	
		245631	B. WING _		03/1	C 17/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	violations are thoro §483.12(c)(3) Previneglect, exploitation investigation is in p §483.12(c)(4) Repoint extinction investigations to the designated represe accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMEI by: Based on observative review, the facility from the corrective action to abuse of 1 of 1 resifor further abuse by Findings include: Review of the 11/6/state agency (SA) if	evidence that all alleged ughly investigated. ent further potential abuse, and, or mistreatment while the rogress. ort the results of all evadministrator or his or her entative and to other officials in attein law, including to the State and Evadministration of the State alleged violation is verified invevacion must be taken. Now is not met as evidenced sion, interview, and document alled to take appropriate prevent the subsequent dent (R1) who was at high risk of 2 of 2 residents (R2 and R3).	F 61	F610 □ Investigate/Prevent/Correct Alleged Violation 1. R2 was moved off the Special Card Unit (SCU) on 1/25/2021 and R3 was moved off of the SCU on 3/22/2021 order to further protect R1. R1 has been involved in any further similar since the last event that occurred be R1 and R3 on 3/13/2021. All reside	are as in not events etween nts will	
	(SCU) and observe hand in her shirt. R he was doing and w NA-A noticed the reach other. Review of the 11/10 investigation summidentified NA-A was	vay of the special care unit d R2 sitting next to R1 with his 2 was unable to verbalize what was removed from the area. Egistered nurse (RN) on duty. To remain separated from 0/21 at 11:37 a.m., ary submitted to the SA is walking up the hallway and next to R1 with his hand in		be reviewed to determine if they are higher risk of receiving sexual abus and/or determine if they have a hist sexual behaviors towards others. Tidentified as being at a higher risk or receiving sexual abuse, which inclu R1, will have a new vulnerability assessment completed and will be planned to be observed for signs of sexual abuse. Residents identified a history of sexual behaviors toward others, including R2 and R3, will ha	ee ory of hose of des care to have	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			COM	SURVEY PLETED
		245631	B. WING			03/-	C 1 7/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		13	TREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH KNISS, PO BOX 539 UVERNE, MN 56156	1 00/	172021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	her shirt. Staff immeresidents and notifical last seen in the hall incident. R2 had deverbalize details of prior incidents betwo contacts were notificated incident. R2's contacts were incident from the incident of the second incident incident. R2 were to be kept. Review of the 1/23/SA identified license was providing supe R1 was seated in a front of her and R2 adjacent to R1. LPN wake another resident incident. R2 with the incident. R2 with the incident. R2 with the incident. R2 with the incident incident incident incident were incident but could have the resident had the incident had the incident but could have the resident had the incident but could have the incident and incident but could have the incident but could have the incident but could have the incident and incident but could have the incident and incident but could have the incident and incident and incident but could have the incident and in	ediately separated the ed the RN on duty. R2 was way a few minutes prior to the mentia and was unable to the incident. There were no een the R1 and R2, all parties ed appropriately. There were from either resident following are plan was updated to keep ons with female residents to m situations if inappropriate	F 6	10	new vulnerability assessment compand will be care planned to be observed for signs of sexual aggression or subehaviors towards others. 2. All residents have the potential traffected. 3. Director of Nursing and Administration on Plan on 4/6/2021. Facility staff will be educated the Administrator or Designee regates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable of Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specificates the Protection Plan Policy by 5/17/2021	erved exual o be crator ated by rding ection ally, exual ds for 4 gnee e if the ng high risk of the 5 care rmine if ed to	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245631	B. WING				C 1 7/2021
	PROVIDER OR SUPPLIER	RNE		STREET ADDRESS, CITY, S 1300 NORTH KNISS, PO LUVERNE, MN 56156	BOX 539	00/	17/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD SED TO THE APPROPE FICIENCY)	BE	(X5) COMPLETION DATE
F 610	recall the event. Imitimmediate separative reassigned to sit in during meals. R2 with checks. R2's care padministration reconscheduled document location. The interd 1/25/21, to discuss move R2 from the Separated from the residents resided. The any interventions of reviewed and interventions of reviewed and interventiated he had may be a seistance of 1 staff move independently wheelchair. R2's diawith and without be weakness, and a himpaired cognitive for a benign brain tumber in the residents and the residents are seeking. Staff were female residents are behaviors occurred.	mediate interventions included on of R2 from R1. R2 was the solarium out of sight of R1 as placed on frequent visual plan and treatment of were revised to include nation for staff visualize his isciplinary team (IDT) met on the incident and decided to SCU. R2 was placed on a unit SCU where only male the report made no mention of whether R1's care plan was rentions added to prevent	F 6	10			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245631	B. WING			03/1	C 1 7/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		130	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH KNISS, PO BOX 539 VERNE, MN 56156		.,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	1) 12/20/20, R2 wa attempted to grab s assistance to transf 2) 1/23/21, R2 was towards staff and g during morning card 3) 1/28/21, R2 attembecause his believe 4) 1/31/21 R2 was a.m. cares and at labuttocks. 5) 2/11/21, R2 put hand made sexually redirected R2. 6) 3/3/21, R2's behave a continued to have behaviors. R2 had documented over 5 sexual comments a member. During an interview RN-A identified R2 R2 used to reside a moving to the SCU sexually inappropriatistory of exit seeki until he was sexual resident. He was the (all male) and has have up in the a.m. during to the a.m. during to item and the sexual resident. R2 inappropriate with sup in the a.m. during toileting. R2 had a continued to grab a sexual resident. R2 inappropriate with sup in the a.m. during toileting. R2 had a continued to grab a sexual resident. R2 inappropriate with sup in the a.m. during toileting. R2 had a continued to grab a sexual resident. R2 inappropriate with sup in the a.m. during toileting. R2 had a continued to grab a sexual resident.	gress notes identified on: as sexually inappropriate and ataff's breasts during fer. sexually inappropriate rabbed staff in the groin area es. Impted to get into the SCU ed his wife was in the SCU. Very "sexual during" during unch grabbed a staff member's his hand between an NA's legs inappropriate comments. Staff avior review charting identified ve occasional sexual hi shifts with behavior weeks. Three shifts included and grabbing at a staff on 3/17/21 at 9:50 a.m. with had poor cognition and insight. In the Red wing prior to he R2 had a history or being ate with staff. R2 also had a ng and was moved to the SCU by inappropriate with another en moved to the Green Wing	F 6	510			

			COM	TE SURVEY MPLETED		
		245631	B. WING _			C / 17/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP COI 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		71172021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	recall the date but we unit on the day it or gotten R2 up in the the night staff to play him with poker chip staff assisted reside the last recliner on recliners in the complaced R2 on the or where R1 was sitting the hallway, she ob with his hand up R1 residents and reporting mediately. After the supervise R2 when residents. Staff were from R2, and provide puzzles, and other more recent encour meal. R2 was transfollowing the incide. During an interview the director of nursing R2 had a history of inappropriateness. Unattended by staff providing a.m. care 1/23/21, R2 was left dining area. R2 approbserved being sexually inappropriating 11/6/21, and was not inappropriateness the R2 was able to mot and at times attemprooms. Staff were the	e ago. NA-A was unable to was working the day shift in the curred. The night staff had morning. NA-A had instructed ace R2 at a table and provide is to keep him occupied while ent with a.m. cares. R1 was in the right side of a bank of mon area. The night staff oposite side of the recliners ag. As NA-A was coming down served R2 sitting next to R1 I's shirt. She separated the red the incident to the nurse the incident staff were to he was around other female the to also keep R1 separated de R2 with distractions, activities. R2 had another inter with R1 during the noon ferred to the Green wing int as that was an all male unit. I on 3/17/21 at 3:21 p.m., with ing (DON) identified R1 and encounters involving sexual On 11/6/21, R1 was left during while they were is to other residents. On it unattended in the SCU proached R1 and was cally inappropriate. R2 was ate towards staff only prior to out on the radar for sexual owards residents until 11/6/21. invate independently in the unit ofted to enter other resident's or redirect him and supervise residents. Staff were trained	F 61			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245631	B. WING				C 17/2021
	PROVIDER OR SUPPLIER	RNE		130	REET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH KNISS, PO BOX 539 IVERNE, MN 56156	<u>, 00/</u>	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	to redirect him whe second encounter with the action took place. Neither resident hat after the encounter.	n he had behaviors. R2's was less than one minute, and be outside of R1's clothing. d signs of distress during or . R2 was transferred to a and had no attempts to return	Fε	310			
	R3 wheeled over to and placed one har to be reaching to go hand. Staff had take dining area and had minute before retur Staff intervened and and initiated an action o signs of distress						
	severe cognitive im behaviors during as extensive assist wit mobility, total assist assistance with am	rly MDS identified R1 had pairment. R1 had no seessment period, required h toileting, dressing, and bed tance with eating, and limited bulation and transfers. R1 had mer's dementia and anxiety.					
	impaired cognitive in related to dementia time, or situation. Recommunicate her no intervention was additional time.	plan identified R1 had functions and thought process . R1 was not aware of place, .1 was not able to eeds. On 11/6/20, an ded that staff were to keep R2 1/26/21, an intervention was					

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE		CON	(X3) DATE SURVEY COMPLETED		
		245631	B. WING _			C / 17/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP CO 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	R2 apart from each interaction between 3/15/21, an interver keep R3 away from interactions between R1's progress notes sexual abuse perpet to keep R1 and R2 supervision. Staff fain a second sexual was sexually assaud another resident R3 facility identified R1 abuse related to he increased supervisifrom occurring, nor known sexual behavincreased risk to foother residents. Review of R1's 3/1/identified she had of limitation, and sens The assessment in maltreatment prevenention she was at following the 11/6/2 R3's 1/25/21, quart severe impairment, during the assessmindependently, was once in his wheelch assist with Activities	d staff were to keep R1 and other and supervise any the two residents. On attion was added for staff to R1 and supervise any in the two. Is identified following the strated on R1 by R, staff were apart and provide appropriate alled to do so, which resulted abuse event on 1/26/21. R1 lted on 3/13/21 a third time by B. There was no mention the was at increased risk for r dementia and required on to prevent further abuse identified residents with viors towards staff were at cus those behaviors towards 21, vulnerability assessment cognitive impairment, physical ory/communication limitations. dicated to see care plan for ention plan. There was no a increased risk for abuse 1 incident. Berly MDS identified he had No behaviors were noted tent period. R3 ate independent with locomotion lair, and required extensive is of Daily Living (ADL). R3's traumatic brain injury (TBI),	F 61			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245631	B. WING _		03	C / 17/2021
	PROVIDER OR SUPPLIER	ERNE		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	impaired cognitive and impaired though of a motor vehicle area also had mood anxiety disorders. From and comments that On 7/27/18, staff where was being sexually continued, staff we place and re-approdifferent staff memblessen sexually in a 3/13/21, an intervent of supervise interact and remove R3 from behaviors occurred an activity in a separate present. The facility risk for potential in a residents knowing in 2018. Review of R3's 1/25 identified he had in cognitive impairmed sensory and commassessed to have a rof maltreatment town was no indication of the form of the form of the presidents.	ed care plan identified R3 had function related to dementia the processes related to history accident that resulted in TBI. affective disorder, sexual and R3 made impulsive decisions a were sexually inappropriate. Here to redirect R3 firmly if he inappropriate and if behaviors are to remove him to a safe ach later. Staff were to try bers or use 2 staff if needed to peropriate behaviors. On the inappropriate behaviors. On the inappropriate inappropriate and if behaviors with female residents in situation if inappropriate in Staff were to distract R3 with a rate area if behaviors were appropriate behaviors with the had the behaviors with the had the behaviors with staff in the had the behaviors. There the taff accurately assessed R2 in appropriate behaviors and was therefore at otential abuse of other.	F 61			
	R3 had special nee all interactions with	resident Care Sheet Identified as as staff were to supervise female residents. If sexual, ct behavior or comments.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245631	B. WING			C / 17/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156	•	71172021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	ensure R3 was dist supervised when all Review of R3's behthrough 3/16/21 ided 1) 1/7/21, R3 made staff inappropriately 2) 1/10/21, R3 made during cares. 3) 1/13/21, R3 was the staff during care 4) 1/15/21, R3 was the staff. 5) 1/27/21, R3 had during the evening 6) 2/1/21, R3 asked could squeeze staff. 7) 2/2/21, R3 made statements towards 8) 2/3/21, R3 making grabbing at staff during at staff during at staff during at staff during cares. 11) 2/2/21, R3 made comments towards 10) 2/6/21, R3 made comments towards 10) 2/6/21, R3 made comments towards 11) 2/22/21, R3 made comments towards 11) 2/22/21	ation staff were alerted to anced and appropriately round female residents prior. avior notes from 1/1/21 antified the following. On: several attempts to grab at and made sexual comments. It is esexual comments to staff making sexual comments to ese. making sexual comments to many sexual comments to esexual comments to esexual comments and staff during cares. It is sexual comments and estaff during cares. When staff no comments and advancements are several sexually inappropriate staff. It is esexual comments and advancements are sexual remarks to staff during cares and priately touch staff 2 times. It is estaff names and told staff to estaff. It is a staff names and told staff to estaff. It is a staff names and told staff to estaff names estaff names and told staff to estaff names est	F6			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION DING	(X3	B) DATE SURVEY COMPLETED
		245631	B. WING	i		C 03/17/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE	RNE		STREET ADDRESS, CITY, STATE, ZIP 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156		00/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIAT	
F 610	periodically ask "horeferring to a femala 16) 3/14/21, R3 was staff members brea 17) 3/14/21, R3 matowards female staff 18) 3/15/21, R3 not comments to staff to the line of t	w about that little girl" e resident. s noted attempting to grab at a list during transfer. de several sexual comments if through the evening shift. ed to make frequent sexual hroughout shift. 1 at 9:15 a.m., with nursing entified she was the one who to between R1 and R3 that amon area of the Special Care is sitting in the recliner in the R3 was sitting in his by wall in front by R1. NA-A resident to the dining area and the common area, witnessed in top of R1's shirt over her is to stop as she walked eplied "she likes me". She nonverbal and smiled when in to remove R3 from the area. Is also in the area but had her ind R3, as she was assisting the time. LPN-A did hear directed at R3 and assisted the nurse instructed us to "keep after that. NA-A revealed R3 king sexual comments or however, R3 had never ent before to her knowledge. Was able to wheel his self	F 6	510		
	identified she was s	7/21 at 9:35 a.m., of R1 sleeping in the recliner located a on the SCU. No concerns ime.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED		
		245631	B. WING _		03	C / 17/2021		
	PROVIDER OR SUPPLIER	ERNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156			00/11/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 610	identified he was significant where an activate female residents with mediate area. Interview on 3/17/2 practical nurse (LP) the common area or resident when R3 to She reports she has residents at the time comment to R3 "you that" and turned to two. She revealed separated the rest R3 in eyesight. Observation on 3/11:00 p.m., of the considering in a reclinate behind R3. Significant walking through the of R3, however, state area. Interview on 3/17/2 identified the only rany sexual behaviounless he is resting does not attempt to	7/21 at 10:05 a.m., of R3 leeping while sitting in his e side of the room in the dining vity was taking place. No ere near. Staff were in the care near near near near near near near n	F 61	0				
	was sleeping in a r	7/21 at 2:00 p.m., identified R1 ecliner in the common area						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(2		SURVEY PLETED
		245631	B. WING			03/1	C 1 7/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156)E		772021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD B		(X5) COMPLETION DATE
F 610	nurse (RN)-B identi supervisor on 3/13/ an incident with R1 breast. Later on that LPN had reported to making comments at R1 so the staff most at R1 so the supervision of R3 do confirmed that R3 would supervised while he to ensure R1's safe. Review of memo to staff were to supervised most and female resident report to the RN im discussion or action. Interview on 3/17/2 administrator reveas sexual abuse he would not put into place to ensinvolved to prevent interventions into plincident of the same the unit. He agreed followed for R1 and the second incident they were not to be been left alone at the occurred. He identified involving R3 "could" incident ground incident involving R3 "could".	at 2:05 p.m., with registered ified she was the evening 21. Earlier in the day, R3 had where he touched R1's at same day in the evening, an o her R3 was talking to R1 of "that little girl" and pointing noved him to another unit to V. R3 did not get close to R1 unit was always staffed with ommon area for constant luring the evening shift. RN-A was now to be appropriately e was around other residents by and any other resident's. In staff dated 3/13/21, identified wise all interactions with R3 ts. Staff are to remove R3 and mediately if any inappropriate ins are witnessed.	F6	610			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245631	B. WING				C 1 7/2021
	PROVIDER OR SUPPLIER ERANS HOME - LUVE			STREET ADDRESS, CITY, STATE, ZIP CO 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156)DE		17/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 610	residents and we do the beneficial SCU stated R1 had no si unable to recall the facility did not prote reoccurrence. "You resident and predict there was nothing a the first incident wit already a victim of a supervision. Staff fi plans. He agreed th prevented the seco R2 but felt there wa though staff docum behaviors to staff pi The Administrator in the SCU that had a behavior was R3. Review of the 11/19 Resident Protection abuse was any non with a resident. Will an individual, not wi to inflict injury or ha employee or volunte they were to report supervisor or office immediately ensure made to the facility per state and federa components were in staff were responsil were educated on h were to assess, pla monitor residents w	licies in place to protect the o not want to move them off of unit if we do not need to". He igns of fear and R3 was event. He disagreed that the	F6	510			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		245631	B. WING	i			C 17/2021
	PROVIDER OR SUPPLIER		1	13	TREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH KNISS, PO BOX 539 UVERNE, MN 56156	<u> 00/</u>	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	and sensory deficits behaviors such as a rooms, wandering, inappropriate. Addit communication disc residents requiring dependent on staff. were to be identified resident involved ar prevent future occu protected from the attention was to inc safety for other resiresident could be at environment, consideration in location.	s, aggressive behaviors, entering other residents' and being socially tional risk factors included orders, nonverbal, and heavy care or are totally Appropriate interventions d and implemented for the all other residents to rrences. Residents were to be alleged offenders. Additional lude consideration to provide dents as appropriate. If the	F	610			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 5, 2021

Administrator Mn Veterans Home - Luverne 1300 North Kniss, Po Box 539 Luverne, MN 56156

Re: Event ID: PT9511

Dear Administrator:

The above facility survey was completed on March 17, 2021 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,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/20/2021 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00411 03/17/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS. PO BOX 539 **MN VETERANS HOME - LUVERNE** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

Minnesota Department of Health

Licensure.

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

The following complaints were found to be

notice of assessment for non-compliance.

On 3/17/21, 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

INITIAL COMMENTS:

04/12/21 **Electronically Signed**

STATE FORM PT9511 If continuation sheet 1 of 2

TITLE

(X6) DATE

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME - LUVERNE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156 (X5)		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 SUBSTANTIATED: H5631017C (MN67041), and H5631018C (MN7093), however NO licensing 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, the facility must acknowledge receipt							
MN VETERANS HOME - LUVERNE 1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 SUBSTANTIATED: H5631017C (MN67041), and H5631018C (MN7093), however NO licensing 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, the facility must acknowledge receipt			00411	B. WING		03/1	7/2021
LUVERNE, MN 56156 X44 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DEFICIENCY)	NAME OF I	PROVIDER OR SUPPLIER					
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 SUBSTANTIATED: H5631017C (MN67041), and H5631018C (MN7093), however NO licensing 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, the facility must acknowledge receipt	MN VET	ERANS HOME - LUVE	·KNF				
SUBSTANTIATED: H5631017C (MN67041), and H5631018C (MN7093), however NO licensing 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, the facility must acknowledge receipt	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
	2 000	SUBSTANTIATED: H5631018C (MN70 orders were issued. Minnesota Departm the State Licensing Federal software. The facility is enroll signature is not requal page of state form. is required, the facility is enrolled to the state form.	H5631017C (MN67041), and 193), however NO licensing				

Minnesota Department of Health

STATE FORM PT9511 If continuation sheet 2 of 2