STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Haven	1109 East Highway 7 Montevideo, MN 56265

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on observation, interview, and document review the facility failed to complete a timely comprehensive elopement risk assessment that addressed window type as a possible exit for mobile residents who were at risk for elopement for 1 of 3 residents (R1) who had a history of exit seeking. This resulted in immediate jeopardy (IJ) when R1 eloped from a window in her room and was found 1/2 mile from the facility approximately an hour later by the police and family member. The immediate jeopardy began on 12/28/24, when R1 eloped from the facility by exiting through the window in her room and was found an hour later 1/2 mile from the facility. The immediate jeopardy was identified on 1/9/25, and the assistant administrator was notified on 1/9/25, at 4:40 p.m. The immediate jeopardy was removed on 1/10/25, but noncompliance remained a lower scope and severity of a D with no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding include: R1's Face Sheet dated 1/8/25, indicated R1 had diagnoses of encephalopathy (disease of the brain that causes altered mental state and confusion), hallucinations, tremors, and insomnia (inability to sleep). R1's hospital Discharge Summary dated 12/23/24, identified R1 did attempt to elope from the hospital during her stay. The report also noted that upon discharge to the nursing home, R1 was exhibiting signs of paranoia and not wanting to go to the facility. R1's admission minimum data set (MDS) dated [DATE], identified R1 was admitted to the facility on [DATE], had moderate cognitive impairment with delusions. The MDS further indicated R1 had a history of wandering. R1 required supervision with walking but was independent with transferring and bed mobility. R1's progress noted dated 12/28/24 at 3:48 a.m., noted nursing assistant (NA)-B redirected R1 back to her room but was very difficult to redirect and had been restless most of the night. At 3:00 a.m. NA-B noted a cold breeze coming from R1's bedroom door and upon entering R1's room, noted R1 was not in the room, the window was open, and the screen was off the window. The administrator and law enforcement were notified. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Police Department Incident Report dated 12/28/24, indicated the police department received a report on 12/28/24 at 3:23 a.m. that R1 had left the facility through a window. R1 was located with a law enforcement drone and transported by ambulance to the ED to be evaluated after being in the elements for about an hour. R1's ED Provider Note dated 12/28/24 at 4:19 a.m., indicated R1 arrived at the ED with agitation, confusion, hallucinations, limited exposure to the cold, and evidence of falling onto her knees. R1's Baseline Care Plan dated 12/23/24, did not include wandering or elopement risks with individualized intervention to prevent/mitigate risk for elopement. The care plan identified R1 was admitted with weakness and confusion, disoriented to time and place along with communication was clear. She understood along with at times understanding others. She required supervision with transferring walking throughout the facility, used a walker, and needed staff assistance with toileting and dressing. R1's record reviewed between 12/23/24 through 12/27/24, had not identified risk for elopement even though the hospital discharge summary dated 12/23/24 identified R1 attempted to elope from the hospital. The MDS also identified R1 had a history of wandering. There was no indication the facility had completed a comprehensive risk assessment for elopement/wandering. R1's progress note dated 12/23/24 at 10:46 p.m., noted R1 wanted to go home and was not accepting staff's redirection, wandered into other resident's rooms, and was aggressive with staff. Staff placed a wander guard bracelet on R1's left wrist and increased staff supervision. R1's progress note dated 12/24/24 at 9:28 p.m., noted R1 had cut the wander guard off and threw it in the garbage. No extra wander guards were available so R1 was placed on hourly checks. R1's baseline care plan was not revised to include hourly checks. R1's progress note dated 12/25/24 at 11:32 p.m., noted R1 was found in another resident's bathroom with no wander guard on. R1 was also noted to be impulsive, hard to redirect, trying to open the exit doors and wandering the hallways. R1 had a coat, shoes, and head band and told staff she was going for a walk. Staff placed a new wander guard bracelet on R1 at 6:30 p.m. R1's progress note dated 12/26/24 at 12:52 p.m., noted staff found R1 with some of her belongings wanted to leave and was redirected by staff. R1's progress noted dated 12/26/24 at 9:01 p.m., noted R1 presented at the nursing station, requested to go home, and staff redirected R1 back to her room. R1's progress note dated 12/28/24 at 1:29 a.m., noted R1 was restless and wandering in and out of her room. R1 was given Melatonin (a sleep aide). During an interview on 1/9/25 at 12:20 p.m., NA-A indicated she worked the 10 p.m.-6 a.m. shift on 12/27/24, and R1 was very exit seeking from 10:00 p.m. to 2:00 a.m. Further indicated R1 wanted to go to the store, wanted her family to pick her up, and needed constant redirection but the redirection was not working. NA-A then identified her co-worker (NA-B) toileted R1 at 2:30 a.m. and encouraged R1 to lay down in bed. At 3:15 a.m., NA-A noticed R1's door was closed so opened it but could not find R1, then noticed the room was cold, the right crank window was open, and the screen was pushed out. NA-A immediately told the charge nurse and started searching for R1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/9/25 at 12:45 p.m., NA-B indicated she worked the 10pm-6am shift on 12/27/24, R1 was wanting to leave, was getting more antsy, and was not responding to redirection. NA-B requested a Melatonin for R1 at 1:00 a.m. and redirected R1 back to her room at least a couple more times. NA-B convinced R1 to lay down in bed at 2:30 a.m. but R1 insisted on staying in her clothes and had a pair of shoes by her. NA-B was in another resident room about 3:15 a.m. and heard other staff yelling for R1 and she helped search for her. NA-B indicated the facility protocol was to check on every resident every hour at night. During an interview on 1/8/25 at 3:15 p.m., registered nurse (RN)-A indicated she began her work shift at 2:00 a.m. on 12/28/24 and was aware R1 was an elopement risk. RN-A observed R1 in the recliner in her room at 2:00 a.m. and was notified at approximately 3:15 a.m. R1 had eloped out of the window in her room. RN-A immediately contacted the administrator and implemented the elopement policy. During an interview on 1/8/25 at 2:50 p.m., family member (FM)-A indicated she was notified on 12/28/24 during the early morning hours that R1 had gotten out of a window at the facility and went out to look for her. FM-A found R1 walking through the Subway sandwich parking lot wearing jeans, slippers, short sleeve shirt, and a sweatshirt coat. FM-A noted R1 wrapped in herself, shivering and got her into the vehicle further identifying R1 appeared cold but not freezing. R1 had mud on both knees of her jeans and told FM-A that she had crawled across the highway. FM-A indicated she had accompanied R1 to the ED. R1 was really confused and had a couple of bruises on her knees but no other noted injuries. During an interview on 1/8/25 at 3:45 p.m., the social worker (SW) reported she completes the elopement risk assessments on the residents upon admission but completes them within the assessment reference date (ARD) with the MDS and not always the first admission day. The SW indicated upon admission, R1 did not appear to be an elopement risk as there was not a history of wandering or elopement. R1's Elopement Risk Observation on 12/30/24 (two days after R1's elopement), indicated reason for R1's admission was dementia care and cognition was severely impaired. Further identified R1 was independent with mobility and was at risk for elopement due to the following risk factors: elopement success in the past, removing device, verbalizing statements about leaving, changes in medications, history of leaving facility, recent move to the facility, wandering in the past 60 days, depression, hallucinations, and other symptoms and signs involving cognitive functions and awareness. Interventions included: activities, door alarm band (wander guard), photograph posted, physician update, redirection, frequent checks, med changes, and window cranks removed from windows (R1s). Observations of the facility on 1/8/25 and 1/9/25 at various times throughout both days, revealed handle cranks on common area windows. Although the elopement risk assessment identified the cranks were removed from R1's windows, it did not identify the risk and interventions for other windows in the facility that R1 would have access to. An observation and interview 1/9/25 at 10:25 a.m., the administrator took the screen off in R1's room and measured the crank window opening to reveal a 16-17 inch wide opening and the bottom sill to be approximately 32 inches to the ground. The administrator verified the windows were all the same operationally and size throughout the facility. Administrator indicated he had not considered evaluating other residents at risk for elopment that had the physical abillity to exit through a window as part of their assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow up interview on 1/9/25 at 10:40 a.m., SW indicated the facility was aware the windows were a way to elope from the facility because a resident who no longer resided at there had eloped out of windows several times. Further indicated, the other residents that were at risk for elopement and new admission residents were not assessed for their ability to elope out the windows. During observation and interview on 1/8/25 at 2:50p.m., R1's windows were without the cranks. R1 was sitting in recliner, mumbling, and difficult to understand. R1 declined interview and stated she was not doing good. During a follow up interview on 1/9/25 at 4:10 p.m., R1 was sitting in the recliner in her room with legs over the side of the arms of the chair. R1 stated she was adjusting to staying at the facility because she had no choice and that her biggest problem was that she loved to be outdoors even in the coldest weather. R1 loved to go for walks, get fresh air, and go to the store which no one at the facility would allow her to do. R1 then indicated she was upset because of her stroke, dementia, and the need to stay in the facility. R1 did not mention the elopement from the facility. The facilities undated Admission Assessment Form indicates Elopement Risk Assessment was completed on admission day and then reviewed quarterly, annually, and significant change. The facility policy titled Elopement dated 12/28/24, indicated the purpose was to ensure the safety of all residents, protect any residents who are at risk for elopement, and to provide staff an organized plan for searching for an eloped resident. Procedure was to attempt to prevent departure, obtain assistance and detailed steps to take following an elopement but did not address prevention of elopement. The immediate jeopardy that began on 12/28/24, and removed on 1/10/25 and was verified through observation, interview, and document review, when the facility implemented the following interventions: -Updated the Elopement Risk Assessment tool to include assessment of physical ability to elope from the windows. -Updated the Facility Elopement policy to include to complete the elopement assessment the day of admission, readmission, change of condition, or as needed. -Removed all window cranks in common areas. -Reassessed all residents at risk for elopement for their physical ability to elope out the windows. -Reviewed elopement policy and educated staff on recognizing elopement hazards, opportunities, window cranks all interventions