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	06/05/2025

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 - Actual harm 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** Based on interview and document review, the facility did not assess or analyze trends of falls to determine causal factors or root cause and implement interventions to prevent or reduce the risk of falls with major injury for 1 of 3 residents (R1) reviewed who had falls. This resulted in actual harm when R1 suffered spinal compression fracture at T12 (thoracic spine last vertebrae), L1 and L2 (lumbar spine between the top two vertebrae) and a rib fracture as a result of two unsupervised falls. Findings include: R1's face sheet dated 6/5/25, identified diagnoses of Parkinson's disease (condition that affects movements), dementia (decline in mental ability), and depression (mood disorder characterized by persistent sadness). R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment with diagnoses of Parkinson's Disease, dementia with behaviors, and depression. R1 had no behaviors, rejection of cares or wandering. R1 required maximal assist of one staff person for activities of daily living (ADL)s, bed mobility and transfers. R1 was occasionally incontinent of bowel and bladder and did not have a toileting schedule. R1 walked and used a walker and wheelchair. R1 received antipsychotics, antidepressants and anticoagulants. R1 did not have restraints or alarms. R1's physician orders indicated on 11/27/24 to walk resident with assist of 1-2 with gait belt followed by wheelchair to meals. Also, document when restless. R1 fall risk assessment dated [DATE], indicated high risk for falls score of 18, indicating R1 was at high risk for falls. Review of facility incident report list from 3/28/25 thru 6/3/25, indicated R1 had seven falls as follows: Fall 3/28/25 (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress notes dated 3/28/25 at 4:25 p.m. R1 was in wheelchair in dining room, R1 attempted to get up out of wheelchair and walk; staff witnessed resident fall, he did not hit his head, denied pain, and there was no injury noted at this time. When asked what he was doing R1 replied, this happens 2-3 x's a week. R1 vital signs stable. R1 encouraged to get assistance with transferring or walking, R1 was redirected with activity, food, drink, and toileting. Will encourage fluids. Family, director of nursing, nurse manager notified and telephone order on clipboard. Facility event report dated 3/28/25, indicated R1 had a witnessed fall in the dinning room at 3:30 p.m. R1 just had a snack and denied any injury or pain after the fall, R1 had good range of motion (ROM). Staff listed possible causes as cardiac/respiratory disease, and the use of analgesic and antipsychotics. Intervention included educating R1 to ask for help when getting out of chair, and redirection with activity, food, fluids, and toileting. These interventions were effective, and the care plan was followed. The incident report lacked a root cause analysis of the fall. R1's interdisciplinary note (IDT) dated 3/31/25, indicated witnessed fall, no injuries noted. R1 had diagnoses of dementia and has poor safety awareness. R1 was impulsive and restless at times. Evening staff will walk with resident at beginning of shift. R1's fall care plan was revised 3/31/25 with the following interventions; staff to ambulate R1 at beginning of evening shift at approximately 3:30 p.m., due to R1 frequently getting restless at this time. Review of R1's ambulation record from 1/1/25 thru 6/5/25 indicated an order dated 11/27/24, to walk R1 to meals with assist of 1-2 staff with gait belt to all meals, follow with wheelchair. Also document when restless. The following documentation was identified: January 2025- no documentation record. February 2025-ambulated twice on the 2/4 and twice on 2/11. March 2025- no documentation sheet. April 2025- ambulated 4/6 and 4/20 the rest were blank May 2025- blank June 2025- blank. R1's physician note dated 4/8/25, indicated R1 had Parkinson's Disease, dementia without behavioral disturbance and was stable. R1 had recurrent falls, and gait instability. He was impulsive and may not wait for staff assistance related to the dementia. R1 was on Zyprexa to assist with this. There were no new orders or interventions listed. Fall 4/12/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 4/12/25 at 12:49 p.m., R1 was found lying on the floor on his back by the foot of the bed. Wheelchair was noted next to bedside table. R1 was lifted via total mechanical lift with three staff assist. R1 complained of pain to his forehead and knees, ice applied and scheduled Tylenol given. R1 had a 3.0 centimeter (cm) x 3.0 cm bump with 2.0 cm x 1.0 cm abrasion/bruise on the left side of forehead. He also had a 1 cm x 1 cm abrasion to left elbow. Staff were educated not to leave R1 alone in room with a known history of self-transfers. Range of motion (ROM), vital signs and neuros within normal limits for R1. Family, and physician notified. Facility event report dated 4/12/25, indicated R1 had an unwitnessed fall at 11:40 a.m., in his room. R1 was sitting in his wheelchair and not able to identify what happened. R1 had moderate pain in his forehead and knees, with a bump and abrasion to his forehead. Possible contributing factors included R1 does self-transfers and received analgesics and antipsychotics. Immediate interventions were neurological checks as fall was unwitnessed and had a head injury. R1's interdisciplinary team (IDT) note date 4/14/25 at 8:45 a.m., and updated R1's care plan to not leave R1 alone in his room when he is in the wheelchair. Fall 4/19/25 R1's progress note dated 4/19/25 at 6:41 p.m., indicated R1 was found on floor in Haven lounge. R1 had been sitting in recliner watching TV and eating popcorn, with gripper socks on. R1's wheelchair was beside the recliner and was found laying on his back and on the foot pedals of another resident's wheelchair. Four staff attempted to use a full mechanical lift sheet but R1 yelled out in pain and pointed to his left eye and groin area. R1 was sent to the hospital, family, physician and management were notified. Facility's event report dated 4/19/25 at 5:54 p.m., indicated R1 had an unwitnessed fall on 4/19/25 in the Haven Lounge. R1 complained of moderate pain in his stomach and head. R1 had a possible head and hip injuries and was sent to the emergency department (ED). There were no deformities noted but R1 had pain with range of motion (ROM). The event report did not list any contributing factors for the fall and R1 was on antipsychotics. Care plan was followed and event report lacked a root cause analysis of the fall. R1's ED physician note dated 4/19/25, indicated R1 being found down after an unwitnessed fall at facility with trauma to his occipital (back of head) scalp area with an occipital scalp [NAME] (swollen bruise). CT report indicated T12 compression deformity, newly visualized since 2024, recommend correlation with point tenderness. Lidoderm (pain) patch applied and Tylenol 650 mg every 6 hours as needed for pain. R1 was discharged back to the facility to follow up with primary care physician as needed. R1's IDT note dated 4/21/25 at 9:00 a.m., indicated R1 had fall with injury and was sent to the ED. R1 has T12 fracture. R1's nursing home physician round note 4/23/25, indicated follow up ED visit. Nursing notes indicated that R1 was not having pain symptoms or discomfort. R1 has advanced dementia. R1 had improved back to his baseline health status. No new orders or fall interventions were identified. Fall 5/6/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 5/6/25 at 4:16 p.m., indicated R1 had an unwitnessed fall and was found lying on his right side by nurses' station. Staff previously spoke to resident 5 minutes prior. R1 sent to ED. Facility's event report dated 5/6/25, indicated R1 had an unwitnessed fall at 4:14 p.m., by the nurses' station. R1 would not allow ROM to hips/legs, had no pain and was sent to the ED for evaluation due to previous fracture. R1 had dementia, and this was a possible contributing factor. R1 received analgesics and antipsychotics. Immediate intervention was to send R1 to the ED for evaluation. Family, physician and management were notified. Care plan was being followed at the time of the fall. R1's ED physician progress note dated 5/6/25, indicated R1 was brought to ED after a fall with right shoulder pain. R1 had recent T-spine fracture. CT of chest, abdomen, and pelvis revealed unchanged T12 vertebral body compression fracture. No acute fractures. Kidney stone noted and urinalysis had abnormal finding and R1 was started on antibiotic and returned to the facility. R1's IDT note dated 5/7/25, R1 had unwitnessed fall at the nurse's station. R1 went to the ED, no injuries and diagnosed with urinary tract infection (UTI) and toileting plan was updated. R1's care plan intervention dated 5/7/25, identified staff to toilet after supper. Fall 5/12/25 R1's progress note dated 5/12/25 at 8:10 p.m., R1 had unwitnessed fall at nurses' desk. Activity aide (AA)-A who was near R1 heard R1 hit the floor and called for help. Two nurses and one NA assisted R1 off the floor via a sit to stand lift. R1 was complaining of pain to back, head, and right leg. Vital signs were stable and sent to the ED. Review of facility's event report dated 5/12/25, indicated R1 had an unwitnessed fall at the nurses station. The report listed AA-A was in the vicinity. R1 complained of moderate pain in head, back and right leg. R1 had no visible injuries and complained of pain with ROM to lower extremities. The event report further indicated R1's neurological disorder was a possible contributing factor. R1's ED note dated 5/12/25, identified R1 was brought in by ambulance for evaluation after an unwitnessed fall. R1 was complaining of pain of headache and back pain. CT was done of thoracic spine and revealed acute non-displaced fracture of L1 and L2 spinous process (a small wing-like bone projection that extends outward from each vertebra along the spine). R1 discharged back to the facility and advised to continue pain patch, follow up with primary physician, and return to ED for any concern or any worsening symptoms. R1's IDT note dated 5/13/25 at 9:04 a.m., indicated R1 had become weak related to not ambulating as often. Orders for physical therapy (PT) to evaluate for strengthening and occupational therapy (OT) to evaluate for wheelchair positioning. R1's care plan intervention dated 5/13/25, identified physical therapy (PT) to evaluate for strengthening and occupational therapy (OT) to evaluate for wheelchair positioning. Fall 5/15/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 5/15/25 at 12:57 a.m., indicated R1 was found sitting on the mat/floor, holding onto the grab bar. R1 was sent to the ED for evaluation due to his previous fractures was listed as the intervention. R1's ED physician progress note dated 5/15/25, identified R1 had been seen after a fall out of bed. Chest, abdomen and pelvis computed tomography scan (CT) identified R1 had a minimally displaced acute-appearing fracture of the right anterior seventh rib,constipation, and lung opacity (hazy gray areas on CT or x-rays) favoring mild infectious/inflammatory process. He was started on Augmentin (antibiotic) and to follow up with physician, use pain medication as previously directed and was discharged back to facility. R1's safety event-fall report dated 5/15/25, identified R1 had an unwitnessed fall at 12:57 a.m., and was found in his room sitting on the mat holding the grab. R1 had been observed at 11:30 p.m., and was sleeping in bed. R1 had complaints of pain in knees and was sent to the emergency department (ED) for evaluation. R1's fall focus care plan intervention were revised 5/15/25, identified R1's bed to be in lowest position with mat on floor and pharmacist review of medications. R1's pharmacy review dated 5/15/25, identified a medication review had been requested due to R1 falling three times in past week. R1 was on an antibiotic on 5/15/25 for lung opacity after being seen in the ED. R1 had multiple medications with potential side effects of dizziness, and ortho hypotension (a sudden drop in blood pressure that occurs when a person stands up after sitting, or lying down) which could contribute to falls. These medication included Fluoxetine, Mirtazapine, Olanzapine, Quetiapine, Sinemet, and Tamsulosin. Pharmacist's suggested course of action included: 1- Consider doing orthostatic blood pressure twice daily for three days to rule out hypotension as a contributor to falls. 2- If recent labs have not been done, could consider a complete metabolic panel (CMP) or a complete blood count (CBC). 3- Please review the above listed medication with the potential side effect for dizziness. R1 was receiving Seroquel 50 mg twice daily, Olanzapine 2.5 mg daily, Mirtazapine 30 mg at bedtime and Fluoxetine 10 mg daily. Could consider a trial decrease on Olanzapine to 1.25 mg if appropriate for R1. Review of R1's medication and treatment administration record dated 5/1/25 through 5/31/25 did not identify any orthostatic blood pressures were completed. Interview on 6/4/25 at 4:21 p.m., nurse manager (NM)-A stated the pharmacist recommendations were faxed three times to MD-A and faxed back without any changes. NM-A further stated the MD-A was rounding on 6/5/25 and would address the recommendations with him at that time. NM-A stated they have not completed any orthostatic blood pressures for his falls. They do not think it was an orthostatic issue but were related to his impulsivity. Fall 6/3/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 6/3/25 at 7:10 p.m., identified R1 had just been in dining room finishing supper and was found five minutes later on the floor in front of a room. R1 was toileted at 3:00 p.m., and had gripper socks on at the time of the fall. R1 was transferred off the floor with a total mechanical lift and blood pressure was noted to be lower than normal. ROM good to all extremities with no pain or injuries noted. R1 was taken to the bathroom and had a large bowel movement. R1 was highly agitated yelling, and combative with neuros. R1's fall event report dated 6/3/25, identified R1 had an unwitnessed fall at 6:56 p.m. in the hallway. Immediate intervention of toileted and neurological checks. R1's progress note dated 6/4/24 at 6:45 a.m., identified medication nurse was interviewed and R1 was agitated and combative with all evening cares and when nursing assistants attempted to toilet R1 at 5:00 p. m. and 6:00 p.m., R1 would not allow nursing assistants to take him to the bathroom. Intervention included 1:1, bring R1 to quiet area, feed him supper, warm blanket, and attempt other staff to toilet him. Toileting schedule set up before supper to prevent R1 from getting agitated when he had the urge to have a bowel movement. Medical doctor (MD) will round on 6/5/25 and pharmacist wil be consulted on medication times if there are other options for psychotropic (drug that affects a person's mental state) medications related to dementia and Parkinson's disease. R1's physician progress notes dated 6/5/25, identified R1 had six falls since March had Parkinson's symptoms that were stable along with dementia without behavioral disturbance. R1 continued to be impulsive and get up on own, mainly in the afternoon. Had 6 falls since March. Continue diligence as able. R1 currently taking Seroquel by neurology, will continue this. R1 also taking Remeron and Prozac, which could contribute to increased agitation and R1 getting up without assistance. MD-A recommended decreasing dose of Remeron to 15 mg and to discontinue the Prozac. R1 also takes blood thinner due to history if pulmonary embolism and deep vein thrombosis. If falls continue, may need to discuss with family on discontinuing this medication. R1's falls care plan start date of 3/1/24, indicated R1 was at risk for falls due to Parkinson's disease, impaired cognition, weakness and history of falls. Interventions included: -R1 will not be left unattended in the BR due to impulsivity, decreased safety awareness and history of self-transferring/falls, dated 7/22/24; -Dycem gripping material placed under wheelchair cushion to promote positioning, dated 8/16/24; -R1 to wear gripper socks at bedtime and gripper socks or shoes during the day, dated 8/27/24; -Remove wheelchair foot pedals and place in storage bag located on wheelchair when not transporting, dated 9/9/24; -Gripper tape placed in front of bed, dated 9/16/24 -Physical and Occupational Therapy referral as needed to promote strength, endurance and mobility, dated 11/18/24; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Due to increased restlessness encourage R1 to rest in recliner throughout the day, dated 1/3/25; -Staff to walk with R1 at beginning of evening shift approximately at 3:30 p.m., due to R1 frequently getting restless at this time, dated 3/31/25; -Do not leave alone in room in wheelchair, dated 4/14/25; -Toilet before supper 5/7/25; -Physical therapy to eval for strengthening and Occupational therapy to eval for wheelchair positioning, dated 5/13/25; -Bed in lowest position, dated 5/15/25; and -Pharmacist review of medications, dated 5/15/25. Interview on 6/3/25 registered nurse (RN)-B stated the R1 had numerous falls in the past three months, with two fractures. RN-B was not able to articulate the R1 was to be toileted at 2:30 p.m. and before supper or that R1 was to ambulate to meals. Interview on 6/3/25 nursing assistant (NA)-P stated try to prevent falls with R1, make sure that R1 is at the nurses' station, give him snack, help him watch TV. Was not able to articulate that R1 had a ambulation or toileting schedule. During clarification interview on 6/6/25, NA-P was able to get the [NAME] walk book and identified R1's walking sheet. NA-P verified that nothing was signed off for the month of June. Interview on 6/4/25 NA-D stated R1 was to be toileted every 2 hours and when he was agitated. NA-D could not articulate that R1 was to be walked to meals and when agitated. Interview on 6/4/25 NA-V stated R1 did not have a walking program, and there was not a toileting schedule for R1. Interview on 6/6/25 NM-A was not able to provide needed documentation of R1's ambulating to meals or the toileting times of 2:20 p.m. and before supper were being completed. Interview on 6/4/25 at 9:00 a.m., director of nursing (DON) reviewed falls and was unable to identify the root cause of R1's falls or if the care plan was being followed. DON further stated her expectation was that staff identified the root cause and that immediate interventions were put into place. The interdisciplinary team also reviewed the fall with interventions to make sure the interventions were evaluated for appropriateness. Although the facility identified interventions, there was no indication these interventions were being implemented consistently, nor were there any ongoing analysis of the falls to determine if the interventions were effective. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/4/25 at 4:25 a.m., administrator stated the facility was notified of funding availability for a performance-based incentive payment program ([NAME]) project for a fall prevention program which they plan to start this month. All falls need to have appropriate immediate intervention implemented at the time of the fall and then the IDT reviews it at their next meeting to verify the intervention is appropriate and working to prevent further falls. Facility quality assurance and performance improvement (QAPI) notes from January 2025 thru May 2025, indicated the following: -January 14, 2025, QAPI discussed F689 as part of the plan of correction (POC), audits regarding their surveys. Audit had been completed three times a week. Results overall have been successful. Some concerns noted with getting them all completed, especially on the weekend when leadership is not present. Audits will be reduced to one time per week and management will look at new education topic to be covered. Administrator fur reviewed the Minnesota quality indicators with the committee, which included falls with injury. The facility had a significant number of falls during the past three to four months, but the injuries have decreased significantly. Committee to continue to monitor. -February 11, 2025, facility level quality marker report was reviewed by administrator with committee. Area's facility is falling in the high percentile included falls and falls with injury. Committee discussed involving therapy more especially at the time of admission and utilizing the screening forms by staff. The fall risk form being completed was also discussed regarding what actions to take after the form is completed. At risk resident were also being monitored each week at the weekly risk meeting. -April 8, 2025, March falls were reviewed. There were 34 falls for the month, one resident had 13 falls, eight residents had 2 or more falls, and 20 of the falls occurred during the evening and nights shifts. There was one fall with injury. The committee discussed how falls could also be a possible [NAME] project. The facility fall policy dated 9/2024, did not indicate that an immediate fall intervention should be implemented. Facility undated procedure entitled Events indicated an attached table that indicated when a fall even should be open and under who fills out indicated for licensed staff at time of fall that assesses resident with pertinent fall information; charge nurse assigned to resident for shift will complete remaining sections ***BE SURE TO IMPLEMENT AN IMMEDIATE INTERVENTION AND USE CRITICAL THINKING TO DETERMINE THE CAUSE OF THE FALL***