STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on interview and document review the facility failed to ensure 1 of 1 grievance policy and procedures were followed. The facility failed to post the grievance policy prominently and throughout the facility and provide forms to submit a grievance anonymously if desired. In addition, the facility also failed to document all grievances, the action taken to resolve grievances and the summary of the resolution to each grievance. This had the ability to affect all 54 residents. Findings include: Interview on 9/9/24 at 12:09 p.m., with R39 who reported that he must wait for someone to come help him. He likes to get up around 7:30 a.m., and no one came to help him until 9:00 a.m. and he was so mad he could have burnt the place up. Interview on 9/9/24 at 1:27 p.m. with R9 who reported the staff are good when they have time. The staff try however, this morning she had put her call light on to get up and had to wait 2 hours before someone came to help her and that is not unusual. Interview on 9/11/24 at 2:43 p.m., with R48's family member identified she had complained about long call light wait times however, nothing had ever occurred related to long wait time. Review of the grievances for the last year provided was a word document that listed dates and concerns and included identified long call light wait times reported on 9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24. Only follow up documentation was on 12/13/23, as the concern identified resident was currently in quarantine due to COVID-19 and family was educated on infection control process and the call light review found that the call light had not been turned on. All other grievances related to long call light times had no action taken or resolution identified. The surveyor requested the investigation and resolution of the reported long call light wait time concerns with no further documentation provided. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 9/11/24 at 1:39 p.m., with licensed social worker (LSW)-A who identified she was unsure of who all the grievances were for the dates that had been requested (9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24) however, she was able to figure out some of the residents. She reported the call lights go through the call phone and staff report they do not have enough call phones. She further reported she had no formal grievances it was just residents telling her and she would make a note on the word document that she had provided. She confirmed that she did not fill out a grievance form. Upon admission the facility reviews how to make a grievance and provided a copy of the grievance policy. She revealed there was no form for the residents or families to utilize to make a grievance. She reported families will make concerns known by email or just tell her. She identified the process was for the resident and/or family to go to the source first, if not resolved they could come to her or the administrator, and if still not resolved they may be referred to the ombudsman or to make a state report. Interview on 9/11/24 at 2:07 p.m., with R53 who was unsure how to report a complaint. R53 reported she would just tell her son and contact the attorney downtown. Interview on 9/11/24 at 2:12 p.m., with R5 who identified he did not know what to do or who to tell if he had a complaint or concern. Interview on 9/11/24 at 2:13 with R20 who identified she would not tell anyone if she had a complaint as she did not want to [NAME] up the place. She identified she would tell her family and they would tell her to just keep it to yourself. She reported she did not want to ruffle any feathers so she does not complain. Interview on 9/11/24 at 2:19 with R9 who identified she reports to registered nurse (RN)-C or the social worker if she has any concerns. She also revealed that other residents will come to her and ask her to report as they do not want to bother the staff. Interview on 9/11/24 at 2:39 p.m., with FM-F reported they were unsure how to make a complaint no one had ever explained that to them. Interview on 9/11/24 at 2:43 p.m., with family member (FM)-E was not sure of a policy or process but would tell the nurse working if had a concern. Review of the blank September 2023, Grievance Form identified the following area's to be documented on: 1) Resident name 2) Date and time of concern 3) Details of concern 4) Statement of witness regarding concern 5) List any contributing factors 6) What immediate action was taken place upon learning of the concern (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7) Actions taken 8) Comment or recommendation 9) Signature of individual completing the form There were following pages of the form, that included a place to document by the grievance officer if concern was reportable, the type of concern it was, a place to document investigation findings and summary of investigation. A page to document the resolution or action taken to resolve the grievance, the time and date the resident and/or representative was notified of the resolution, a place to document if the physician was notified of resolution, ombudsman if applicable, the director of nursing and the administrator. Interview on 9/11/24 at 4:34 p.m., with director of nursing (DON) identified grievance were handled by the social worker. All grievances should be documented and kept for records. She agreed there should be forms available for residents, families, or staff to assist residents with if they have a complaint, and for anonymous grievances also. The DON stated there needed to be improvement in this area for sure. Interview on 9/12/24 at 8:47 a.m., with administrator identified any time a grievance comes forward it was reported to LSW-A, the DON, or himself. All grievances were overseen by the social worker and reviewed at the daily interdisciplinary team meeting (IDT). He reported during the IDT meeting we come up with an action plan and then the social worker would review that with the resident and family. He reported the facility also reviewed grievances during the QAPI meeting. He would expect that the policy would be followed, and the facility would utilize the forms available to document grievances on. He further agreed that the grievance forms should be available for residents, staff, and representatives to fill out or make an anonymous complaint and kept for records for a minimum of 3 years. He was unaware the facility grievance forms had not been utilized for documenting grievances. Review of the September 2023, Grievance policy and procedure identified the facility encourage residents and/or representatives to communicate grievances verbally or in writing. The facility further, encouraged residents and/or representatives to first discuss their concern informally among themselves. If grievance was not resolved then the grievance should be brought to the attention of the grievance officer, the administrator or the designee for assistance to direct the resident or representative to the proper department for resolution. If a resolution has not occurred, the grievance shall be reduced to written form and the grievance officer, administrator or designee would address as soon as possible but no later than five working days when possible. If resident or representative was not satisfied with the decision of the grievance officer, administrator or designee they may contact the Office of Ombudsman or Office of Health Facility Complaints. The policy indicated that the grievance officer would keep on file paper or electronic written grievance documents for 3 years. The policy had no mention that the facility would document grievances, the action taken to resolve the grievance and the summary of the resolution. The policy further had no mention that the policy would be posted throughout the facility and residents or representatives could make anonymous grievances if desired.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to ensure a fall with injury and potential neglect was reported to the State Agency (SA) for 1 of 3 residents (R11) reviewed for falls. Findings include: R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure. R11's fall report indicated on 8/29/24, R11 had a fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation. In review of Facility Reported Incidents (FRI), it was not evident R11's fall was reported to the State Agency. R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples. R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29. Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff don't want to switch to the Hoyer [total lift]. R11's annual Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand related to a recent fall. Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Fall Risk assessment dated [DATE], indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to perform that function. An option for required the use of assistive devices such as a cane, walker or wheelchair was left blank. During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell . NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts. During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the verbal reminder to follow care sheet. Her expectation was that all staff would be educated on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being unpredictable in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management. During an interview on 9/12/24 at 8:13 a.m., with the administrator identified his expectation was that all staff including agency staff, would have been trained to follow care sheets and care plans and would have followed the care sheets and care plan for R11. Further stated he expected the facility would have reported R11's fall to the SA per facility policy. Review of a facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property revised 7/24, identified Neglect was defined as a failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Further identified it was the facility's policy to report and suspected Abuse, Neglect, Exploitation, Mistreatment, or Misappropriation of Resident Property immediately.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to complete an accurate and thorough investigation of falls to determine the root cause, if the care plan was followed, and if the fall was reportable to the State Agency (SA) for 1 of 3 residents (R11) reviewed for falls. Findings include: R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure. R11's fall report indicated on 8/29/24, R11 had a fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation. R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples. R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29. Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff don't want to switch to the Hoyer [total lift]. R11's annual Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand related to a recent fall. Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. R11's Fall Risk assessment dated [DATE], indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to perform that function. An option for required the use of assistive devices such as a cane, walker or wheelchair was left blank. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell . NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts. During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the verbal reminder to follow care sheet. Her expectation was that all staff would be educated on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being unpredictable in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management. R11's records lacked evidence that a thorough investigation and/ or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29. During an interview on 9/11/24 at 3:17 p.m., director of nursing (DON) verified a thorough investigation of R11's fall including an RCA and contributing factors had not been done. DON stated her expectation was that a thorough investigation of R11's fall would have been completed to reduce future falls for residents and to mitigate any injuries related to resident falls. During an interview on 9/12/24 at 8:13 a.m., administrator stated the investigation of R11's fall was not thorough enough to determine if the care plan was followed or that neglect did or did not occur. Administrator stated his expectation was that a thorough investigation of R11's fall would have been done to prevent future falls. Review of a facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property revised 7/24, identified Neglect was defined as a failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identified Investigation is the process used to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause analysis investigation and analysis would have been completed. The information gathered was to be given to administration.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on interview and document review the facility failed to ensure call lights were answered timely for 4 of 4 residents (R9, R29, R39, and R48) reviewed for activities of daily living (ADL's). Findings include: R39 Interview on 9/9/24 at 12:09 p.m., with R39 who reported that he must wait for someone to come help him. He likes to get up around 7:30 a.m., and no one (satff) came to help him until 9:00 a.m., and he was so mad he could have burnt the place up. He reported the pool staff are really crabby they do not give a [expletive] as they are only here a short time. One time a pool staff came and fell asleep in the parking lot in her car. R39's 8/30/24, quarterly Minimum Data Set (MDS) identified Brief Interview for Mental Status (BIMS) score as 15 cognition was intact. He had verbal behaviors directed towards others andrequried sustantial to partial assistance by staff for cares. He took scheduled pain medication, an antidepressant, anticoagulant, and a diuretic. R39 had diagnoses of anemia, coronary artery disease, hypertension, demenia, and depression. R39's 9/9/24, Care Sheet identified he was a fall risk, he was to get up first by 7:00 a.m., needed 1 staff assistance for cares and then was independent with transfers and toileting in his room. R9 Interview on 9/9/24 at 1:27 p.m. with R9 who reported the staff are good when they have time. The staff try however, this morning she had put her call light on to get up and had to wait 2 hours before someone came to help her and that is not unusual. R9's 8/16/24, quarterly MDS identified her BIMS score was 15 and her cognition was intact. She had no behaviors and required partial assistance with cares. She had frequent pain and rated her pain an 8 on a scale of 1 to 10. She took daily pain medication, antianxiety, antidepressant, antibiotic, diurtic, and hypglycemic medications and she was on oxygen. R9 had diagnoses of heart failure, heypertension, uanxiety, depression, asthma, and imflammatory bowel disease. R9's 9/9/24, Care Sheet identified she was a fall risk, used an EZ sit to stand lift with one staff or pivot transfer with 2 staff, and she was unable to walk at this time. She needed assistance of one staff for cares and toileting. Interview on 9/11/24 at 9:45 a.m., with registered nurse (RN)-C who identified the call light response time was a problem. There were many variables that could be the reason why the call lights were not addressed timely, but it was an issue staff were aware of. When the facility had an interim administrator, the call light response time was being addressed at QAPI and the interim administrator was out on the floor all the time and the call light average response time was down to about 10-20 minutes however, that has not continued since the interim was no longer present in the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R48 Interview on 9/11/24 at 2:43 p.m., with R48's family member identified she had complained to facility staff about long call light wait times however, nothing had ever occurred related to long wait time, or was conveyed as to what the facility would do to decrease the time or investigate why it was occurring. R48's 8/12/24, significant change MDS identified her BIMS score was 15 and her congition was intact. She had no behaviors and required partial assistance with cares. She had one fall since her last assessment with no injury. She had frequent pain and rated her pain an 8 on scale of 1-10. She took daily pain medication, antipsychotic, antianxiety, antidepressant, diuretic, and hypoglycemic medicatoins and she was on oxygen. R48 had diagnoses of cancer, anemia, thyroid disorder, and anxiety. R48's 9/9/24, Care Sheet identified she was a fall risk and she required one staff for cares. Review of call light logs from 9/5/24 through 9/10/24 found: 1) R39 on 9/8/24 activated his call light at 7:04 a.m., and it was on for 86 minutes. 2) R9 on 9/8/24 activated her call light at 9:23 a.m., and it was on for 41 minutes and again activated her light at 1:48 p.m., and it was on for 49 minutes. On 9/9/24 R9 activated her call light at 7:28 a.m., and it was on for 82 minutes and again activated her call light at 7:41 p.m., and it was on for 50 minutes. On 9/10/24 she activated her light at 8:25 a.m., and it was on for 42 minutes. 3) R48 on 9/6/24 activated her call light at 11:57 a.m., and it was on for 52 minutes. On 9/7/24 she activated her call light at 10:18 a.m., and it was on for 54 minutes and again at 11:09 a.m. she activated her light, and it was on for 58 minutes. On 9/9/24 she activated her call light at 8:01 a.m., and it was on for 42 minutes. Review of staff assignment sheets for the day shift identified on 9/6/24 there had been a staff call-in (unable to work) however, a replacement was found. On 9/7/24 there had been one staff call-in and an area identified as a split with no staff assigned to work that area. It was unknown if the facility was down a second staff on the day shift. On 9/8/24 it was identified that there was one staff call-in and one staff that arrived to work late. On 9/9/24 there no call-ins. On 9/10/24 there had been one staff call-in. R29 R29's quarterly Minimum Data Set, dated dated dated [DATE], identified R29 had intact cognition and had diagnosis which included myasthenia gravis (a disease that weakens your muscles), low iron in the blood, and high blood pressure. R29 required staff assistance with ADL's which included toileting, dressing, and transferring. R29 was incontinent of bladder. R29's care plan dated 10/20/20 identified R29 required assist with toileting. R29 was to call for assistance and staff were to answer R29's call light promptly. R29's care sheet dated 9/9/24, identified R29 needed assist of one staff as needed with transfers and toileting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Luther Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 East Highway 7 Montevideo, MN 56265	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/24 at 9:48 a.m., R29 stated there were a few times in the past few weeks where staff had helped him to the bathroom but did not return when he put on the call light so he had to get himself off the toilet. R29 stated I could have fallen. During an interview on 9/11/24 at 9:51 a.m., NA-D stated it was difficult to answer call lights timely. NA-D stated Sometimes we are in another room assisting a resident which makes it hard to answer all the call lights timely. NA-D identified the goal was to answer call lights within 5 minutes but that it was difficult to do. Review of R29's call light logs from 8/30/24 through 9/10/24 revealed: On 8/29/24 R29 activated his call light by the bed at 9:16 a.m., and it was on for 54 minutes. On 8/29/24 R29 activated his bathroom call light at 11:37 a.m., and it was on for 189 minutes. On 9/4/23 R29 activated his bathroom call light at 10:55 a.m., and it was on for 180 minutes. Review of the grievances from September 2023 through September 2024 identified long call light wait times were grieved by residents and/or families on 9/29/23, 10/18/23, 12/6/23, 12/13/23, 2/16/24, 4/5/24, 4/10/24, 4/11/24, and 8/7/24. The only follow up documentation for the avove mentioned dates was on 12/13/23, as the concern identified a resident was currently in quarantine due to COVID-19, and family was educated on infection control process and the call light review found that the call light had not been turned on. All other grievances related to long call light time grievances had no resolution identified or proposed action to be taken. Interview on 9/11/24 at 4:34 p.m., with director of nursing (DON) identified she would expect call lights to be answered within 5-10 minutes. Interview on 9/11/24 at 4:49 p.m., with nursing assistant (NA)-C identified that it was hard at times to get the call lights answered timely. She revealed if staff are in another room assisting another resident staff could not just leave to go answer a call light. She reported the goal was that call lights would be answered within 5 minutes but that was hard to do. NA-C was unaware if her or other staff's failures to answer call lights were brought forth to management to identify concerns by staff on the ability to assist residents timely with ADL's. Interview on 9/11/24 at 4:55 p.m., with licensed practical nurse (LPN)-A identified there was a problem with call lights being answered timely. She felt it was because there were several residents who required 2 staff and a mechanical lift, and several residents who required total assistance with cares. The staff are not charting how much work they are doing and that was why they were staffed the way they were. She felt if staff would do a better job on charting the heavy cares they are doing would show and that would get them more assistance on the floor. I have tried to educate the direct care staff to chart more frequently as they can chart right from their phones. She further noted staff could chart while in a resident's room while waiting for a resident to finish using the bathroom. Staff were supposed to try to get the call lights answered within 10-15 minutes. LPN-A had not voiced her concerns to management, however call light audits had been done. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/12/24 at 8:59 a.m., with administrator identified his expectation was that call lights would be answered timely, and no resident should have to wait an hour to have their call light answered. Review of the 8/14/21, Call Light, Use Of policy identified staff were to respond promptly to resident call lights. Call lights will signal to the [NAME] phones and appear on the marquee. Staff were to answer call lights promptly and never make a resident feel like staff are too busy to give assistance. 45844

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(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 45844

Based on observation, interview, and document review, the facility failed to appropriately assess and/or follow the care plan and ensure safe transfers were performed for 3 of 3 residents (R11, R16, and R37) while using sit-to-stand mechanical lifts (EZ stand) (requires a resident to be partial weight-bearing) to prevent or mitigate falls or risk thereof. This resulted in an immediate jeopardy (IJ) for both R11 and R16 who fell from and EZ-stand and required hospital evaluation and treatment). Both events had the potential for serious harm, injury, impairment, or death.

The IJ began on 8/29/24, when nurse aide (NA)-A failed to follow R11's care plan and ensure 2 staff transferred R11 while using an EZ-Stand. R11 let go of the bars on the EZ -Stand and fell backwards out of the sling, resulting in a laceration to the back of her head. R11 was previously identified in June 2023 to be inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff don't want to switch to the Hoyer [total lift]. Staff failed to identify NA-A's failure to follow the care plan. On 8/31/24, NA-B failed to follow the care plan for R16 and transfer her with 2 staff performing the transfer using an EZ-Stand. During the 1 staff transfer, R16 held her breath, passed out while she was supposed to be partial weight bearing, and was lowered to the floor. R16 was then transferred to the hospital for further evaluation and treatment. R16 was identified previously to be unsafe to use an EZ stand in June 2024, due to her inability to always bear weight and behaviors of holding her breath, but was not re-assessed by staff for the need to use a total lift for transfers. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 9/10/24 at 2:37 p.m. The immediate jeopardy was removed on 9/12/24 at 7:46 a.m., but noncompliance remained at a lower scope and severity of a D: No actual harm with potential for more than minimal harm that was not immediate jeopardy.

Findings include:

R11

R11's Face Sheet dated 8/29/24, identified R11 had diagnosis which included dementia, diabetes mellitus (DM), and acute kidney failure.

R11's fall report indicated on 8/29/24, R11 had a fallen in her room while being transferred by a nursing assistant using the EZ-Stand. R11 had let go of the bars on the EZ-Stand, fell out of the sling and was believed to have hit her head. A laceration was present to the back of R11's head and R11 was sent to the ER for evaluation.

R11's progress note dated 8/29/24, at 11:24 p.m., identified the computed tomography (CT) scan of R11's head was negative and the laceration to R11's head did not require any stitches or staples.

R11's records lacked evidence a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would have included but not been limited to if R11's care plan had been followed at the time of the fall on 8/29/29.

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Luther Haven	1109 East Highway 7 Montevideo, MN 56265

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physical therapy (PT) note dated 6/9/23, identified R11 was inconsistent with participation of the EZ-Stand: requires assist of two with the EZ-Stand: unable to recommend anything else and staff don't want to switch to the Hoyer [total lift]. R11's annual Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment. R11 required substantial/maximum assist for sit to stand and for toileting. R11's Comprehensive Care Area Assessment (CAA) identified R11 had an activities of daily living (ADL) deficit related to a history of falls, dementia age, and limited and impaired mobility. R11 had a history of unsafe self- transfers. R11's care plan dated 8/29/24, identified R11 had self-care deficits with ADL's and was at risk for falls related to a history of falls, dementia, limited and impaired mobility. Identified R11 required assist of two with an EZ-Stand for transfers. PT was to evaluate R11 for transfers in the EZ-Stand related to a recent fall. Review of the NA care sheet (abbreviated care plan used by NA's) dated 8/29/24, identified R11 required assistance of 2 staff and the EZ-Stand with transfers. R11's Fall Risk assessment dated [DATE], indicated R11 was at high risk for falls. The care plan was noted to not have been reviewed at that time to identify if current interventions were appropriate. R11 was not able to perform independent standing without staff assistance for the assessment as staff noted she was unable to perform that function. An option for required the use of assistive devices such as a cane, walker or wheelchair was left blank. During an telephone interview on 9/9/24 at 5:11 p.m., nursing assistant (NA-A) stated she had worked the evening of 8/29/24, when R11 fell . NA-A stated while she was transferring R11 alone in the EZ-Stand R11 had let go of the EZ-Stand bars, slipped out of the sling and fell backwards. R11 had hit her head resulting in a laceration and it was bleeding. NA-A stated she was unsure of what R11 had hit the back of her head on. NA-A worked for a staffing agency and the day of R11's fall was only her second or third day working in this facility. NA-A was unaware R11 required two staff assist with the EZ-Stand because she had not received any care plan or care sheet education during her orientation to the facility or prior to working with R11 and was unsure of the last time she received any training on mechanical lifts. During an interview on 9/10/24 at 7:17 a.m., the clinical nurse manager (CM)-A (also the MDS nurse) stated it was discovered NA-A had transferred R11 alone with the EZ-Stand instead of using two staff per R11's care plan and care sheet. Staff were to use the care sheets to identify how residents transfer. NA-A was unaware R11 required the assist of two staff and the EZ-Stand for all transfers. CM-A elaborated NA-A worked for a staffing agency, was new to the facility, and was was unsure how much orientation NA-A had received from the facility before working independently. After R11's fall, the following week, she had verbally reminded NA-A to ensure that care sheets were to be followed but was unsure if any other staff received the verbal reminder to follow care sheet. Her expectation was that all staff would be educated on NA care sheets and to have followed the care sheets and use two staff while using the EZ-Stands per policy. (continued on next page)

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(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

During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated she had seen R11 related to the fall from the EZ-Stand where staff were using one staff instead of two while transferring R11. PT-A stated staff were to use two assist with the EZ-Stand to transfer R11 because R11 had a history of being unpredictable in the EZ-Stand. Her expectation was the all staff would have followed R11's care plan and PT recommendations for R11. PT-A had not voiced any concerns to management.

R16

Review of the 9/1/24, at 1:40 p.m., report to the State Agency (SA) identified on 8/31/24 at 9:09 a.m., R16 had a fall at 9:09 a.m At approximately 11:30 a.m., R16 began experiencing pain in her left lower extremity and was transferred to the local ER, was found to have a fracture in her leg (noted later by the radiologist to be consistent with a disease process vs the fall) and had to be transferred to a regional hospital for further evaluation and treatment.

A follow up email to the SA dated 9/5/24 at 10:35 from director of nursing (DON) stating during the investigation it was revealed that a nursing assistant had been using the EZ-Stand independently and had not been following R16's care plan.

R16's fall report identified on 8/31/24 at 9:15 a.m., R16 had been lowered to the floor in the EZ-Stand. R26 was later sent to the ER, and subsequently hospitalized for a leg fracture and a report had been filed with the SA and an investigation initiated. No other details were included on the fall report.

Review of the facility's investigation file identified R16 required assist of two staff with EZ-Stand with transfers. The investigation determined only one staff had been used for the transfer, but could not determine through their root cause analysis as the care plan had not been followed, however, it was also noted R16 likely passed out from holding her breath during the transfer.

R16's Face sheet dated 9/8/24, identified R16 had diagnosis which included diabetes mellitus (DM), hypertension (elevated blood pressure), and vertigo (dizziness).

R16's Comprehensive Care Area Assessment (CAA) dated 10/19/23, identified R16 had an activities of daily living (ADL) deficit related to impaired mobility and chronic pain. R16 had a history of falls. R16 was noted to have moderate cognitive impairment identified on her ADL section of her CAA. R16 had no behaviors noted.

R16's quarterly Minimum Data Set (MDS) dated [DATE], identified R16 had intact cognition. R16 required substantial/ maximum assist for sit to stand and for toileting. R16 had no behaviors noted.

R16's care plan dated 10/26/24, identified R16 had self-care deficits with ADL's and was at risk for falls related to impaired mobility and a history of falls. R16 required two assist with use of the E-Z Stand for transfers.

Review of nursing assistant (NA) care sheet dated 8/30/24, identified R16 required the assist of two staff with use of an EZ-Stand for transfers.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R16's fall risk assessment dated [DATE], identified R16 was at high risk for falls. R16 was noted to have intermittent confusion, poor recall, judgement, and safety awareness. R16 was not able to stand on both feet, without holding onto anything to walk and was not noted to use an assistive device, such as a can, walker, or wheelchair and was chair-bound. Review of a PT note dated 12/26/23, identified R16 was referred to PT as she held her breath during transfers using the EZ stand. Per the registered nurse, this caused some bursting of blood vessels in her facial area. The physician had requested the referral. Pt noted per staff nothing had changed. The room was very tight (not a lot of room to maneuver a mechanical lift). R16 was not open to suggestions most of the time and staff had to cue her to not hold her breath. Physically, she did well hanging onto the EZ stand. Patient can be very stubborn and abusive to staff and therapy. There was no indication R16 was assessed for partial weight bearing as required for use an EZ stand or if PT recommended the use of a total lift since they were aware staff reported her holding her breath to the point of extreme (bursting blood vessels), which could lead to an episode of unconsciousness. Review of a progress note dated 6/6/24, indicated EZ-Stand is not recommendable anymore because R16 does chicken wings elaborating her elbows were not straight (in line with her body) and had an outward V formation and anytime can give up and fall. R16's progress notes identified on: 1) 6/9/24, indicated resident was doing chicken wings and gets purple/red (faced from holding her breath) during transfers. 2) 8/31/24 at 9:09 a.m., identified R16 held breath during transfer in EZ stand causing her to pass out and be lowered to the ground. R16 did not want to be seen in the ER. 3) 8/31/24 at 9:15 p.m., identified around 11:30 a.m., R16 began having left leg pain. Previously, she only allowed ice at the time but has now agreed to be seen in the ER and was transferred to the ER. 4) 9/1/24 at 1:05 a.m., identified ER called and stated R16 was being transferred to another facility due to a left leg fracture. R16's CT scan titled final report dated 9/1/24 at 7:34 a.m., identified R16 had a left leg fracture. During a telephone interview on 9/10/24 at 4:14 p.m., NA-B stated she had worked the evening of 8/31/23, when R16 was lowered to the floor. NA-B stated while she was assisting R16 off the toilet alone without other staff in attendance, using the EZ-Stand. While transferring, R16 held her breath, blacked out and slid out of the lift sling. NA-B stated she had to lower R16 to the floor. NA-B stated she was aware she was suppose to use two staff and the EZ-Stand to transfer R16 but she had not asked for help because R16 does not like a lot of the other staff. NA-B stated the nursing assistant (NA) care sheet says to use two staff but that is difficult because R16 only liked certain staff. NA-B stated it was important to use two staff with the EZ-Stand while transferring R16 because of safety related to R16 had history of holding her breath during transfers. (continued on next page)

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(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	During an telephone interview on 9/10/24 at 9:03 am., medical director (MD) stated he was aware that certain residents required the EZ-Stand and two staff assist to transfer. MD stated his expectation was that staff would have followed R11 and R16's care plan and the facility policy regarding the use of lifts. Assessments should be performed upon admission, quarterly, yearly, or as needed to correlate with residents abilities or changes. During a telephone interview on 9/11/23 at 7:58 a.m., licensed practical nurse (LPN)-E stated R16 has struggled and was unable to hold her arms in line with her body, and her arms would V out aka chicken wing for some time now while using the EZ-Stand. R16 required assist of two staff to use the EZ-Stand because of R16 not being able to have proper arm alignment (chicken wings) while using the EZ-Stand. LPN-E further stated R16 was not safe to be transferred with only one staff member with the EZ-Stand related to the potential for a fall. LPN-E was aware R16 was known to hold her breath and likely fell related to that, and not following the care plan by ensuring 2 staff were present. During an interview on 9/10/24 at 7:17 a.m., clinical manager CM-A stated it was discovered NA-B had transferred R16 alone with the EZ-Stand instead of using two staff per R16's care plan and care sheet. CM-A stated staff were to use the care sheets for all transfers. CM-A stated NA-B stated she had performed R16's transfer with the EZ-Stand independently because R16 did not like many of the other staff. CM-A stated NA-B was aware that two staff and the EZ-Stand were required for all of R16's transfers. CM-A was aware R16 had a history of holding her breath during transfers, and noted it was important to use two staff and the EZ-Stand for all transfers to try to prevent falls and to mitigate any injuries from falls. R16 had not been assessed to identify if she would require the use of a total body lift for safety. During an interview on 9/11/24 at 3:47 p.m., physical therapist (PT-A) stated R16 had been seen by therapy this past year related to R16 holding her breath in the EZ-Stand. PT-A stated therapy had recommended to continue using two staff assist with the EZ-Stand to transfer R16 for safety related to R16 holding her breath during transfers. PT-A stated her expectation was the all staff would have followed R16's care plan and PT recommendations for R16. R37 Review of R37's 7/17/24, quarterly MDS assessment identified her cognition was intact. R37 had diagnosis of heart failure, history of a tibia fracture, and history of falling. she was independent with her wheelchair, and required substantial/maximal assistance with transfers, dressing, personal hygiene, and bed mobility. Review of the facilities current nurse aide care sheets identified R37 was non-ambulatory due to right leg fracture, required assistance of 1 staff for transfers using a sit to stand mechanical lift for transfers, and a full body mechanical lift as needed. The care sheet did not identify what parameters staff should use to identify when it was appropriate to use a full mechanical lift rather than a sit to stand lift. Observation on 9/9/24 at 1:34 p.m., identified nursing assistant (NA)-A placed the harness across R37's back and connect the straps to the sit to stand, placed feet on the platform, and secured the safety strap. NA-A used the lift to stand R37 for a transfer, R37's knees were bent, her elbows were pointing outward vs next to her person, and she appeared to not be able to bear weight. (continued on next page)

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(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	Interview on 9/9/24 at 1:35 p.m., with NA-A identified she uses her care sheets to identify how many staff or what level of assistance the resident requires. She was unable to identify what would prompt her to use a full mechanical lift rather than a sit to stand lift or when she would notify the nurse that the resident is not safe to use the sit to stand lift if they cannot bear weight as an EZ stand requires. During an interview on 9/10/24 at 11:46 a.m., director of nursing (DON) verified both R11 and R16 required two staff assist and EZ-Stand for all transfers. DON verified staff were to be using the care sheets to care for the residents. DON stated NA-A had not known about the care sheets and facility had no documentation of training on care plans or care sheets for NA-A prior to or after R11's fall. DON stated there was not a good process for orientation of agency staff but going forward there would be a better process. DON also verified the only education that was received after both of the above falls was verbal reminders for staff to ensure that the care sheets are followed. She was was unable to determine if all staff had received the verbal reminders. The DON stated she was unsure of when/if all staff received mechanical lift competencies. DON stated her expectation was that all staff would have received education about the care sheets after R11 and R16's falls and would have followed the care sheets for R11 and R16, but could not ensure all staff were notified. The reason R11 and R16 required two staff and the EZ-Stand was to reduce falls and mitigate any injuries from falls. DON further stated competency training should be given to all employees to reflect current knowledge of the facility's resident specific needs and services. During an interview on 9/12/24 at 8:13 a.m., with the administrator identified his expectation was that care sheets and care plans for R11 and R16 should have been followed. All staff including agency staff would have received education on care sheets and care plans prior to working at the facility. Review of a facility policy titled EZ Lift and/or EZ Stand revised 8/11/15, identified staff were to ensure resident safety at all times while using the EZ Lift/ EZ Stand assist of two staff is required at all times unless care plan states assist of one. Review of a facility policy titled Fall Protocol undated identified fall events would be completed in Matrix and immediate interventions put into place related to fall. The immediate jeopardy that began on 8/29/24, was removed on 9/12/24, when it was verified the facility: 1) Reviewed and updated policies related to care sheets, care plans, and using the EZ Lift/Stand. 2) Educated all licensed staff and nursing assistants including agency staff and performed competencies on how to appropriately use the EZ Stand and Care sheets. 3) Updated the orientation checklist for agency staff. 4) Re-assessed all residents currently using an EZ Stand to determine if they were able to be partial weight bearing per manufacturer's guidelines in order to use the EZ Stand. 5) Educated staff on incident reporting to the SA. (continued on next page)

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(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	47497

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024

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Luther Haven	1109 East Highway 7 Montevideo, MN 56265

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and record review, facility failed to ensure 8 of 8 nursing assistants ((NA)-A, NA-B, NA-F, NA-G, NA-H, NA-I, NA-J, and NA-K) 4 of 4 registered nurses (RN)-D, RN-E, RN-F and the infection preventionist (IP)), and 1 of 1 licensed practical nurse (LPN)-F were deemed competent on the operatioon of mechanical lifts and following care plans and care sheets, upon hire, yearly thereafter, or as needed when identified concerns with competence were noted. This had the potential to affect all 54 residents who had/may use mechanical lifts, and had care plans and care sheets. Findings include: Review of the NA employee files identified: 1. NA-A had a hire date of 8/27/24. 2. NA-B had a hire date of 2/4/22. 3. NA-F had a hire date of 3/27/24. 4. NA-G had a hire date of 6/11/24. 5. NA-H had a hire date of 5/15/23. 6. NA-I had a hire date of 1/22/4. 7. NA-J had a hire date of 7/17/24. 8. NA-K had a hire date of 4/25/24. None of the above mentioned NA staff had competencies performed for the use of mechanical lifts, following care plans, and care sheets. Review of the licensed and registered nursing staff employee files identified: 1. The IP had a hire date of 5/9/11. 2. RN-D had a hire date of 5/31/24. 3. RN-E had a hire date of 7/31/24. 4. RN-F had a hire date of 5/9/24. 5. LPN-F had a hire date of 12/21/22. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	None of the above mentioned staff had competencies performed for the use of mechanical lifts, following care plans, and care sheets. During an interview on 9/9/24 at 5:11 p.m., NA-A stated she worked for a staffing agency and was new to the facility. NA-A had been working independently at the facility for a few weeks now. NA-A could not recall receiving any training and/or had competencies performed on the operation of mechanical lifts, care plans, or care sheets prior to being allowed to work independently at the facility. During an interview on 9/10/24 at 4:14 p.m., NA-B stated she had worked at the facility for over 2 years now. NA-B was unsure if she had received training and/or had competencies performed on the operation of mechanical lifts, care plans, or care sheets During an interview on 9/11/24 at 3:16 p.m., the director of nursing (DON) verified there were no competencies regarding operation of the mechanical lifts, or following care plans or care sheets upon hire or yearly. The DON stated the orientation process for all staff including agency staff could be improved. Her expectation was that all staff including agency staff would have been competent on the operation of mechanical lifts, and following care plans and care sheets to ensure resident safety. The DON further stated competency training should be given to all employees to reflect current knowledge of the facility's resident specific needs and services as outlined in the facility assessment. Review of the [NAME] Haven Staff Development Policy revised May of 2019, identified all personnel must participate in initial orientation and regularly scheduled in-service training classes. Staff were to receive training on topics required by federal and state guidelines, based on the employee's department department/specific job, and on topics identified through the facility assessment. Training records were be filed in employee's personnel file and/or maintained by the scheduler.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on observation and interview the facility failed to follow their policy and ensure discontinued medications for 5 of 5 residents (R12, R16, R52, R55, R108) were removed timely and not co-mingled with other current medication supply located in the East and [NAME] double locked narcotic medication drawer within the medication cart. Findings include: Observation and interview on [DATE] at 2:26 p.m., of the west medication cart narcotic count between registered nurse (RN)-A and licensed practical nurse (LPN)-A. During the controlled substance count it was identified that R12 had 4 bottles of morphine 100 milligrams (mg)/5 milliliter (ml) with 3 of the bottles being partially used and one bottle being unopened who staff reported had passed away on [DATE]. R108 had 2 bottles of morphine 100 mg/5 ml that were unopened who staff reported had discharged on [DATE]. R55 also had 2 bottles of morphine 100 mg/5 ml that were unopened in the cart, staff reported she had passed away on [DATE]. R12's [DATE], Physician Order Report identified morphine concentrate 100 mg/5 ml 0.25 ml three times a day for chronic pain. R12's [DATE], progress note identified resident passed away at 4:15 a.m., hospice was notified and family. R108's [DATE], Physician Order Report identified morphine solution 10 mg/5 ml administer 1.25 ml every 4 hours as needed for shortness of breath. R108's [DATE], progress note identified discharge to the U of M for a couple weeks with no bed hold wanted. R55's [DATE], Physician Order Report identified morphine solution 20 mg/ml administer 0.5 ml every hour as needed for adult failure to thrive. Morphine solution 20 mg/ml administer 0.75 ml every hour as needed for adult failure to thrive. Morphine solution 20 mg/ml administer 1 ml every hour as needed for adult failure to thrive. R55's [DATE], progress note identified resident expired at 7:15 a.m., Hospice was notified and family. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on [DATE] at 2:40 p.m., of the east medication cart narcotic count between LPN-B and LPN-C. During the controlled substance count it was identified that R52 had 5 Fentanyl 25 mcg/hr patches and 9 hydrocodone/APAP ,d+[DATE] mg. Staff reported those medications had been discontinued. R16 had 15 oxycodone 5 mg tables, 3 punch cards of hydrocodone/APAP ,d+[DATE] mg tablets totaling 86 tablets, and morphine solution 100 mg/5 ml with 18.5 ml remaining. Staff reported that R16 passed away on [DATE]. LPN-B confirmed that the nurse should be removing the discontinued medications out of the medication cart as soon as possible and destroying. The controlled medications require 2 licensed staff to destroy and with the staffing challenges it has been really hard to get the medication destroyed. LPN-C further confirmed as licensed nurses when someone passes away or discharges the medications should be removed from the medication cart and destroyed. R52's [DATE], Physician's Orders identified an order to discontinue Fentanyl patch and start morphine SR 30 mg PO twice a day as needed for break through pain. R52's [DATE], Physician's Orders identified an order to discontinue Norco. R16's [DATE], Physician Order Report identified morphine concentrate 100 mg/5 ml administer 0.5 ml every hour as needed for severe pain or shortness of breath. Physician order report had no mention of Oxycodone 5 mg or hydrocodone ,d+[DATE] mg. R16's [DATE], label on the Individual Narcotic Record sheet identified hydrocodone/APAP 5 mg/325 mg every 6 hours as needed for severe pain. R16's [DATE], individual narcotic record sheet identified oxycodone 5 mg every 6 hours as needed for moderate pain or severe pain. R16's [DATE], progress note identified resident passed away at 5:10 p.m., family and hospice notified. Interview on [DATE] at 2:48 p.m., with RN-B confirmed discontinued medications should not be kept in with active medications and should be removed and destroyed right away. Interview on [DATE] at 2:50 p.m., with director of nursing identified she had not had time to review the medication destruction policy but confirmed that discontinued medications should not be kept in the cart co-mingled with other active medication very long. Review of the [DATE], Medication Destruction/Disposal policy identified medication would be destroyed and disposed of in a timely manner that complies with both federal and state guidelines in addition to guidelines set by the Board of Pharmacy and recommended by the pharmacist.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47497 Based on observation, interview, and document review, the facility failed to ensure staff were not co-mingling personal food and effects with resident food. This had the potential to affect all 54 residents who ate food prepared from the kitchen. Findings include: Observation on 9/9/24 at 10:45 a.m., during the initial tour of the facility kitchen with the dietary manager present, a reach-in refrigerator in the baking area of the kitchen had two separate compartments. The top compartment contained 5 tumbler style drink cups with straws sticking out of staff's, and 2 Tupperware containers containing staff personal food. The refrigerator also contained food used for residents including butter, frosting, liquid eggs, ice cream topping, and glucerna supplements. The bottom compartment was not cooling and contained staff effects including shoes, pretzels, clothing, and bags containing unknown items of staff's. Interview on 9/10/24 at 1:17 p.m., with the dietary manager identified she agreed with the above findings and did not know why staff had been storing things in the resident kitchen refrigerator. She would expect staff to follow policy and use the staff break room fridge and lockers to store their food and personal items. Review of the facilities 2017, Personal Hygiene Training Policy identified street clothing, coats, purses, packages, and other personal effects will be stored in employee lockers and not in the kitchen.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on interview and document review the facility failed to implement 1 of 1 facility assessment protocol related to ensuring staff competencies were identified and completed respective to staff duties performed. Findings include: Refer to F726 Interview on 9/12/24 at 9:04 a.m., with administrator stated the facility competency requirements listed on the facility assessment did not reflect the practice of staff training on the floor. The facility had recently made changes to the facility assessment, under the direction of regulation mandated for nursing homes in July of 2024. All staff were not informed and were not updated of the facility assessment changes recently. The Quality Assessment and Assurance (QAA) committee was to approve the assessment revision and would relay to all staff the facility's operational goals related to person-centered cares, staffing services, and resources. Review of 9/2024 [NAME] Haven Nursing Home 2024 Facility Assessment Tool identified staff education and competencies were necessary to provide support for the residents. The facility identified staff education, training, certifications, testing, and facility policies to support the care needed for the residents. In addition, the facility would identify processes and oversight that would meet residents needs through regulatory, operational, maintenance and staff training requirements. Lastly, the facility would review resources annually, and would evaluate day to day operations, including emergencies, to ensure residents care maintain their highest practicable physical, mental and psychosocial well-being.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47497 Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 54 residents. Findings include: Review of the quarterly QAPI meetings covering March of 2024 through July of 2024, identified the facility departments were submitting data to be reviewed by the committee as follows: QAPI minutes dated 3/28/24 identified: 1) The facility departments had brought forth concerns regarding urinary tract infections (UTI's) with contributing factors of standing order concerns with providers, antibiotic stewardship, and staff training. The QAPI committee did not identify a analysis of the data, a measurable goal, or an action plan to help reduce the prevalence of UTI's in the facility. 2) The infection preventionist identified the facility had 5 UTI's, 2 residents with pneumonia, 2 with respiratory symptoms, 2 with confirmed norovirus, and 34 residents on precautions due to norovirus. 2 staff had tested positive for covid, and 35 call ins with varying symptoms. The committee discussed the need for audits to be completed, however the minutes did not identify that the data had been analyzed to identify a root cause, a measurable goal, or an action plan to help reduce the risk for spread of infection. QAPI minutes dated 4/22/24 identified: 1) The facility licensed social worker brought forth grievances and State Agency reporting for residents concerned with rough care, falls with multiple fractures, resident with multiple bruising, call lights being answered timely, and resident to resident altercations. The QAPI minutes did not identify an analysis of the date to identify a root cause, a measurable goal, or an action plan. QAPI minutes dated 7/9/2024, identified: 1) The facility had an ongoing performance improvement project (PIP), the minutes identified they had been consulting with wound care for recommendations, they had 4 residents with pressure ulcers 1 present on readmission, then 2 present on admission, and 1 facility acquired. The minutes did not identify an analysis of the data to determine a root cause, a measurable goal, or a meaningful action plan to help reduce the risk for pressure ulcers and improve skin integrity. 2) During the month of June the facility had 10 falls with no injury or minor injury and 4 falls with major injury. The QAPI minutes again did not identify an analysis of the data to determine a root cause, a measurable goal, or an action plan to help reduce the risk of falls or injuries. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 9/11/24 at 4:48 p.m., with the administrator identified they had not been working on anything but the Performance Improvement Project (PIP) for skin, the PIP had stared in January of 2023, at that time they had a rate of 7.4 percent and a goal of 4.4% but they had not analyzed the data since starting the project. He was not sure what the action plan was other than to consult with the wound care nurses. He identified he would expect they should be following the facility QAPI plan. The Facility Quality Assurance Plan dated May 2022, identified the QAPI team would review data and input monthly to look for potential topics for improvement, they would analyze data, and review feedback and input from residents, staff, families, volunteers, providers, and stakeholders. would complete a systematic analysis and systemic action by completing a root cause analysis to identify the underlying cause and contributing factors. The QAPI team will develop action to address identified root cause and contributing factors of issues or events that will affect change at the systems level. They were to test actions and revise policies and or procedures as appropriate. To ensure the planned changes or interventions are implemented and effective in making and sustaining improvements, the facility would choose measures that tie directly to the new action and they would conduct ongoing periodic measurements and audits. The QAPI team would review the results to ensure that the new action has been effective.