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	08/20/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 2 of 15 sampled residents (R8 and R29).Findings include: R29 undated, current diagnoses sheet identified that R29 had a diagnosis of altered mental status, social phobia, depression, hallucinations, and psychotic disorder with delusions. R29's 2/02/23, Level I Preadmission Screening and Resident Review (PASRR) identified a referral for an OBRA Level II assessment for mental illness was required. R29's 2/08/23, Level II PASARR was completed and identified R29 had a mental illness. R29's 2/08/23, admission Minimum Data Set (MDS), section A identified R29 had no mental illness documented. R29's subsequent MDS assessments for section A from 2/8/23 through 7/25/25, identified they also had been marked no for mental illness. Interview and document review on 8/20/25 at 10:11 a.m., with the social worker (SW) identified R29's Level II PASARR diagnosis of mental illness was not marked on the MDS because R29 was not eligible to receive additional services. The SW did agree, when staff answered the question on the MDS Section A: A1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDS should have been coded as yes. Interview on 8/20/25 at 10:34 a.m., with director of nursing (DON) identified she would expect the MDS to reflect accurate assessments of resident's condition and agreed the MDS' should have been checked yes. Review of undated [NAME] Haven MDS Completion and Submission Timeframes policy identified the nurse manager, or designee was to ensure resident assessments was completed in accordance with federal and state guidelines. There was no mention of how the facility would ensure accurate assessments occurred, who had been trained to perform them, and if oversight was to be provided.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document the facility failed to have a process for monitoring personal refrigerators located in 1 of 15 sampled resident's (R23) room to ensure temps were monitored, food was not expired, and the refrigerator maintained to prevent potential food born illness. Findings include: Observation on 8/18/25 at 11:30 a.m., in R23's room identified a small dorm style refrigerator. Inside the refrigerator was a small freezer. The refrigerator contained sausage, sliced cheese, several bottles of boost supplement, and soft chocolate candy. The freezer contained an item wrapped in white paper labeled Souse (meat made from various parts of the pig such as head, feet, and ears) with a freeze by date of July 2024. The freezer nor refrigerator contained a thermometer. Outside of the refrigerator identified no log to show that staff were monitoring or maintaining the refrigerator. Interview on 8/20/25 at 9:00 a.m., with the administrator identified the facility was not monitoring the refrigerator. He noted they should be monitoring to ensure the food was safe to eat and they need to revise the facility process for personal refrigerators. Interview on 8/20/25 at 11:26 a.m., with the infection preventionist identified not monitoring and maintaining resident personal refrigerators was concerning. This could lead to a food-born illness. The facility should have a process to ensure the food residents are consuming is fresh, safe, and sanitary to avoid potential illness. Residents at the facility are here because they require care and should not be expected to maintain their personal refrigerators and ensure the food they consume is safe. The facilities Resident Personal Refrigerator Policy identified Residents at [NAME] Haven will be permitted to have a personal refrigerator in their room. The refrigerator will be the responsibility of the resident and/or their family. Residents or their families will be responsible for ensuring the refrigerator maintains a temperature of 41 degrees or below.