

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MN Veterans Home - Luverne		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 North Kniss Avenue Luverne, MN 56156	
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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide safe transfer for 1 of 1 resident (R1) who required the use of a mobility van mechanical lift. This resulted in actual harm when R1 fell from the mobility van to the ground which resulted in significant ongoing pain, administration of pain narcotics and a decrease in activities of daily living (ADL)s. The facility implemented corrective action prior to the investigation, so the deficiency was issued at Past Noncompliance. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had moderately impaired cognition, no behaviors, and no rejection of cares. R1 required staff assist with dressing, personal hygiene, and transferring. R1 required a manual wheelchair but was independent with mobility. R1's diagnoses included heart failure, arthritis, aphasia (language disorder that affects how you communicate), hemiplegia (paralysis on one side of body), and seizure disorder. R1 denied having pain but did receive scheduled pain medication. R1's pain assessment dated [DATE], identified R1 did not have any pain or hurting in the five days prior with no other information provided. R1's care plan revised on 9/12/25, directed assist of one to two staff with stand-aid lift, and large harness and one staff assist with upper and lower body dressing. On 12/22/25 at 12:50 p.m., a Plan of Care Note indicated R1 had a fall while getting out of the facility van at his appointment destination. The note further identified the facility van driver noted R1 to have a laceration to back of head, right wrist, and ambulance was called. Hospital ED noted dated 12/22/25 at 1:46 p.m., identified R1 had mild wedging (wedge fracture) of T1, L1, and moderate wedging of LA. The report also identified the fractures are age indeterminate (unsure of age), old but there were no comparison studies. The bones are demineralized which limits detection of nondisplaced acute fracture; with the limitation, there is no definite acute fracture or dislocation identified in the cervical spine. Hospital discharge notes dated 12/25/25 at 10:38 a.m., indicated back pain was musculoskeletal pain; imaging did show some concern of wedging though uncertain on chronicity (age of fracture). Supportive care with plan for therapy consults and pain medication was needed. On 12/26/25 at 1:08 p.m., a Hospital Return Note identified R1 returned to facility after hospitalization for chronic obstructive pulmonary disease (COPD) exacerbation, pneumonia, right wrist wound, and lower back pain. The note further identified R1 was not alert or oriented per baseline and complained of lower back pain during transferring and rolling in bed. R1 was unable to rate pain due to cognition but did attempt to swing out at staff related to the pain and Hydrocodone (narcotic pain medication) ordered for pain. R1 returned with a large hematoma and jagged skin tear to his right hand and a red area to the back of his head. On 12/26/25 on 3:07 p.m., therapy note indicated R1 transferred poorly, demonstrated increased confusion, and had some pain. R1 to utilize a full body lift for transfers and care plan updated. On 1/1/26, R1 required assistance with eating and pain with repositioning was 5-6/10 (pain scale of zero as no pain and ten as the worst pain). Physician visit note dated 1/2/26 at 10:45 a.m., identified R1's physician saw him for the</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245631	Facility ID: 245631 If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>one-week post fall visit and indicated when R1 fell from the facility van, he suffered from a new onset of back pain. Physician review of the hospital notes indicated the concern was for chronic vertebral compression fractures, lumbar region times two but also concerned because he had over this area. The note also identified R1 had become more lethargic and not eating well after the start of the fentanyl patch and discontinued the medication and reassess the next week. Noted that R1 had changed from his baseline. Impression noted as recent fall with new compression fractures versus back pain and chronic compression fractures. On 1/2/26 at 6:55 p.m., assessment reference date (ARD) Charting identified R1 was needing more assistance with ADLs; assist of 1-2 staff with dressing, transfers, and repositioning; assist of 2 staff needed for bed mobility and changing incontinent products; 2 staff needed for transferring with full body lift; and staff assist needed with locomotion. R1 has had increased pain but had improved slightly. R1's Pain Interview for MDS dated [DATE], identified R1 had frequent pain that interfered with therapy and day to day activities almost constantly. R1 rated his pain a 9 on a 0-10 pain scale and verbal descriptor identified very severe, horrible as the intensity of his pain. On 1/6/26 at 1:21 p.m., registered nurse (RN) manager follow up post incident note identified the facility van driver had lowered the lift ramp to the ground and went inside to assist resident onto lift, not realizing lift was on the ground and pushed R1 backwards and off the edge, causing wheelchair to tip over backwards. R1 landed on his hands and knees on the lift ramp and 911 was called to take R1 to emergency room (ER) for evaluation. Outcome showed no broken bones or internal bleeding noted; R1 sustained abrasion to posterior scalp and skin tear to right hand/wrist; complained of back pain but no acute injuries noted on imaging. A change of condition MDS initiated related to resident pain and change in transferring abilities. Physician visit note dated 1/6/26 at 2:00 p.m., identified R1 was seen for follow up to back pain and increase somnolence (sleepiness) and staff needed to move R1 every four hours and that triggered pain. The note further indicated R1's compression fracture was thought to possibly be new but was hard to say; at the very least it was exacerbated by his recent injury. Plan was to increase the Norco (hydrocodone with acetaminophen) to every four hours as needed. R1's care plan updated 1/9/26, maximal assistance of 2 with upper and lower body dressing using the log roll due to back pain; transfer with stand-aid lift with 1-2 and large harness and full body lift with assist of two and large sling as needed; and maximum assistance with rolling in bed, maximum assist with sitting to lying and lying to sitting on the side of the bed related to back pain. 1/9/26 2:56 p.m., physician notified that R1 continues to have 5-9 (out of 10) pain ratings at times since fentanyl patch (narcotic pain patch) was discontinued. 1/9/26 at 10:36 p.m., R1 refused to get up from bed for supper after multiple attempts and reapproaching resident. R1 did not want to eat when offered as he stated, pain bad with a yelling voice and pushed staff away. R1's December 2025 medication administration record (MAR) identified: -Acetaminophen 1000 mg twice daily for polyosteoarthritis and only identifying pain level of 2 during 9 of 43 administrations and pain level of 3 during 1 of 43 administrations, with an average pain level of .50 over the 21 day period (42 administrations) until 12/26/25 hospital return. R1's documented pain levels ranged from 2-9 from 12/26/25 to 12/31/25, which averaged a pain level of 4.27. -Start date of 12/26/25, fentanyl transdermal patch (narcotic analgesic) 72 micrograms per hour (mcg/hr.) every 72 hours for severe back pain; -Lidocaine (medication to block pain signals to the brain) external patch 5% to back one time a day related to low back pain to apply two patches daily and remove per schedule- hydrocodone-acetaminophen (narcotic analgesic) 5-325 milligrams (mg) one tablet every six hours as needed for pain greater than a 4 out of 10 (received eleven as needed doses between 12/26/25 and 12/30/25) R1's January 2026 MAR indicated (1/1/26-1/16/26): -lidocaine external patch twice daily; -acetaminophen 1000 mg</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>twice daily; with pain rating from 1-10, and an average pain level of 5 over 16 days.-fentanyl transdermal patch every 72 hours until 1/2/26.As Needed (PRN) Medications-hydrocodone -acetaminophen 5-325mg one tablet every six hours as needed for low back pain and was increased to every four hours on 1/6/26. R1 received 21 as needed doses for pain ratings that ranged from 1 to 10 between 1/1/26 and 1/13/26, with an average pain level of 6.7. -oxycodone (narcotic pain medication) one tablet every four hours as needed for pain was ordered on 1/9/26. R1 received ten as needed doses for pain ratings ranging from 2-8 between 1/9/26 and 1/12/26.Observation on 1/13/26 at 1:30 p.m. and 2:40 p.m., R1 was noted to be in recliner chair with eyes closed and headphones on. R1 did open his eyes to voice but then closed them again. Follow up observation on 1/14/26 at 11:13 a.m., noted R1 to bed in bed with eyes closed and did not respond to voice.Interview on 1/14/26 at 11:32 a.m., family member (FM)-A indicated R1 had a fall and was having back pain and was not coming back like he was. FM-A stated R1 had three vertebrae that had hairline fractures but was not sure if they were new or old ones [fractures].During an interview on 1/13/26 at 1:30 p.m., the facility safety officer (SO) indicated he did all the training for the staff regarding the facility mobility van and lift when new staff was hired or began to use the van. The SO denied doing yearly refresher trainings, competencies, or that he had any documentation or proof of training or competency on the employees that are authorized to drive the van and wheelchair lift. The SO stated he was in the process of coming up with one. The SO identified he was aware of R1' fall off the van's wheelchair lift and described it as the driver (D)-A unfolded and lowered the lift to the ground instead of just unfolding it and did not attach the safety belt so when R1 was pushed out of the van, the lift platform was not there and R1 and the wheelchair fell to the ground. The SO stated he inspected the van and lift following R1's fall from the van and found it to be in normal working order. The SO denied having a policy or lift manual for the vehicle but demonstrated the lift instructions posted on the van doors.During an interview on 1/14/26 at 10:40 a.m., D-A had been driving the facility van for approximately four years and received training when he started driving the van but just recently did some retraining on the facility van after R1's fall. D-A further indicated the facility was short of van drivers, and he had been working quite a few extra shifts. D-A stated he was overworked, stressed out and was distracted while unloading R1 from the van after transporting him to an appointment. D-A further stated, while unloading R1 from the facility van, he had lowered the lift platform to assure it was on level ground but forgot to bring the lift back up to the van; he entered the van and pushed R1's wheelchair backward and the lift platform was not there so the resident fell out backward with the wheelchair landing on top of him on the ground. D-A immediately went into the clinic to get R1 help and called 9-1-1. D-A stated the training stated he should have properly turned R1 around so he was forward facing and did not apply the safety belt. D-A expressed remorse about R1's fall incident and has since received retraining and cut back on driving hours.During an interview on 1/13/26 at 3:50 p.m., D-B identified as an authorized driver of the facility vans and used the wheelchair lift on the van for approximately seven years. D-B stated she received training from her supervisor when she first started driving and when the facility got a new van, they received a quick rundown on operating the van but did not include any wheelchair lift training. D-B also denied receiving a formal competency training or annual training, but the facility has implemented annual training and competency for all staff that are authorized to drive the van after R1's fall from the van.During an interview on 1/14/26 at 11:32 a.m., family member (FM)-A stated she was aware of R1's fall from the van and that R1 had been having a lot of pain in his back especially bad when he moves. FM-A stated the x-rays found R1 had three hairline fractures in his vertebrae but was not sure if they were old or new fractures. FM-A further</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>stated, it is hard to visit him now because he is so sleepy, further identified that the facility staff were having a hard time controlling R1's pain and the pain medications were making him too sleepy so they cut back on the pain medications and then he had horrible pain so they put him back on the pain medications. FM-A stated, I am very uneasy about his [R1's] progress; he is just not coming back like he was. During an interview on 1/14/26 at 1:51 p.m., registered nurse (RN)-A identified R1 had some back and leg pain prior to his fall from the van lift but not to the extent R1 has pain now after the fall. RN-A further identified R1 had significant pain when staff reposition or transfer him. RN-A further indicated R1 had a change in condition after the fall from the van lift as he was usually alert and oriented but is now very confused and did not even know who his wife was. R1 required more assistance with activities of daily living (ADL)s, not eating well, did not have the stamina he used to have, not going to activities like he used to, more constipation issues, and was very sleepy when he got his pain medications. RN-A stated R1 still had significant bruising on his right arm, and they were still treating the injury on his right hand but the bruising on the back of his head had improved. During interview on 1/13/26 at 4:11 p.m., the administrator identified that during the root cause analysis (RCA) following R1's 12/22/25 fall from van wheelchair lift, the facility noted there was no annual training and no policy on the van's wheelchair lift. The facility provided a list of six staff that were authorized to use the facility mobility vans and wheelchair lifts. The facility also has three mobility vans with lifts in use. The facility did not have policies on the operation of the van, the wheelchair lift, or on transporting residents outside of the facility. The Past Noncompliance began on 12/22/25. The deficient practice was corrected by 12/31/25, after the facility implemented a systemic plan that included the following actions: D-A and all facility van drivers and wheelchair lift operators were retrained and assured competent prior to allowing staff to transport residents. Additionally, a standard of work (policy) was formulated on 1/9/26 to ensure staff have the proper protocol in writing to follow the van/transporting residents; initiated annual training and competency to all van operators; and the SO was educated on his requirement to ensure proper documentation for qualifications, education, and competency of the van operators.</p>		