DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	-		-		AND TRANSMITTAL	ID: 0BBR
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00148
1. MEDICARE/MEDICAID PROVID	DER	3. NAME AND AI (L3) <b>PINE HAVE</b>				4. TYPE OF ACTION: $\underline{7}$ (L8)
NO.(L1) 245359		(L4) 210 NORTH				1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAIE (L2) 664240300	D NO.	(L5) PINE ISLA			(L6) <b>55963</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)	8. Full Survey After Complaint
<sup>(L9)</sup> 08/29/2		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Fun Survey Arter Compraint
6. DATE OF SURVEY	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	0 15 ASC 16 HOSPICE	09/30
2 AOA 3 Other		04 5111	00 01 1/51	12 MIC	10 HOST ICE	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia			And/Or Approved Waivers Of	0,
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
		1 4	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	<ul><li> 7. Medical Director</li><li>IF) 8. Patient Room Size</li></ul>
12.Total Facility Beds	<b>66</b> (L18)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>66</b> (L17)	B. Not in Comp				
14. LTC CERTIFIED BED BREAKDO		Requirements	and/or Applied	waivers:	* Code: A 15. FACILITY MEETS	(L12)
14. LIC CERTIFIED BED BREAKDC 18 SNF 18/19 SNF	19 SNF	ICF	IID		13. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
66	19 511	icr	IID		1801 (e) (1) 01 1801 (j) (1).	
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gary Nederhoff	, Unit Superv	visor (	09/6/2016	(L19)	K <u>amala Fiske-Downing, Hea</u>	Ith Program Representative 9/6/2016
PA	RT II - TO BE	COMPLETED	BY HCFA RI	( )	L OFFICE OR SINGLE S	TATE AGENCY (L20)
19. DETERMINATION OF ELIGIBII	LITY	20. COM	IPLIANCE WIT	H CIVIL	21. 1. Statement of Finan	ncial Solvency (HCFA-2572)
1. Facility is Eligible to I	Participate	RIG	HTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	-				5. Bour of the Above	· · · · · · · · · · · · · · · · · · ·
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	<b>G</b> DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
11/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
21 DO DECEIDE OF OME 1520				DATE		
31. RO RECEIPT OF CMS-1539		2. DETERMINATION	N OF AFFRU VAL	DALE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245359

September 6, 2016

Mr. Steven Ziller, Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

Dear Mr. Ziller:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 21, 2016 the above facility is certified for:

66 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 66 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 6, 2016

Mr. Steven Ziller, Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

RE: Project Number S5359025

Dear Mr. Ziller:

On August 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 12, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 14, 2016, effective August 21, 2016 and therefore remedies outlined in our letter to you dated August 1, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

## **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION A. Building		DATE OF RE	VISIT
	B. Wing	Y2	8/29/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HAVEN CARE CENTER I	NC	210 NORTHWEST 3RD STREET		
		PINE ISLAND, MN 55963		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
			10	14			10				10
ID Prefix	F0242		Correction	ID Prefix	F0244		Correction	ID Prefix	F0279		Correction
Reg. #	483.15(b)		Completed	Reg. #	483.15	(c)(6)	Completed	Reg. #	483.20(d), 483.20	D(k)(1)	Completed
LSC			08/21/2016	LSC			08/21/2016	LSC			08/21/2016
ID Prefix	F0282		Correction	ID Prefix	F0309		Correction	ID Prefix	F0312		Correction
Reg. #	483.20(k)(3)(ii)		Completed	Reg. #	483.25		Completed	Reg. #	483.25(a)(3)		Completed
LSC			08/21/2016	LSC			08/21/2016	LSC			08/21/2016
ID Prefix	F0314		Correction	ID Prefix	F0329		Correction	ID Prefix	F0412		Correction
Reg. #	483.25(c)		Completed	Reg. #	483.25	(I)	Completed	Reg. #	483.55(b)		Completed
LSC			08/21/2016	LSC			08/21/2016	LSC			08/21/2016
ID Prefix	F0425		Correction	ID Prefix	F0431		Correction	ID Prefix	F0441		Correction
Reg. #	483.60(a),(b)		Completed	Reg. #	483.60	(b), (d), (e)	Completed	Reg. #	483.65		Completed
LSC			08/21/2016	LSC			08/21/2016	LSC			08/21/2016
ID Prefix	F0465		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.70(h)		Completed	Reg. #			Completed	Reg. #			Completed
LSC			08/21/2016	LSC			_	LSC			
REVIEWI STATE A		REVIEW (INITIAL	S)	DATE		SIGNATURE OI	SURVEYOR			DATE	
			N/kfd	9/6/201	6		10160				29/2016
REVIEWI CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOW 7/14/201	<b>IUP TO SURVE</b>		ETED ON		CK FOF ORREC	R ANY UNCORRE	ECTED DEFICIEN DIES (CMS-2567)	NCIES. WAS SENT TO T	A SUMMARY OF HE FACILITY?	□ YE	s 🗌 no

## **POST-CERTIFICATION REVISIT REPORT**

				DATE OF REVI	ISIT
	A. Building 02 - PINE HAVEN CARE CEN B. Wing	ien in the second s	Y2	8/12/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE HAVEN CARE CENTER I	NC	210 NORTHWEST 3RD STREET			
		PINE ISLAND, MN 55963			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
NFPA 101 Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0018	07/14/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC				LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
	TL/kfd	9/6/2016		37008	8/12/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVE	Y COMPLETED ON		R ANY UNCORRECTED DEFICIEI CTED DEFICIENCIES (CMS-2567)	NCIES. WAS A SUMM SENT TO THE FACI	MARY OF ILITY? YES NO

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICA	ID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFICAT	ION A	ND TRANSMITTAL	ID:	0BBR
	PART I -	TO BE COMPI	LETED BY THE	STAT	E SURVEY AGENCY	Fac	cility ID: 00148
1. MEDICARE/MEDICAID PROV NO.(L1) <b>245359</b>	IDER		DRESS OF FACILIT			<ol> <li>TYPE OF ACTION:</li> <li>1. Initial</li> </ol>	<u>2(</u> L8) 2. Recertification
2. STATE VENDOR OR MEDICA (L2) 664240300	ID NO.	(L4) 210 NORTH (L5) PINE ISLAN	IWEST 3RD STRE ND, MN	ET	(L6) <b>55963</b>	<ol> <li>Termination</li> <li>Validation</li> </ol>	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE O (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEGORY 05 HHA 09 I	ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
<ol> <li>6. DATE OF SURVEY 07</li> <li>8. ACCREDITATION STATUS:</li> </ol>	// <b>14/2016</b> <sup>(L34)</sup> (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 10 1 07 X-Ray 11 1	NF ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP 12	RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATI	ION	10.THE FACILITY	' IS CERTIFIED AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirement	<u>s:</u>
To (b):			equirements		2. Technical Personnel	6. Scope of Servi	ices Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Direc	tor
12 Total Engility Pada	<b>66</b> (I 18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room S	Size
12. Total Facility Beds	66 (L18)	V. D. M. H. G.	r un		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	<b>66</b> (L17)		pliance with Program and/or Applied Waive	ers:	* Code: <b>B</b> *	(L12)	
14. LTC CERTIFIED BED BREAKI	DOWN				15. FACILITY MEETS		
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
66							
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE Justin Main, H	FE NE II	Date : 0	8/11/2016	K	18. STATE SURVEY AGENCY		Date:
		COMPLETED I		L19)	OFFICE OR SINGLE S		(L20)
19. DETERMINATION OF ELIGIE	BILITY	20. COM	IPLIANCE WITH CIV	/IL		ncial Solvency (HCFA-2572)	
1. Facility is Eligible to	o Participate	RIGH	ITS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (H	CFA-1513)
2. Facility is not Eligil	-				5. Dour of the Above	· .	
2. Tacinty is not Engli	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEMENT	Г	26. TERMINATION ACTION	: (L3	30)
OF PARTICIPATION 11/01/1986	BEGINNING	<b>J</b> DATE	ENDING DATE		VOLUNTARY 00 01-Merger, Closure		<u>ARY</u> et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Me	et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider S	Status Change
(1.07)			(L44)			00-Active	
(L27)	B. Rescind S	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)		(L	(			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL DAT	Έ			
	(L32)		(L	_33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 1, 2016

Mr. Steven Ziller, Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

RE: Project Number S5359026

Dear Mr. Ziller:

On July 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 <u>Email: gary.nederhoff@state.mn.us</u> Telephone: (507) 206-2731 Fax: (507) 206-2711

### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 23, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 23, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

#### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

#### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FO	RM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			DATE SURVEY COMPLETED
		245359	B. WING _			07/14/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	
	VEN CARE CENTER I	NC		21	0 NORTHWEST 3RD STREET	
	VEN CARE CENTER I			P	INE ISLAND, MN 55963	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
F 242 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has been your verification. 483.15(b) SELF-DE MAKE CHOICES The resident has the schedules, and heat her interests, assess interact with membrinside and outside t	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with ETERMINATION - RIGHT TO e right to choose activities, of the consistent with his or essments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that	F 24	42		8/21/16
	by: Based on interview failed to provide che for 2 of 3 residents choices. Findings include: R42's annual Minim 4/14/16, indicated F required assist of o	NT is not met as evidenced and record review the facility bices for frequency of bathing (R42, R43) reviewed for num Data Set (MDS) dated R42 was cognitively intact and ne staff for bathing. R42's			Tag F242 Self-Determination/Participation Pine Haven Care Center staff respect th residents' rights to 1) choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care and 2) make choices about aspects of his or her life in the facility that are significant to the residen	ıt.
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE
Electron	ically Signed					08/10/2016

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.

PRINTED: 08/10/2016

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE			0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMI	PLETED
		245359	B. WING _			07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER	INC			IO NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 242	Continued From pa	age 1	F 24	12			
	current care plan, i assistance for bath	ndicated R42 required ning and preferred showers. hedule sheet dated 7/7/16,			The facility recognizes the right of resident or resident representative make informed choices about care treatment including the right to det	to and	
	identified R42 was Fridays for the day	scheduled for a tub bath on			his/her bathing schedule, frequence type of bath. The residents are encouraged to participate to the gr extent possible in the care planning	ey, and eatest	
	chose the bath for	her and she "went along with received a bath once a week			process and the staff assists them exercising their rights by discussin the resident (or the resident's representative) the resident's conc	in g with	
	was cognitively inta staff for bathing. R	OS dated 6/8/16, indicated R43 act and required assist of one 43's current care plan, iired assistance for bathing and nge bath.			treatment options, personal preferences of and any potential consequences of accepting or refusing the recommenter treatment.	f	
	7/7/16, identified R	ty bath schedule sheet dated 43 was scheduled for a tub Tuesdays during the day shift.			A policy for determining the reside bathing preferences has been draf the related procedures reviewed a revised. As part of the admission p residents are asked about preferen	ted and nd process,	
	allowed to choose R43 further stated	3 p.m., R43 stated she was not the frequency of her bathing. she received a bath once a efer a bath twice a week.			and the importance of choosing wh wear, type of bath, snack availabili locking up personal belongings, ch arise/bedtime, having reading mat- available, listening to favorite musi	nat to ty, loosing erial	
	(NA)-E stated staff know when a resid bath. NA-E stated	3 p.m., nursing assistant reference the bath sheet to ent is scheduled to receive a somebody "higher up" ident's bath day upon			keeping up with the news, participa religious services/practices, etc. A are made to follow preferences for and services to the greatest extent possible. The resident's preferred schedule, frequency of bathing, an	ating in ttempts cares bathing d type	
	stated she was res admission process upon admission or	4 p.m., registered nurse (RN)-B ponsible for the nursing of residents. RN-B stated he bath a week was provided 6 further stated short term			of bath (tub/shower/sponge/bed ba be addressed and his/her preferen included in the individualized plan The resident/legal representative v asked about satisfaction with cares/services during the quarterly	ices of care. vill be	

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		AND HUMAN SERVICES			F	FORM A	08/10/201 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	X3) DATE COMP	SURVEY LETED
		245359	B. WING			07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 242	residents let staff k they prefer. Short te their rooms which r accommodate the p did not ask residen baths a week the re social services ask upon admission. RI long term residents preferred. On 7/12/16, at 3:18 services (DSS)-A s ask about resident preference. On 7/12/16, at 3:25 RN-B was unable to process for residen staff usually assign admission and adm assigned which day bath. RN-A stated a of bathing was not ever asked upon ad the resident's initial within five days of a resident if they wan of care. RN-A state frequency of bathin On 7/12/16, at 3:35 responsible for the	now how many baths a week erm residents have showers in	F 2	242	<ul> <li>conferences, with significant change more often if indicated.</li> <li>During the mandatory meeting Augus 2016, the nursing staff will be informed the residents' right to make choice regarding heath care services consist with his/her interests, assessments, a plans of care including the right to had their bathing preferences respected.</li> <li>Resident number 42 - The RN clinicate manager will interview the resident regarding her preferred bathing type frequency. The resident's plan of care the nursing assistants' care references cards will be reviewed and updated an necessary to reflect her bathing preferences. The social worker will continue to ask the resident about her satisfaction with cares during their one-to-one visits; the resident's satisfaction with cares will also be discussed during the quarterly care conferences.</li> <li>Resident number 43 – The resident is currently in the hospital. Upon her ret to the facility, the resident will be interviewed by RN clinical manager regarding her preferred bathing type frequency. The resident's plan of card the nursing assistants' care references.</li> </ul>	st 15, ed of stent and ave al and re and e as er is turn and re and e as	
	bath unless they wa her know if a reside bathing.	ant more. AA-F stated staff let ent requested a change in a.m., the director of nursing			necessary to reflect bathing preferen The social worker will continue to ask resident about her satisfaction with ca during their one-to-one visits; the resident's satisfaction with cares will	ices. k the ares	

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		<u>/IB NO.</u> (X3) DATE	E SURVEY
D PLAN O	F CORRECTION	IDENTIFICATION NUMBER:		i		PLETED
		245359	B. WING		<b>07</b> /-	14/2016
IAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	/EN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 242	Continued From pa	age 3	F 242			
	preferences. The r	ents were asked about bathing esidents are assigned a bath s they specifically requested		be discussed during the routine care conferences.	e	
	they wanted one m A policy regarding to bathing was reques	the choice for frequency of sted. On 7/14/6, at 7:20 a.m., a facility did not have a policy		Respect for the resident's right to self-determine and participate in he care decisions as well as their satisf with cares will be monitored by the 9 Workers during one-on-one intervie during the routine care conferences through feedback from Resident Co meetings. The Life Enrichment staff continue to ask the resident about th importance of choosing the type of as part of the minimum data set completion process. Any care conce will be communicated to the approp department manager/supervisor. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting ar October 2016 quarterly Quality Assu- and Improvement Committee meeting	faction Social ws, and buncil f will he bath erns riate	
F 244 SS=E	483.15(c)(6) LISTE GRIEVANCE/REC	EN/ACT ON GROUP OMMENDATION	F 244	Completion date: August 21, 2016		8/21/16
	must listen to the v grievances and rec and families conce	r family group exists, the facility iews and act upon the commendations of residents rning proposed policy and ns affecting resident care and				
	This REQUIREME	NT is not met as evidenced				

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TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245359	B. WING			07/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	07/1	4/2010
	VEN CARE CENTER			21	IN NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 244	Continued From pa	age 4	F 24	4			
	review, the facility	failed to resolve resident in regards to nursing, dietary			Resident and Family Groups		
	and social service to the facility by the potential to effect r	department concerns reported e resident council. This had the esidents who needed tivities of daily living.			Pine Haven Care Center respects a promotes the existence of the Resid Council. The concerns and recommendations of the families ar residents are reviewed and taken in	dent nd	
	Findings include:				consideration during decision-makin the development of policies and		
	did not consistently raised during resid council made sugg	5 p.m., R14 stated the facility y follow up on grievances ent council. When the resident jestions/raised concerns, consistently get back to the			procedures affecting resident servic The facility attempts to accommoda Councils' recommendations to the greatest extent possible.		
	resident that made	the complaint.			The Resident Council meetings are routinely attended by interdisciplinal	ry care	
	Review of the Resi revealed the follow	ident Council meeting minutes ring grievances:			team department managers and the administrator. The Life Enrichment Director/designee facilitates the me		
		council meeting minutes lepartment concerns included			writes the meeting minutes, ensure the appropriate department manage	s that	
	taking too long to g or call light not with	get ready for bed, overbed table nin reach, not obtaining a nurse ing too long to use the			notified of resident concerns, and tr resolution of the concerns.		
	bathroom, call light overall poor call lig	I time too long in the morning, ht response times including l be right back and do not			The polices and procedures for conducting the Resident Council me were reviewed and revised. The me		
	manager would me change to get this	decided that the nurse eet with staff today at shift matter addressed quickly and ke place to see if it improved.			agenda and minutes will be expand routinely include action plans and fo up to resident concerns.		
	indicated dietary co being fed right whe	council meeting minutes oncerns included a resident not en assisted, mostly cold food at			During the August 3, 2016 monthly Assurance and Assessment meetin importance of responding to resider concerns and the procedures for	g, the nt	
	pizza, Sundays we	o/none puree, request for re always beef and mashed ents would like something			addressing resident concerns were reviewed with the department mana As discussed, the department mana will continue to address/investigate	agers.	

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		E & MEDICAID SERVICES			IB NO. 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION   ()     NG	X3) DATE SURVEY COMPLETED
		245359	B. WING		07/14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 244	Continued From pa	age 5	F 2	44	
				resident concerns; the resolution/finc	
		council meeting minutes		will be reported during the next Resid	
		oncerns included nursing and		Council meeting. The minutes of pre	
		cation about tests/prep, dietary		four Resident Council meetings were reviewed to ensure that the residents	
		requests for more variety on dent requested he receive a		concerns/comments were addressed	
		nes not just egg salad, and		the findings/resolution communicated	
		icerns included privacy		documented. Dave Christianson,	a and
		ould be addressed with staff.		Long-term Care Ombudsman, was a	a
				guest speaker at the July 26, 2016	
		council meeting minutes		Resident Council meeting and review	
		concerns including questions		the residents' rights including the right	
	stated they learned	th notification. Residents I of a resident death in the		care and services that meet professi practice standards.	Ional
		ents further stated were a			
		build like to support each other		During the mandatory meeting Augus	
		here would be a team formed or resident notification of death.		2016, the staff will be reminded of th resident's right to have concerns rep	
	and a plan made it	or resident notification of death.		and addressed in a timely manner ar	
	6/28/16 - resident o	council meeting minutes		the expectation that the care will be	
		concerns related to obtaining		provided in a timely manner as outlin	ned in
		nurse. The nurse manger		the plan of care. Resident rights and	
		communication between		tips/suggestions to improve the resid	
	nursing staff.			care and quality of life are included in monthly staff newsletter.	n the
		neeting minutes failed to		To monitor compliance, the	
		ation of follow up for the I from 2/23/16 through 6/28/16.		To monitor compliance, the Administrator/Designee will audit the	<b>`</b>
				Resident Council minutes for the ne	
	On 7/13/16, at 11:1	1 a.m., activity director (AD)-C		three months to assure that residents	
	stated the manage	rs assigned concerns were		concerns are being addressed in a ti	
		care of it. Managers were to get		manner and that resolutions/respons	
		solutions which would be		are being reported to the Resident C	
		minutes. AD-C stated the nutes are sent out every month		and/or specific residents as appropri Compliance will be reviewed at the	ale.
		email with a reminder to get		monthly Quality Assurance and	
		stated if no resolution was		Assessment Committee meeting and	d the
		minutes in the last six months		October 2016 quarterly Quality Assu	
	the resolution was	"probably not there."		and Improvement Committee meetin	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/10/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245359	B. WING		07/	14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	VEN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 244		p.m., the administrator stated	F 244			
F 279 SS=D	when grievances we council meeting, ea at the time of the m went back and work email should be the grievances or conce was to follow up at the meeting by each de resolve the concern concerns were brout resolution would prot The administrator s practice to document to be reviewed later The facility policy R indicated minutes of concerns and sugger response to sugges 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an	ere expressed at the resident ich department manager there eeting took the information ked on the concern. AD-C's esecond reminder of erns to be addressed. Staff the next resident council epartment what they did to h. The administrator stated ught up in the meeting and any obably be verbal, not written. tated it was not facility nt resolution to the concerns r with residents. esident Council, dated 4/7/09, of the council would reflect all estions addressed and facility stions. k)(1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's	F 279			8/21/16
	to be furnished to a	describe the services that are ttain or maintain the resident's physical, mental, and				

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		AND HUMAN SERVICES				FORM	08/10/2016 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245359	B. WING			<b>07</b> / <sup>-</sup>	14/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including f under §483.10(b)(4 This REQUIREMEN by: Based on interview failed to develop a of the diagnosis of de (R44) reviewed for Findings include: R44's physician orce an order for citalop 40 milligrams once progress note dated diagnosis of major R44's medication re R44's depressive s R44's PHQ-9 (deprindicated score NA indicated a score or address the diagno specific symptoms On 7/14/16, at 9:35 services (DSS)-A si monitoring the use DSS-A reviewed R4 depression was not stated R44 had bee admission and she	<ul> <li>veing as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment</li> <li>NT is not met as evidenced</li> <li>v and record review the facility comprehensive care plan for pression for 1 of 5 residents unnecessary medications.</li> <li>ders dated 7/14/16, identified ram (Celexa) (anti-depressant) a day. R44's physician d 4/4/16, identified the depression and indicated egimen included Celexa for ymptoms.</li> <li>ession test) dated 4/6/16, and the one dated 6/30/16, f 7. R44's care plan failed to sis of major depression and</li> </ul>	F 2	279	Tag F279 – Comprehensive Care F Pine Haven Care Center uses the r of the comprehensive assessment of develop, review and revise the resid comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetabl meet the resident's needs as identif the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physic mental, and psychosocial well-being 3) recognizes the residents' right to cares/services. The care plan related policies/proce and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. During the August 15, 2016, manda meeting, the staff will be 1) reminder the facility policies for care plan implementation/reviews/updates 2) reminded that the residents' care plan implementation/reviews/updates 2) reminded that the residents' care plan implementation/reviews/updates 2)	esults to dent's les to fied in e cal, g and refuse edures	

Facility ID: 00148

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# PRINTED: 08/10/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG	00	
		245359	B. WING _			14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
PINE HA		NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 279	Continued From pa Celexa.	-	F 27	instructed that care plan depression and related i	nterventions for	
	stated that it was we use of an antidepre The facility policy P Usage, dated 1/23/ monitoring of all tar assist in the assess relationship of psyc facility policy for the was requested but	sychotropic Medication 06, indicated consistent get symptoms will be done to sment of the risk/benefit hotropic drug therapy. A comprehensive care plan not provided.		residents with a diagnos The social worker has re- of care for resident numbrevised it to include the or- depression and related or- and interventions. To monitor compliance, it will audit the care plans or- with the diagnosis of depresent that mood symptoms, good interventions are appropresent Care plans will be revise As part of the quarterly or- process, the interdisciplic continue to review the care completeness, accuracy Compliance will be revier monthly Quality Assurant Assessment Committee October 2016 quarterly of and Improvement Commitations	eviewed the plan ber 44 and has diagnoses of goals, treatments, the social worker of all residents pression to assure bals, and riately addressed. d as necessary. are conference nary team will are plans for , and relevancy. wed at the ce and meeting and the Quality Assurance	
F 282 SS=E	PERSONS/PER C/ The services provided b	led or arranged by the facility y qualified persons in	F 28	82		8/21/16
	accordance with ea care. This REQUIREMEN by: Based on observa	y qualified persons in ich resident's written plan of NT is not met as evidenced tion, interview and record ailed to follow the care plan for		Tag F282 Services by C Personnel per Care Plar		

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	E & MEDICAID SERVICES	0.00				0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245359	B. WING			07/1	4/2016
ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
/EN CARE CENTER	INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
bathing for 1 of 3 r choices; for transfe observed being tra behaviors accurate medication for 1 of unnecessary medi was not allowed to care planned; and residents (R53) ob Findings include: R43's current care assistance for bath bath. R43's quarte R43 was cognitive one staff for bathin The facility bath so identified R43 was shower on Tuesda On 7/13/16, at 11:2 supposed to have receive it. R43 did provided. "I am jus	esidents (R43) reviewed for ers for 1 of 3 residents (R14) insferred; for monitoring target ely for the use of anti-psychotic 5 residents (R44) reviewed for cations; 1 of 1 resident (R45) sleep late into the a.m. as for nail care for 1 of 3 served for nail care. plan, indicated R43 required hing and was to have a sponge rly MDS dated 6/8/16, indicated ly intact and required assist of ig. chedule sheet dated 7/7/16, scheduled for a tub bath or ys for the day shift. 26 a.m., R43 stated she was her bath on 7/12/16 but did not not know why her bath was not it assuming they were busy."	F 2	282	and services that meet professional standards of quality and are deliver appropriately qualified persons (e.g licensed, certified) in accordance we each resident's written plan of care interdisciplinary care planning team uses an assessment process to de an individualized care plan for each resident that supports the highest practicable level of function and we 2) implements procedures and prace as outlined in the plan 3) reviews th at least quarterly and with significan changes in condition and 4) makes modifications as necessary. The facility has policies and proced for developing individualized plans and communicates the resident's c needs to the direct care givers by u the "pocket care plan" (PCP). The I are routinely updated to reflect revis the interdisciplinary plan of care.	Il red by J., rith . The h 1) velop h velop tices he plan ht lures of care are lse of PCPs sions in	
bath was 7/5/16. I morning report wh was not informed I yesterday. On 7/13/16, at 12: (DON) stated if R4	NA-D stated she had received en she came on duty and she R43 had not received a bath 41 p.m., the director of nursing 3 had not received her bath,			care must be followed 2) that job performance expectations include I aware of and following the resident of care with a focus on nail care, ba frequency, assisting with transfers respecting sleep/wake preferences of the need for monitoring/document	being 's plan athing and and 3) nting	
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER VEN CARE CENTER SUMMARY ST (EACH DEFICIENC REGULATORY OR I bathing for 1 of 3 r choices; for transfe observed being tra behaviors accurate medication for 1 of unnecessary medi was not allowed to care planned; and residents (R53) ob Findings include: R43's current care assistance for bath bath. R43's quarte R43 was cognitive one staff for bathin The facility bath sc identified R43 was shower on Tuesda On 7/13/16, at 11:2 supposed to have receive it. R43 did provided. "I am jus On 7/13/16, at 11:2 (NA)-D stated the bath was 7/5/16. I morning report who was not informed F yesterday. On 7/13/16, at 12:2 (DON) stated if R4	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245359         PROVIDER OR SUPPLIER       245359         VEN CARE CENTER INC       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 9       bathing for 1 of 3 residents (R43) reviewed for choices; for transfers for 1 of 3 residents (R14) observed being transferred; for monitoring target behaviors accurately for the use of anti-psychotic medication for 1 of 5 residents (R44) reviewed for unnecessary medications; 1 of 1 resident (R45) was not allowed to sleep late into the a.m. as care planned; and for nail care for 1 of 3 residents (R53) observed for nail care.         Findings include:         R43's current care plan, indicated R43 required assistance for bathing and was to have a sponge bath. R43's quarterly MDS dated 6/8/16, indicated R43 was cognitively intact and required assist of one staff for bathing.         The facility bath schedule sheet dated 7/7/16, identified R43 was scheduled for a tub bath or shower on Tuesdays for the day shift.         On 7/13/16, at 11:26 a.m., R43 stated she was supposed to have her bath on 7/12/16 but did not receive it. R43 did not know why her bath was not provided. "I am just assuming they were busy."         On 7/13/16, at 11:32 a.m., nursing assistant- (NA)-D stated the last day documented for R43's bath was 7/5/16. NA-D stated she had received morning report when she came on duty and she was not informed R43 had not received a bath yesterday.         On 7/13/16, at 12:41 p.m., the director of nursing (DON) stated if R43 had not received her bath,	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         245359       B. WING         245359       B. WING         PROVIDER OR SUPPLIER       JUNMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 9       bathing for 1 of 3 residents (R43) reviewed for choices; for transfers for 1 of 3 residents (R14) observed being transferred; for monitoring target behaviors accurately for the use of anti-psychotic medication for 1 of 5 residents (R44) reviewed for unnecessary medications; 1 of 1 resident (R45) was not allowed to sleep late into the a.m. as care planned; and for nail care for 1 of 3 residents (R53) observed for nail care.         Findings include:         R43's current care plan, indicated R43 required assistance for bathing and was to have a sponge bath. R43's quarterly MDS dated 6/8/16, indicated R43 was cognitively intact and required assist of one staff for bathing.         The facility bath schedule sheet dated 7/7/16, identified R43 was scheduled for a tub bath or shower on Tuesdays for the day shift.         On 7/13/16, at 11:26 a.m., R43 stated she was supposed to have her bath on 7/12/16 but did not receive it. R43 did not know why her bath was not provided. "I am just assuming they were busy."         On 7/13/16, at 11:32 a.m., nursing assistant- (NA)-D stated the last day documented for R43's bath was 7/5/16. NA-D stated she had received morning report when she came on duty and she was not informed R43 had not received a bath yesterday.	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A. BUILDING.         245359       B. WING         PROVIDER OR SUPPLIER VEN CARE CENTER INC       2         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 9       bathing for 1 of 3 residents (R43) reviewed for choices; for transfers for 1 of 3 residents (R14) observed being transferred; for monitoring target behaviors accurately for the use of anti-psychotic medication for 1 of 5 residents (R44) reviewed for unnecessary medications; 1 of 1 resident (R45) was not allowed to sleep late into the a.m. as care planned; and for nail care for 1 of 3 residents (R53) observed for nail care.         Findings include:       R43's current care plan, indicated R43 required assistance for bathing and was to have a sponge bath. R43's quarterly MDS dated 6/8/16, indicated R43 was cognitively intact and required assist of one staff for bathing.         The facility bath schedule sheet dated 7/7/16, identified R43 was scheduled for a tub bath or shower on Tuesdays for the day shift.         On 7/13/16, at 11:26 a.m., R43 stated she was supposed to have her bath on 7/12/16 but did not receive it. R43 did not know why her bath was not provided. "I am just assuming they were busy."         On 7/13/16, at 11:32 a.m., nursing assistant- (NA)-D stated the last day documented for R43's bath was 7/5/16. NA-D stated she had received morning report when she came on duty and she was not informed R43 had not received her bath, evas not informed R43 had not received her bath,	OF DEFICIENCIES FOORRECTION       (X1) PROVIDERSUPPLIER/LAN IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         PROVIDER OR SUPPLIER       245359       STREET ADDRESS, CITY, STATE, ZIP CODE         ZEN CARE CENTER INC       STREET ADDRESS, CITY, STATE, ZIP CODE         VEN CARE CENTER INC       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH CORCINCY OR LSC IDENTIFYING INFORMATION)       D PROVIDERS PLAN OF CORRECTION (EACH CORCINCY OR LSC IDENTIFYING INFORMATION)         Continued From page 9 bathing for 1 of 3 residents (R43) reviewed for choices; for transferred; for monitoring target behaviors accurately for the use of anti-psychotic medication for 1 of 5 residents (R44) reviewed for unnecessary medications; 1 of 1 resident (R45) observed being transferred; for monitoring target behaviors accurately for half care for 1 of 3 care planned; and for anil care for 1 of 3 care planned; and for anil care for 1 of 3 care planned; and for anil care for 1 of 3 care planned; mand was to have a sponge bath. R43's quarterly MDS dated 6/8/16, indicated R44 was conditively intact and required assistance for bathing and was to have a sponge bath. R43's quarterly MDS dated 6/8/16, indicated R44 was conditively intact and required assist of one staff for bathing.       The facility has policies and proced for developing individualized plans ausoutlined in the plan 3 reviews th at least quarterly and with significa- teeds to the direct care plan" (PCP). The are routinely updated to reflect revi the interdisciplinary plan of care.         The facility bath schedule sheet dated 7/7/16, identified R43 was scheduled for a tub bath or shower on Tuesdays for the day shift.       The facility has policies and	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER SUPPLIER/LIA DENTIFICATION NUMBER:       (X2) MUTPLE CONSTRUCTION       (X3) DATE A. BUILDING       (X3) DATE COM         PROVIDER OR SUPPLIER       245359       B. WING       07/1         VEN CARE CENTER INC       PROVIDER SUPPLIER/ VEN CARE CENTER INC       PROVIDER VEN SUPLIER/ VEN CARE

Facility ID: 00148

		& MEDICAID SERVICES				<u>MB NO.</u>	APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY PLETED	
		245359	B. WING			07/-	14/2016	
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PINE HA		INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 282	Continued From pa	age 10	F 2	282				
	R14's current care assistance for trans	plan, indicated R14 required sferring form one position to deconditioning related to low			care preferences and following the resident's individualized plan of car Resident number 43 – The resider	re.		
bac pers usir On be t R1 <sup>2</sup> EZ faile care On be t star mod	back pain with inter	vention of provide two idance and physical assist			plan for bathing was reviewed and appropriate. The direct care staff w informed that the resident's assign day is Saturday morning. If the bat	found /as ed bath		
	be transferred by n R14's bed into R14	a.m., R14 was observed to ursing assistant (NA)-B from 's wheelchair. NA-B used the cal lift to transfer R14. NA-B			given on Saturday, the charge nurs be notified. Resident number 14 – The resider	se is to		
		14 with two assist as per R14's			ability to transfer has been reasses the resident continues to require tw to assist with the EZ stand lift. The	ssed; vo staff direct		
	be transferred by o stand lift. NA-B stat	a.m., NA-B stated R14 was to ne or two assist using the EZ ted it depended on R14's staff assist was used to			care staff have been informed of the continuing need for two person ass transfers. The care plan was review and found to appropriately address transferring.	sist with wed		
		a.m., the DON stated R14 ed using the EZ stand lift and			Resident number 44 – The resider diagnosis of frontotemporal demer delusional thoughts. The resident e nearly continual string pulling/hand	ntia with exhibits		
ad <sup>ı</sup> me his Ev me	adverse side effect medications after tr history of psychosis Evaluate effectiven medications for pos	plan, indicated potential for s due to use of antipsychotic raumatic brain injury, long s. Interventions included: ess and side effects of ssible decease/ elimination of			motions related to parasitosis. Eve though the behavior is exhibited ve frequently and seems normal for th resident, the direct care staff have informed that the behavior must be documented on every shift that it is	n ery he been e		
	resident mood and identified the behav strings.	periodically and observe behaviors. The care plan vior of hallucinations, pulling at			observed. Resident number 45 – As address the care plan, the resident has a lif pattern of going to bed late at nigh	e long t and		
	R44 was sitting in h	p.m., observation revealed nis wheelchair in his room. R44 moving his hands back and			sleeping late in the morning. The n assistants have been instructed to the resident to awake naturally; the	allow		

Facility ID: 00148

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TATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:		G	( )	PLETED	
		245359	B. WING		07/14/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 282	his hand of throwin R44 was observed his feet in the hallw and forth. On 7/12/16, at 8:30 be sitting in his who being served break making a rolling mo- On 7/13/16, at 8:22 dining room and hi rolling motion. On 7/13/16 at 1:56 and NA-J stated R of pulling strings, b behavior today. NA document in the co- behavior of hallucin displaying the beha documentation in t no documented be through 7/13/16. On 7/14/16, at 10:1 expected staff to do observed R44 havi of pulling strings. The facility policy of Medication Monitor Guidelines: III. Wh	d then made the motion with og something. At 5:42 p.m., wheeling his wheelchair with vay and moving his hands back 0 a.m., R44 was observed to eelchair in the dining room (fast. R44's right hand was	F 282	nursing assistant PCP has bee accordingly. Resident number 53 – The resi grooming plan of care was revis found appropriate. The direct care aware of the need to provid as part of the resident's routine grooming/bathing procedures. Compliance will be monitored be auditing/observations of the foll one month: 1) resident bathing transfers—observations to be as the Director of Nurses/designed care—observations to be done be Enrichment staff 3) documentat target behaviors—audits to be co by the Social Worker. 4) The interdisciplinary team will review monitor the resident's PCPs for related to the comprehensive c noncompliance will be reviewed at monthly Quality Assurance and Assessment Committee meetir October 2016 quarterly Quality and Improvement Committee n	dent's ewed and are staff e nail care y weekly owing for and signed by e 2) nail by the Life tion of onducted v and accuracy are plan. If nal I be done. the g and the Assurance		

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		0	-	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245359	B. WING	i		<b>07</b> / <sup>.</sup>	14/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 12	F 2	282			
	requested and not p R45 has a diagnosi hemiparesis followin left non-dominant s Heartland Hospice a R45 care plan dated 6/2/16, identified that get up near noon, a her normal pattern a she gets up. Reviewed progress 7/12/16, which show behaviors including breakfast, refusing m morning baths, pind member. These pro- describing behavior when R45 as well a facility that she is no of progress notes th notes including from conference, which i to facility staff that F morning and cares in the afternoon hou During observations 7/12/16, 2:29 p.m. g shop. 7/12/16, 3:06 p.m. i 7/13/16, at 7:20 a.m.	is of hemiplegia and ng cerebral infarction affecting ide. Resident was started on services on 2/17/16. d with last review date of at R45 likes to sleep late, will and decline breakfast, this was at home, offer food drink when a notes from 5/27/16 to wed an increase in R45 being combative, refusing to get out of bed in the norning medications, refusing ching and biting a staff ogress notes were written rs during the morning hours as F-A had identified to the ot a morning person. In review here were three separate in hospice as well as R45 care indicated that F-A had reported R45 doesn't do well in the and visits should be provided urs. s as follows: getting hair done in beauty					

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PRINTED: 08/10/2016

		AND HUMAN SERVICES			FORM	: 08/10/2016 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245359	B. WING		<b>07</b> / <sup>-</sup>	14/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	VEN CARE CENTER I	INC		210 NORTHWEST 3RD STREET		
	VEN CARE CENTER I	INC		PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	asked R45 if she co which R45 replied I told R45 what time don't care. NA-G st and then you can re R45 responded, I d told R45 that she w NA-G stated, I'll che otherwise she'll get 7/13/16, at 7:34 a.n her bedroom and a NA-G stated why de changed and begar upset and stated, d juice or coffee and After this, began ra again stated no I jue 7/13/16, 8:50 a.m. i Interview with licens 7/12/16, at 3:10 p.n become aware of a on 7/11/16. LSW st made aware of this staff not checking th are documenting th Interview with nursi 7/13/16, at 7:13 a.n wake R45 up arour minutes until she's state that she gets in the morning. On stated R45 had aga fed her in her room Interview with NA-G stated she knows h pocket care plan (P	ould get her up for the day to don't get up right away. NA-G it was and R45 responded, I tated, can I get you dressed est and I'll come back to which lon't like to be bothered. NA-G rould be back in 10 minutes. eck back in 10 minutes in a bad mood. n. NA-G re-approached R45 in gain R45 declined to get up. on't you let me get you n lifting the bed. R45 became lon't do that. NA-G offered asked to open R45 curtains. ising the bed again and R45 st want to lay here for a while. in bed asleep. sed social worker (LSW)-B on n. identified that she had just in increase in R45 behaviors tated that she hadn't been prior to 7/11/16 due to floor he 24 hour note text when they				

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		AND HUMAN SERVICES				FORM	08/10/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245359	B. WING			07/	14/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	living (ADL) which s requiring the assist pericare BID and P grooming. PCP ide bladder, transfer, a sensory, skin care, comments. Under of daily, change bed li Hospice, Female C nothing noted about bed until noon. NA- the care plan and s copies of the PCP i NA-G stated these had access to. NA- behaviors when we usually once she is Interview with R45 9:28 a.m. stated, R person and had alw night watching telev spoken often with s with R45 not having up for lunch and su Interview with regis (RN)-B on 7/13/16, unaware that the ca stay in bed until noo R45 family say that mornings are a "ter does better in the a she doesn't do the registered nurse (R and then RN-1 give administrative assis PCP for direct care Interview with RN-1 stated care plans a	specifically identified R45 t of 1 for dressing, bathing and RN. Partial assist of 1 for ntified care for bowel and mbulation, devices, orientation dentures, activities and comments it states, make bed inens weekly, Heartland aregivers only. There was it R45 preference to stay in G stated she has access to showed a binder which had in the 600 wing nurse's station. were the only care plans she G stated R45 usually has e get her up in the morning but up she is better. family (F)-A on 7/13/16, at 45 had never been a morning vays like to stay up late into the vision. F-A stated that she had staff and was very comfortable g breakfast but would like R45 pper. tered nurse case manager at 12:00 p.m. stated she was are plan identified R45 should on and she had never heard c. RN-B went on to state rible idea" for R45 as she fifternoon. RN-B also stated care plans that another N)-1 handles the care plans es the information to the stant (AA)-F to complete the	F 2	282			

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		AND HUMAN SERVICES			FORM	08/10/2016 APPROVED 0938-0391
STATEMENT OF DEFI AND PLAN OF CORRE	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY IPLETED
		245359	B. WING		<b>07</b> / <sup>-</sup>	14/2016
NAME OF PROVIDE	R OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HAVEN CA	RE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
	ACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
gets n comes respon staff u has "n been o Hospid Intervi stated PCP fi inform from H stated inform therap Intervi 7/13/1 reflect expec be refl Intervi (OTA) discha occup Policy but po R53 w of diat Admis	s to her first a nsible for upd utilize when can never been a non the PCP, r ce when they iew with AA-F d she gets the from RN-B. Al nation from the Hospice if chail the information had be on the correction had be on was workin iew with direc of, at 2:29 p.m tion of the correction is that we lected on the iew with occup on 7/14/16, a arged from pho pational therap r: Requested a oblicy was not r vas admitted to betes mellitus asion Record. ignificant chail 4/7/16, revea equired extens nal hygiene wo olan dated 1/2 ance with bat led nail care a	on. The new information and then the AA-F is lating the PCP that direct care aring for residents. Stated R45 morning person, it has always maybe it was removed by started working with her". Fon 7/13/16, at 1:43 p.m. information to update the lso stated she gets direct e therapy department and anges need to be made. AA-F ion was on the PCP but en changed when occupational og with her at meal times. tor of nursing (DON) on n. stated the PCP should be a mprehensive care plan and the what is in the care plan would PCP. pational therapy assistant at 8:21 a.m. stated [R45] was hysical therapy and by on 1/29/16. a policy concerning care plans received. to the facility with the diagnosis s, according to facility	F 282			

Facility ID: 00148

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		AND HUMAN SERVICES & MEDICAID SERVICES		F	NTED: 08/10/2016 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		3) DATE SURVEY COMPLETED
		245359	B. WING		07/14/2016
	PROVIDER OR SUPPLIER	NC	2	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 282 F 309 SS=D	R53 with long and s During interview on registered nurse (R extensive assistance During interview on stated finger her na During interview on of nursing verified F and soiled. She sta staff to provide R53 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho	<ul> <li>7/13/16, at 9:48 a.m.,</li> <li>7/13/16, at 9:48 a.m.,</li> <li>N)-A verified R53 required evith personal hygiene.</li> <li>7/14/16, at 8:25 a.m., R53 ils were long.</li> <li>7/14/16, at 8:40 a.m., director R53's finger nails were long ated she expected nursing the she expected nursing</li></ul>	F 282		8/21/16
	by: Based on observat review, the facility fa related skin injury fo reviewed for non-pr addition, the facility resident (R45) rece coordinated plan of	NT is not met as evidenced ion, interview, and document ailed to identify a non-pressure or 1 of 3 residents (R53) ressure related skin. In failed to ensure that 1 of 1 iving hospice services had a care between facility and ich was communicated to		Regulation 483.25 Tag F309 - Provid Care/Services for Highest Well-being Pine Haven Care Center provides ead resident with the necessary care and services to attain or maintain the high practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team asses	ch est ce

Event ID:0BBR11

Facility ID: 00148

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II	TIPI		MB NO.	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
		245359	B. WING			<b>07</b> /1	14/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 309	Continued From pa	age 17	F 3	09			
		on 7/11/16, at 3:27 p.m., with			each resident at the time of admiss	sion.	
	a skin tear on the r	ight wrist, approximately one			quarterly, with significant changes i		
		open to air and no drainage			condition, and more often as the		
	noted. R53 stated	he bumped into something.			resident's condition indicates. The		
	The Adminsion De	and identified DE2 was			residents' needs including end-of-li		
		cord identified R53 was ility with diagnoses that			and hospice services as well as ca preserve skin integrity and treat ski		
		mellitus and atrial fibrillation.			problems are identified and a plan		
					developed, implemented, routinely	or care	
	The significant cha	inge Minimum Data Set (MDS)			reevaluated, and revised as neces	sary	
	dated 4/7/16, noted	d R53 to have intact cognition,			based on continuing assessments.	-	
		sistance of one staff for bed					
		er, supervision with set up help			The policies and procedures for		
		n, walking in hall and			identifying, reporting, investigating,		
		unit, and required extensive for toilet and personal hygiene.			monitoring and communicating ope areas and other skin lesions were		
		tor tonet and personal hygiene.			reviewed and found appropriate. A		
	R53's care plan da	ted 1/2/15, identified a risk for			licensed nurse evaluates the reside		
		tegrity related to nutritional			skin condition on a weekly basis.		
	deficit, cognitive in	pairment, presence of former			Residents with open skin areas are		
		diabetes and received			reviewed weekly by the interdiscipli	nary	
		apy. Interventions included staff			care team; the nurse		
		nges in skin integrity daily with			practitioner/physician is notified of		
	to proceed as indic	e nurse as needed, and nurse ated.			concerns regarding nonhealing or worsening of skin lesions.		
		a.m., licensed practical nurse			On August 4, 2016, the Director of		
	· /	3 received wound treatment to			Nursing and the Heartland Hospice		
		tomy tube sight. LPN-A further no other wound treatments for			agency nurse coordinator addresse current procedures for coordination		
	R53.				care between the facility and the ho		
					staff as well as implementation and		
	On 7/12/16, at 11:4	10 a.m., nursing assistant			documentation of the coordinated e		
		had assisted R53 with morning			Options for notifying the facility staf		
	cares and identifie	d R53 had no skin issues.			which hospice staff will visit the res		
		10 mm DE0 and an the advector			when the visits will occur, and what		
		13 p.m., R53 sat on the edge of elf lunch. The right outer wrist			cares/services will be provided as we the process for notifying the facility		
		imately two centimeters with			changes in the hospice staff visitati		

Facility ID: 00148

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		AND HUMAN SERVICES				FORM APPRO 000 0938-0 001	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		245359	B. WING _			07/14/2010	6
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		-
PINE HA	VEN CARE CENTER I	NC			0 NORTHWEST 3RD STREET NE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE COMPLE	TIO
F 309	Continued From pa	ge 18	F 30	09			
	an open, dry wound	bed. The skin tear was and had no drainage. At 2:25			schedule were discussed.		
	p.m., the right outer uncovered. R53 sta denied pain.			During the August 15, 2016 mand nursing staff meeting, instruction v include the need to observe for sk lesions and the importance of	vill		
	On 7/14/16, at 8:25 wound had two ster wound had a dark b or drainage.			appropriately identifying, reporting documenting, monitoring and trea lesions. Procedures related to the will be reviewed as well as develo care plans to monitor/treat/preven	ting skin above ping		
	On 7/14/16, at 8:40 a.m., the director of nursing (DON) verified a wound to the outer right wrist of R53. The DON stated after questions arose concerning skin this week, she trained all nursing staff and had all residents re-assessed for skin issues. She stated R53's wrist wound was identified on 7/13/16 with the skin re-assessment. The DON stated she expected staff to report skin issues to nurse right away.				pressure related and other skin le Instruction will be provided to the assistants on the need to be alert injuries/lesions and to immediately the findings to the licensed nurse. Observing and reporting the resid skin condition will continue to be p	sions. nursing to skin / report ent's part of	
					the nursing assistant's bathing pro		
	review dated 5/4/09 Skin Integrity. Skin cares done by the r concerns are noted immediately to the o R45 was started on	Pocument review of facility Skin Ulcer policy eview dated 5/4/09, revealed "D. Monitor skin Integrity. Skin will be observed daily during ares done by the nursing assistant. If any skin oncerns are noted, they are to be reported nmediately to the designated nurse. 445 was started on hospice services on 2/17/16.			During the August 15, 2016 meeti staff will also be informed of the p for coordinating care between the and hospice staff including the ho- procedures for notifying the facility (Nurse, CNA, Social Worker, etc.) visiting the resident, when the visi made, and what care/services the	rocess facility spice of who will be ts will be hospice	
	According to the Admission Record, R45 has a diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, end stage dementia, and				staff will provide as well as how c in the schedule will be communica Resident number 53 – A licensed	nurse	
	identified comfort cathat no longer wish	nure. h a revision date of 6/2/16, are guidelines for resident's to be hospitalized for a n condition. In collaboration			assessed the resident's skin July at which time a 1.5 cm skin tear w identified on the resident's right w strips were applied. A July 18, 201 nurse's note stated that the skin te	as rist; steri 6	
	with the hospice ag	ency will provide hospice and family. Refer to hospice			healed. The care plan was review revised to reflect history of and ris	ed and	

Facility ID: 00148

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	· · /	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	COM	PLETED
		245359	B. WING		07/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 309	Continued From pa	age 19	F3	09		
	interdisciplinary car	re plan and documentation of chart for current updates		skin tears.		
	with each hospice visit. Treatments as ordered for comfort, notify hospice/MD/NP if changes need to be made. On 7/12/16, at 1:30 p.m. the hospice home health			Resident number 45 – The Dire Nursing and the resident's hosp	ice nurse	
				care coordinator have discusse coordination services between and hospice staff. The resident	he facility	
	aide (HHA)-I indica at the facility twice	ted a hospice aid was present a week to provide showers for		coordinated plan of care in his r describing the types of services	ecord that will	
	HHA-I stated follow	as present twice a week. ving her visits she filled out a rovided and left a copy with the		be provided by the hospice age the schedule for the services, a staff will be providing the servic	nd what	
	facility. HHA-I state either the licensed	ed she communicated with practical nurse (LPN) or		nurse, social worker, etc.). The agency will notify the facility of a	hospice any	
	day of her visit.	RN) who was in charge on the roximately 1:45 p.m. trained		changes in the visitation schedu which will then be communicate staff. The care plan was review	ed to the	
	medication aid (TN was on hospice be	IA)-D stated she knew R45 cause it was on the pocket		found appropriate.		
		MA-D stated she found out coming when they arrived at		To monitor compliance with hos schedules, a random audit of re hospice residents will be done f	cords of	
	On 7/12/16, at app stated there was a	roximately 1:50 p.m. LPN-C calendar in R45's room that		weeks to determine if the visits the documented schedule and,	followed if not,	
		spice was coming. LPN-C care plan and notes were Click care (facility		whether the facility staff was no change. If noncompliance is no hospice agency administrative	ted, the	
	documentation sys On 7/13/16, at 9:09	entation system). 3/16, at 9:09 a.m. nursing assistant (NA)-G		notified and additional auditing done.		
	stated she knew how to care for R45 from her pocket care plan (PCP). The PCP identified: dining needs, activities of daily living (ADL's)			To monitor compliance with the identification of new skin proble	ms. a	
	which stated assist pericare BID (twice	of 1 for dressing, bathing and adaily) and PRN (as needed),		licensed nurse will observe the skin condition weekly. The Dire	resident's ctor of	
	identified care for b	or grooming. The PCP bowel and bladder, transfer, s, orientation sensory, skin		Nurses/designee will review the reports for seven days to assure appropriate follow up to acute p	e	
	care, dentures, act	ivities and comments. Under stated make bed daily,		there is evidence that skin prob not identified in a timely manne	lems are	

Facility ID: 00148

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IDENTIFICATION NUMBER: 245359 PPLIER ITER INC RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL	A. BUILDIN B. WING _	NG STREET ADDRESS, CITY, STATE, ZIP COD 210 NORTHWEST 3RD STREET	<b>07</b> /-	PLETED	
ITER INC	B. WING _				
ITER INC			E	14/2016	
RY STATEMENT OF DEFICIENCIES		210 NORTHWEST 3RD STREET	<b>L</b>		
		PINE ISLAND, MN 55963			
Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
om page 20	F 30	09			
nens weekly, hospice, and female ly. There was nothing noted about ere provided to R45 from the cy. NA-G stated she had access to through a binder at the 600 wing n which had copies of the PCP. these were the only care plans she b. t 10:19 a.m. the hospice agency rse patient care coordinator (RN)-J vas a care plan in the front of R45's at listed what activities of daily living e was responsible for on their visits. care plan was integrated into the plan. RN-J stated the hospice located in the front of R45's hard as the schedule the facility should be n instructing their staff of visiting ges were made, hospice would lity of these changes. t 12:00 p.m. RN-B stated she never hen the hospice nurse was going to ity, but it was usually Thursday. the hospice schedule was in the hard chart which identified the ras at the facility on Monday of each RN came on Tuesday of each hedule was dated 2/17/16, which R45 started on hospice services. hat whenever hospice was at the formunicated their visit with floor	•	appropriate follow up is not do additional auditing and staff tra done. Compliance will be reviewed a monthly Quality Assurance and Assessment Committee meeti October 2016 quarterly Quality	t the d ng and the Assurance		
lin wn n of toau vaac e saenia viid swecht oe enea	linens weekly, hospice, and female nly. There was nothing noted about were provided to R45 from the ncy. NA-G stated she had access to a through a binder at the 600 wing on which had copies of the PCP. these were the only care plans she to. at 10:19 a.m. the hospice agency urse patient care coordinator (RN)-J was a care plan in the front of R45's hat listed what activities of daily living be was responsible for on their visits. care plan was integrated into the e plan. RN-J stated the hospice s located in the front of R45's hard vas the schedule the facility should be en instructing their staff of visiting nges were made, hospice would cility of these changes. at 12:00 p.m. RN-B stated she never when the hospice nurse was going to ility, but it was usually Thursday. d the hospice schedule was in the s hard chart which identified the was at the facility on Monday of each chedule was dated 2/17/16, which R45 started on hospice services. that whenever hospice was at the communicated their visit with floor	linens weekly, hospice, and female nly. There was nothing noted about were provided to R45 from the ncy. NA-G stated she had access to a through a binder at the 600 wing on which had copies of the PCP. these were the only care plans she to. at 10:19 a.m. the hospice agency urse patient care coordinator (RN)-J was a care plan in the front of R45's that listed what activities of daily living be was responsible for on their visits. care plan was integrated into the e plan. RN-J stated the hospice s located in the front of R45's hard vas the schedule the facility should be en instructing their staff of visiting nges were made, hospice would stility of these changes. at 12:00 p.m. RN-B stated she never when the hospice nurse was going to ility, but it was usually Thursday. d the hospice schedule was in the s hard chart which identified the was at the facility on Monday of each e RN came on Tuesday of each chedule was dated 2/17/16, which R45 started on hospice services. that whenever hospice was at the communicated their visit with floor ell as herself. They also left a copy of the sin the hard chart. RN-B verified nurse's note in R45's hard chart e past 30 days. at 2:29 p.m. the director of nursing	<ul> <li>linens weekly, hospice, and female inly. There was nothing noted about were provided to R45 from the nocy. NA-G stated she had access to in through a binder at the 600 wing on which had copies of the PCP. these were the only care plans she to.</li> <li>at 10:19 a.m. the hospice agency urse patient care coordinator (RN)-J was a care plan in the front of R45's tart listed what activities of daily living se was responsible for on their visits. care plan was integrated into the e plan. RN-J stated the hospice s located in the front of R45's hard ras the schedule the facility should be en instructing their staff of visiting nges were made, hospice would ility of these changes. at 12:00 p.m. RN-B stated she never when the hospice schedule was in the s hard chart which identified the was at the facility on Monday of each chedule was dated 2/17/16, which R45 started on hospice services. that whenever hospice was at the sommunicated their visit with floor ell as herself. They also left a copy of es in the hard chart. RN-B verified nurse's note in R45's hard chart e past 30 days.</li> </ul>	<ul> <li>linens weekly, hospice, and female nly. There was nothing noted about were provided to R45 from the ncy. NA-G stated she had access to a through a binder at the 600 wing on which had copies of the PCP. these were the only care plans she to.</li> <li>at 10:19 a.m. the hospice agency urse patient care coordinator (RN)-J was a care plan in the front of R45's hard tailisted what activities of daily living se was responsible for on their visits. care plan was integrated into the plan. RN-J stated the hospice solud lility of these changes.</li> <li>at 12:00 p.m. RN-B stated she never when the hospice schedule was in the shard chart which identified the was at the facility on Monday of each chedule was dated 2/17/16, which R45 started on hospice services. that whenever hospice was at the sommunicated their visit with floor ell as heres? I. They also left a copy of es in the hard chart. RN-B verified nurse's note in R45's hard chart e past 30 days.</li> </ul>	

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		AND HUMAN SERVICES			FORM	: 08/10/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
245359		B. WING _		07/14/2016		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HAVEN CARE CENTER INC				210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309 F 312 SS=D	further stated when member of the direc passed on to the ch would pass informa shift change. The D morning there was members of the inte gave a verbal repor the last 24 hours as into the PointClick of hours. The undated facility Resident Receiving care is provided by hospice and the nur responsible for deve care guiding both pi needs and goals. Ti identify which provid various aspects of of State, local and Feo did not address how communicated to di facility. 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives	t care plan (PCP). The DON information was relayed to a ct care staff this should be harge nurse. The charge nurse ation along in daily reports at DON went on to state that each report at 9:00 a.m. for erdisciplinary team. The nurse t of any new information from s well as any notes entered care system for the last 24-72 y policy for Coordination of a t Hospice Services stated, "If the hospice in the facility, the rsing home are jointly eloping a coordinated plan of roviders based on assessed the coordinated care plan will der is responsible for the care and updated according to deral regulations". The policy w the information would be irect care staff within the CARE PROVIDED FOR	F 30	9		8/21/16
	by:	NT is not met as evidenced tion, interview, and document		Regulation 483.25(a)(3) Tag F312		

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		AND HUMAN SERVICES				FORM	08/10/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		245359	B. WING			07/-	14/2016	
NAME OF I	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•		
PINE HAVEN CARE CENTER INC					10 NORTHWEST 3RD STREET INE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	Continued From page 22 review, the facility failed to ensure 1 of 2 residents (R53) reviewed receiveed nail care. Findings include: R53 was admitted to the facility with diagnoses that included diabetes mellitus according to facility Admission Record. The significant change Minimum Data Set (MDS), dated 4/7/16, revealed R53 cognition intact and required extensive assist of 1 staff for personal hygiene which included nail care. R53's care plan dated 1/2/15, identified R53 required assistance with bathing with interventions that included nail care as needed by licensed nurse. Observations on 7/11/16, at 3:26 p.m., revealed R53 with long, soiled finger nails. During interview on 7/13/16, at 9:48 a.m., registered nurse (RN)-A verified R53 required			312	Activities of Daily Living Care Pine Haven Care Center provides to necessary services to maintain good nutrition, grooming, personal care a oral hygiene for residents who are to carry out activities of daily living independently. Based on the comprehensive resident assessme staff provides cares which assist the resident to maintain and enhance the self-esteem and self-worth including assistance nail care as outlined in the of care. The residents' need for assistance with personal hygiene is reassessed quarterly and with sign changes in condition. The plan of correvised as necessary. During the mandatory meeting Aug 2016, the nursing staff will be 1) reinstructed on the facility's policies providing personal hygiene to the	od and unable nt, the e is/her g the plan s ificant are is ust 15, s for		
	During interview on stated the finger na During interview on director of nursing long and soiled. Sh	ce with personal hygiene. 7/14/16, at 8:25 a.m., R53 ils were long. 7/14/16, at 8:40 a.m., the verified R53's finger nails were e stated she expected nursing 3's nail care as needed.			residents 2) reminded that their job description requires knowledge of a responsibility for following the resid plan of care and 3) instructed on th importance of providing nail care. T need to provide cares as necessar improve/enhance the residents' appearance, comfort, and dignity w emphasized. The grooming plan of care for resid number 53 was reviewed and found appropriate in addressing the resid personal care needs. The direct ca are aware of the need to provide na as part of the routine grooming/bat	and ent's e The y to rill be d ent s re staff ail care		

Event ID:0BBR11

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	-ORM	08/10/2016 APPROVED 0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245359			B. WING			07/14/2016	
NAME OF I	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HAVEN CARE CENTER INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312 F 314 SS=D	Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores reco services to promote prevent new sores This REQUIREMEN by:	ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing.		312	procedures. The Life Enrichment Director/designed be responsible for monitoring complia by randomly checking residents' finger nails for appropriate length and cleanliness for two weeks. If noncompliance is noted, additional monitoring and staff training will be d Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and October 2016 quarterly Quality Assurand and Improvement Committee meeting	ance er one. I the rance g.	8/21/16
	review, the facility fa pressure ulcers and ulcers from develop Findings include:	ion, interview and document ailed to treat identified d prevent further pressure bing for 1 of 1 resident (R62). cord, dated 3/15/16, indicated			Tag F314 – Prevent/Heal Pressure S Based on the comprehensive assessment, Pine Haven Care Cente staff ensure that residents who enter facility without pressure sores do not develop pressure sores unless the	er the	

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	-	AND HUMAN SERVICES				M APPROVE <u>0. 0938-039</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		245359	B. WING _	i		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	• •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA		INC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 314	that the resident ha and a fracture of th humerus (long bond the elbow). R62's care plan, da resident was at risk integrity related to h incontinence. There interventions provid R62 would maintain R62's care area as indicated that the re pressure ulcer. It st a special mattress R62's progress not through 7/14/16, ind to the facility with p as well as both hee progress notes indi multiple stage one area which were re survey. R62's medication re indicated that the p	ad diagnoses of repeated falls e upper end of the left e running from the shoulder to ated 3/15/16, indicated the a for an alteration in skin her immobility and e were a number of ded with the goal in mind that	F 3 <sup>-</sup>	14	resident's clinical condition demonstrate that they were unavoidable. Residents receive necessary treatment and service to promote healing, prevent infection, and prevent new pressure areas from developing. Based on the comprehensive skin assessment, care plans are developed to address and minimize risk of skin breakdown. The plans focus on services that maintain skin integrity, prevent pressure sores, and provide treatment as prescribed. The policies and procedures for comprehensively assessing the resident skin condition and risk factors were reviewed and found appropriate. An evaluation of the resident's skin condition skin risk factors, and tissue tolerance wi continue to be completed at the time of admission, readmission from the hospita quarterly, and with significant changes in condition. A licensed nurse observes the residents' skin condition weekly. The physician and dietary manager are notified of open lesions and the plan of care is revised to reflect related interventions. Open lesions are monitore and measured on a routine basis and th	es d e s s' n, ll al, i e ed	
	loss. On 7/13/16 at 7:04 back in bed. At 7:17 (NA)-H entered R67 resident if she woul expressed a desire "so stiff". During thi	a.m., R62 was lying flat on her 7 a.m., nursing assistant 2's room and asked the Id like to get up. The resident to get up and stated she felt s observation, the air mattress s resting directly on the			physician is notified of worsening/nonhealing wounds. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol. The system for notifying the dietary staff of open skin areas was reviewed; no changes were indicated.	f	

Facility ID: 00148

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED	
		245359	B. WING _		<b>07</b> / <sup>.</sup>	07/14/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE			
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREE PINE ISLAND, MN 55963	ΞT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE	
F 314	mattress. NA-H not plugged in. She tur was working, but th The air mattress wa in it. R62 stated sho on at all, she stated it was. At 8: 48 a.m brought R62's brea The breakfast tray cream of wheat, toa juice, a cup of coffe water at her table. I was served for R62 When interviewed of licensed practical n interventions were recurrence of press stated R62 was giv She stated that the R62's coccyx area stiffness when she that it looked like th but R62 had a care 6/22/16 and the res the air mattress. R6 LPN-D stated that n be tried to alleviate When interviewed of trained medication supplements were assistants and nurs it had been served. identified where the supplements off in were then to be del	ted that the air mattress was ned it on and the air mattress nen NA-H turned it off again. as again noted to have no air e did not want the air mattress d that the bed was fine the way ., nursing assistant (NA)-D kfast to her room on a tray. consisted of pudding, a bowl of ast, a cup of milk, a cup of ee. R62 also had a cup of NA-D stated this was all that 2's meal. on 7/13/16 at 8:32 a.m., nurse (LPN)-D was asked what in place to prevent the sure ulcers for R62. LPN-D en the air mattress on 6/21/16. air mattress was initiated for and R62 complained of a lot of went to bed. LPN-D stated the mattress was started then e conference meeting on sident was very upset about 52 did not want to use it. maybe something else should	F 3 <sup>-</sup>	<ul> <li>14</li> <li>During the August 15, 3 meeting, the nursing st reinstructed on the fac policies and procedure include the need to 1) of monitoring and docum the healing/nonhealing implement skin-related and clinician ordered in monitor the effectivene acceptance of the inter will be reminded to not manager if the residen follow the recommende</li> <li>Resident number 62 – assessments indicate is occasional blanchable The resident's air matt discontinued at her rec wheelchair ROHO pres cushion continues. The receiving a dietary sup of weight loss. The car reviewed and revised.</li> <li>Compliance will be mo Administrator/designee orders for supplements dietary department is a and is delivering the or to the nursing care are the use of pressure rec to assure proper use/fu acceptance.</li> <li>Compliance will be rev monthly Quality Assura Assessment Committe</li> </ul>	taff will be ility's skin related s. Discussion will complete weekly entation describing of open lesions 2) I nursing practices nerventions and 3) ass and resident ventions. The staff ify the clinical t chooses not to ed plan of care. Recent skin intact skin with redness on coccyx. ress has been guest; use of a assure reduction e resident is plement due to risk e plan has been nitored by the e by 1) auditing the s to assure that the tware of the order dered supplement a and 2) reviewing duction mattresses unction and resident iewed at the ance and		

Facility ID: 00148

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	TE SURVEY MPLETED	
		245359	B. WING _		07	/14/2016	
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE		
PINE HA	VEN CARE CENTER	INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 314	resident the supplet the supplements in revealed that R62 her name on it. When interviewed TMA-D stated that dietary staff who st order to provide a Practical Nurse (Lf break in communic and dietary. The di received the order When interviewed stated when a residulcer, a plan of car nurse manager wo on a weekly basis new interventions of LPN-D stated she from R62's bed as mattress was not b When interviewed dietary manager st an order from the r was to receive a su When interviewed registered nurse (F been a breakdown resulted in R62 no supplement with m tried an air mattres	ement went to. Observation of a the refrigerator on the unit did not have a supplement with on 7/13/16 at 11:50 a.m., she had just spoken with the tated they never received an supplement to R62. Licensed PN)-A verified there had been a cation between the nursing staff etary department never to provide the supplement. on 7/13/16 at 1:49 p.m. LPN-D dent developed a pressure e would be developed. The build assess the pressure ulcer and would determine if any needed to be implemented. was removing the air mattress she did not know that the air	F 31		ee meeting.		

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		AND HUMAN SERVICES				FORM	08/10/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245359	B. WING			<b>07</b> / <sup>.</sup>	14/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 F 329 SS=D	couple more days to mind. RN-B explain report back to her th been turned on as F When interviewed of director of nursing ( expected the nursing resident had been of mattress on her bed expected the dietary been notified in orde supplement with me Review of the facilit Skin Ulcers, advised department when a 483.25(I) DRUG RE UNNECESSARY D Each resident's drug unnecessary drugs, drug when used in a duplicate therapy); o without adequate m indications for its us adverse consequent should be reduced of combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and of record; and residen	o see if she changed her led the nursing staff did not hat the air mattress had not R62 did not want to use it. on 7/14/16 at 1:23 p.m. the (DON) stated she would have hg staff to be notified that the declining the use of the air d. The DON further stated she y department would have er to provide R62 with the eals. by policy updated on 5/4/09, d to notify the dietary pressure ulcer was identified. EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of noes which indicate the dose or discontinued; or any	F3	314			8/21/16

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		FORM APPROVED OMB NO. 0938-0391				
	IDENTIFICATION NUMBER:				PLETED	
	245359	B. WING _		<b>07</b> /1	4/2016	
PROVIDER OR SUPPLIER						
VEN CARE CENTER I	NC					
SUMMARY STA				1	(X5)	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION DATE	
REGULATORY OR L	SCIDENTIFYING INFORMATION)	TAG	DEFICIENCY)	IAIE	DATE	
behavioral intervent contraindicated, in a drugs.	tions, unless clinically an effort to discontinue these	F 32	9			
by: Based on observat review, the facility fa specific symptoms anti-depressant me (R44) reviewed for addition, the facility assessment prior to medication for 1 of unnecessary medic Finding include: R44's quarterly Min 4/6/16, indicated R4 depression and was medication. R44's physician ord an order for citalopr 40 milligrams (mg) 4/23/14. R44's phys 4/4/16, identified dia and indicated R44's Celexa for R44's de medication adminis identified R44 was for prescribed.	ion, interview and record ailed to identify and monitor for the use of an dication for 1 of 5 residents unnecessary medications. In failed to complete a sleep the initiation of a hypnotic 5 residents (R47) reviewed for ations. imum Data Set (MDS) dated 44 had the diagnosis of s receiving an antidepressant lers dated 7/14/16, identified ram (Celexa) (anti-depressant) once a day with start date of sician progress note, dated agnosis of major depression a medication regimen included epressive symptoms. R44's tration record dated 7/16, receiving the medication as		<ul> <li>each resident's drug regime is free unnecessary drugs. The resident's regime is reviewed by the interdisci care team, physician and consultan pharmacist to assure that medication not used in excessive doses, for excessive duration, without adequat monitoring, without adequate indicat or in the presence of adverse consequences which indicate the du should be reduced or the drug discontinued. An effort is made to id the lowest effective dose of psychol medications and to discontinue the psychotropic medications whenever possible.</li> <li>Pine Haven Care Center staff ensurant 1) residents who have not used psychotropic drugs are not given the drugs unless psychotropic drug the necessary to treat a specific conditii diagnosed and documented in the or record and 2) residents who use</li> </ul>	from drug plinary t ons are te tions, ose dentify tropic use of r re that ese rapy is on as clinical		
	RS FOR MEDICARE OF DEFICIENCIES FORRECTION PROVIDER OR SUPPLIER VEN CARE CENTER I SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa behavioral intervent contraindicated, in a drugs. This REQUIREMEN by: Based on observat review, the facility fa specific symptoms anti-depressant me (R44) reviewed for addition, the facility assessment prior to medication for 1 of unnecessary medic Finding include: R44's quarterly Min 4/6/16, indicated R4 depression and was medication. R44's physician ord an order for citalopr 40 milligrams (mg) 4/23/14. R44's physician ord and indicated R44's Celexa for R44's dem medication adminis- identified R44 was for prescribed.	DF CORRECTION       IDENTIFICATION NUMBER:         245359         PROVIDER OR SUPPLIER         VEN CARE CENTER INC         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 28         behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.         This REQUIREMENT is not met as evidenced by:         Based on observation, interview and record review, the facility failed to identify and monitor specific symptoms for the use of an anti-depressant medication for 1 of 5 residents (R44) reviewed for unnecessary medications. In addition, the facility failed to complete a sleep assessment prior to the initiation of a hypnotic medication for 1 of 5 residents (R47) reviewed for unnecessary medications.         Finding include:         R44's quarterly Minimum Data Set (MDS) dated 4/6/16, indicated R44 had the diagnosis of depression and was receiving an antidepressant medication.         R44's physician orders dated 7/14/16, identified an order for citalopram (Celexa) (anti-depressant) 40 milligrams (mg) once a day with start date of 4/23/14. R44's physician progress note, dated 4/4/16, identified diagnosis of major depression and indicated R44's medication regime included Celexa for R44's depressive symptoms. R44's medication administration record dated 7/16, identified R44 was receiving the medication as	RS FOR MEDICARE & MEDICAID SERVICES         COF DEFICIENCIES         COF DEFICIENCIES         PROVIDER CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245359         B. WING	Image: Method of the construction o	IMENT OF HEALTH AND HUMAN SERVICES       FORM.         SF CPA MEDICARE & MEDICAID SERVICES       OMB NO.         OF ORRECTION       (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) DATA         PROVIDER OR SUPPLIER       245359       IVING       (Y2) MULTIPLE CONSTRUCTION       (Y2) MULTIPLE CONSTRUC	

Facility ID: 00148

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PRINTED: 08/10/2016

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245359	B. WING _			14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 329	identified a score of R44's care plan did major depression. I specific symptoms diagnosis of depress On 7/14/16, at 9:35 services (DSS)-A s monitoring the use DSS-A reviewed R4 was no depression stated R44 had bee admission and she physician progress Celexa. DSS-A stat scores was becaus a little bit, and indic DSS-A stated she h in R44. On 7/14/16, at 10:1 (DON) stated it was the use of an antide DON stated she co needed to be a mon medications. The facility policy d Medication Usage, monitoring of all tar assist in the assess relationship of psyce R47's admission re	and PHQ-9 dated 6/30/16, f 7. I not address the diagnosis of R44's record failed to identify and interventions for the	F 32	<ul> <li>reductions with attempts to mabe haviors using nonpharmacodin interventions.</li> <li>Medications are reviewed by the consultant pharmacist monthly attending physician/nurse praceduring their routine 30/60 day more often as indicated. Base resident's comprehensive ass Pine Haven Care Center stafficientify target behaviors and masymptoms that justify the use psychotropic medications.</li> <li>At the time of the quarterly care conference and more often if material residents receiving psychotropic medications are reassessed be nurses and the social worker. medication type/dose, behaviors symptoms, and other related if are reviewed to assure that the continues to reflect adequate if for use, that related target belowing symptoms are identified and mand that assessments are continuing to related to the use psychotropic medications. The and procedures related to the use psychotropic medications and medications insomnia were reviewed and reviewed and reviewed to the use of the related to the use of the transmet. The and medication of psychotropic medications insomnia were reviewed and reviewed and reviewed to the use of the transmet.</li> </ul>	he y and by the ctitioner visits and d on the essment, routinely nood of re needed, bic y licensed The or/mood nformation e record ndications navior/mood nonitored, npleted as	

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		AND HUMAN SERVICES			FORM	08/10/2010 APPROVEI 0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY PLETED		
		245359	B. WING _		07/-	14/2016		
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE				
PINE HA	VEN CARE CENTER	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 329	Trazodone (antidep to receive 50 mg (n R47's care plan, da the resident had tro getting to sleep and care plan directed t soothing environme bedtime and intervi the resident did at h sleep. This was to h plan on admission. as ordered to prom perform a monthly and as needed. The recommended a per licensed staff. R47's undated slee had been told he sr document indicated which could be rela handwritten docum woke at night occas nights mixed up act R47's 24 hour sleep 6/10/16, had three Of the remaining da did wake up over th sleep. When interviewed or registered nurse (R day sleep log to mo the facility would or upon admission to	ent had been prescribed pressant) for insomnia. He was nilligrams) at bedtime. Atted 10/23/15, indicated that puble sleeping, staying asleep, d getting back to sleep. The o establish a calm, quiet and ent prior to an established ew the resident regarding what nome to establish a restful be incorporated in to the care R47 was to take medications ote sleep. The staff were to sleep log while on medication	F 32	<ul> <li>The daily behavior log will contused to track 1) target behavior the use of antipsychotic medicinterventions to modify behavior the effectiveness of the interventions related to the antidepressant medications will addressed in the care plan and at least quarterly at the resider conference.</li> <li>During the mandatory meeting 15, 2016, the licensed nursing instructed on 1) the documentar procedures for tracking target as well as related interventions effectiveness 2) addressing tarbehaviors/mood symptoms in the plan and 3) the new procedure tracking sleep/wake patterns, or sleep assessments and documnighttime sleep habits. The dimestaff will be reminded of the imbeing observant for behavior/n symptoms and reporting symp charge nurse in a timely mann.</li> <li>Resident number 44 – The care been updated to address the dand symptoms of depression. Worker will complete a depress questionnaire every 90 days at significant change in condition physician will be contacted if the increase in symptoms of depression.</li> <li>Resident number 47 – The rest and symptoms of depression.</li> </ul>	rs justifying ations 2) or and 3) ontions. use of II be discussed nt's care s on August staff will be ation behaviors and their rget the care s for conducting nenting ect care portance of nood toms to the er. re plan has liagnosis The Social sion screen nd with a . The nere is an essed viewed and			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
			A. BUILD	ING _		00111	
		245359	B. WING			<b>07</b> /1	14/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 329	Continued From pa	age 31	F3	329			
	R47's sleep log rev 7/16, stated the res slept all night. R47 stated he did have for an hour or two a sleep. It further sta during the day. When interviewed consultant pharma be completing the When interviewed director of nursing	on 7/14/16 at 1:20 p.m., the (DON) stated staff did monitor			sleep/wake patterns will be tracked three days after which a registered will review the data and complete a assessment. A licensed nurse will continue to document on the resid sleep quality/patterns weekly. The practitioner/physician will be notifie any ongoing problems with insomr resident's care plan has been revie and updated accordingly. To monitor compliance, the Directo Nurses/designee will review the re residents receiving medications to insomnia to ensure appropriate sle tracking/assessments have been completed. The Medical Record	I nurse a sleep ent's nurse ed of nia. The ewed or of cords of treat	
	the need for a sleep assessminitiation of a hypnotic medica Review of the facility docume Insomnia Assessment, advis	e stated she understood about p assessment prior to the otic medication. ty document dated 4/22/09,			Coordinator will review the records admissions for next 90 days to ass admission sleep tracking logs and assessments are completed in a ti manner. To further monitor compliance the	sure mely	
	hypnotic sleeping m assessment and sl upon admission, sl complaints of insor ordered sleeping m discontinuing sleep	nedications. It stated a sleep eep log would be completed eep pattern change or nnia, pre administration of nedications, and 7 days after o medication. The 3 day sleep nented according to acute			Workers will audit the care plans of residents with the diagnosis of dep to ensure that depression and rela mood indicators are addressed. D the consultant pharmacist's month medication audits and the quarterl planning process, the residents' medication regimen will continue to reviewed to assure that medication to manage mood and insomnia are appropriate and are monitored. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting a October 2016 quarterly Quality Ass	f all pression ted puring ly y care o be ns used e and the	

Event ID:0BBR11

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		AND HUMAN SERVICES	FORM APPROVED OMB NO. 0938-0391				
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE			0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245359	B. WING _			<b>07</b> / <sup>.</sup>	14/2016
NAME OF F	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			0 NORTHWEST 3RD STREET		
				PI	NE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 32	F 32				
F 412 SS=D	483.55(b) ROUTINI SERVICES IN NFS	E/EMERGENCY DENTAL	F 41	12	and Improvement Committee meet	ing.	8/21/16
	an outside resource §483.75(h) of this p covered under the S dental services to m resident; must, if ne making appointmen transportation to an	must provide or obtain from e, in accordance with art, routine (to the extent State plan); and emergency neet the needs of each ecessary, assist the resident in hts; and by arranging for d from the dentist's office; and residents with lost or to a dentist.					
	by: Based on observat review, the facility fa were offered for 2 o reviewed for dental concerns. Findings include: R53 had diabetes n facility Admission R Observations on 7/ <sup>7</sup> R53 had missing te lower left of his mou seen a dentist for ye of nursing (DON) ve Document review o Data Set (MDS) dat	NT is not met as evidenced ion, interview and document ailed to ensure dental services f 3 residents (R53, R47) services and who had oral hellitus, according to the ecord. 14/16, at 8:40 a.m., revealed eth on the lower right and uth. R53 stated he had not ears. At that time, the director erified the missing teeth. f significant change Minimum ted 4/7/16, revealed R53's and he required extensive			Regulation 483.55(b) (Tag F412) Routine/Emergency Dental Care Pine Haven Care Center routinely a the residents in obtaining routine ar emergency dental services. The fac assists the resident in making appointments and arranging for transportation to and from the denti office. The family is notified of lost of damaged dentures and resident is referred to a dentist as appropriate. The policies and procedures related dental assessments and referrals h been reviewed and revised. A new assessment form will be implement The need/desire for a dental referrat be routinely discussed during the an care conferences and more frequent	nd cility st's or d to as oral ced. al will nnual	

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PRINTED: 08/10/2016

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	VG	COMPLETED
		245359	B. WING _		07/14/2016
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE,	ZIP CODE
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREE PINE ISLAND, MN 55963	T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLÉTION THE APPROPRIATE DATE DATE
F 412	Continued From pa	age 33	F 41	12	
	included brushing t tooth fragments, no broken teeth, no bl difficulty chewing. I assessment dated exam was many ye teeth. R53's care plan rev R53 required assis interventions include care within reach, a also included offer refer to dentist as r	or personal hygiene which eeth. The MDS identified no b abnormal tissue, no cavity or eeding gums, and no pain or Document review of R53's oral 4/7/16, revealed the last dental ears ago and he had some lost vised dated 4/12/16, directed tance with oral care and led set up supplies for oral assist as needed. Interventions to set up dental appointments, needed and staff provide oral o times a day and as needed.		there are complaints of chewing problems. The contracting with Apple provide on-site dental of explored. During the August 15, 2 staff meeting, the follow discussed: 1) any resid difficulty chewing or com pain or other dental rela should be assessed to need for referral to the 2) the implementation of assessment form and 3 a dental referral at leas	e option of Tree Dental to care is being 2016 mandatory ving will be dent who has mplains of mouth ated problems determine the physician or dentist of the revised oral 3) the need to offer
	nursing assistant (I morning cares afte time daily at bedtim his own teeth at be During interview on assistant (NA)-D st	7/14/16, at 1:30 p.m., nursing ated R53 required assist of supplies for oral care. NA-D		Resident number 53 – receiving hospice service been no complaints of difficulty chewing. Durin July 20, 2016 care cont declined an offer for a constating that they want a appointment only if they care plan has been upo	ces; there have mouth pain or ng the resident's ference, the family dental referral dentist re is an issue. The
	During interview on registered nurse (F evidence of offering missing teeth. R47's admission re the resident had a Lewy bodies.	n 7/14/16, at 1:30 p.m., RN)-B verified the lack of g R53 dental services for ecord, dated 2/24/14, indicated diagnosis of dementia with num Data Set (MDS), dated		Resident number 47 – assessment was comp registered nurse Augus resident had no compla problems chewing. The not wish to see a dentis paining me." The reside be discussed with his w referral will be address has been reviewed and	leted by a st 5, 2016. The aints of pain or e resident did/did st –"teeth aren't ent's oral status will vife; a dental ed. The care plan

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/10/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245359	B. WING		<b>07</b> / <sup>.</sup>	14/2016
NAME OF F	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC	-	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 412	Continued From pa On 7/12/16 at 9:32 were beginning to c decay. He stated it had been to the der was noted to have r upper right side of h had not offered him R47's last oral asse it was unknown who dental exam was. If referral to a dental p R47's nutritional as indicated that he had R47's medical reco been to a dentist or had dental concern extraction. R47's progress note been offered a rout On 7/13/16, at 11:4 (LPN)-A stated that	ge 34 a.m., R47 stated his teeth leteriorate and starting to had been over a year since he ntist. Upon observation, R47 multiple missing teeth on the his mouth. R47 stated the staff a dental appointment. essment, dated 5/4/16, stated en the last time he had a recommended no immediate professional. sessment, dated 6/14/2016, id his own teeth. rd indicated that he had last a 2/24/14. At that time, R47 s which required a tooth es did not indicate that he had ine dental appointment. 8 a.m. licensed practical nurse dental services were offered conference meetings. She	F 412	DEFICIENCY)	r the or rral for at the ence. e and the surance	
	On 7/14/16, at 9:38 stated residents rec assessment. If they offered a dental app issues were not bro conference. If some problem the physici	a.m., registered nurse (RN)-A ceived an annual oral had problems they would be cointment. She stated dental ought up at every care eone was noted to have a an would be notified. She request an appointment				

	-	AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	OI E CONSTRUCTION		0938-0391 E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_		COM	PLETED
		245359	B. WING _			<b>07</b> / <sup>-</sup>	14/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	• • •	
PINE HA	VEN CARE CENTER I	NC			0 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	^	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		DATE
					BEHOLIKOT		
F 412	Continued From pa	ge 35	F 4	12			
	On 7/14/16. at 1:11	p.m., the director of nursing					
	(DON) stated that s	he expected nursing staff to					
	months to a year.	ntment at least every six					
	Review of the docu	ment dated 1/13/06,					
	Assessment, it state	ed that oral assessments					
F 425		n admission and quarterly. RMACEUTICAL SVC -	F 42	25			8/21/16
SS=D	ACCURÁTE PROC						
		ovide routine and emergency					
	drugs and biologica them under an agre	Is to its residents, or obtain ement described in					
	§483.75(h) of this p	art. The facility may permit					
		el to administer drugs if State y under the general					
	supervision of a lice	ensed nurse.					
		de pharmaceutical services					
	(including procedure acquiring, receiving	es that assure the accurate , dispensing, and					
		drugs and biologicals) to meet					
		nploy or obtain the services of sist who provides consultation					
	on all aspects of the	e provision of pharmacy					
	services in the facili	ity.					
		1 <b></b> 1					
	This REQUIREMEN	NT is not met as evidenced					
	Based on observat	ion, interview and record illustrian interview and record is interview and record in the second second second s			Regulation 483.60(a)(b) Tag F425 Pharmacy Services	_	
	review the facility la				T HATHACY SELVICES		

Facility ID: 00148

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PRINTED: 08/10/2016

		AND HUMAN SERVICES			FC	ITED: 08/1 ORM APPI 8 NO: 093	ROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3	3) DATE SUR COMPLETE	
		245359	B. WING			07/14/20	016
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COM	(X5) IPLETION DATE
F 425	qualified staff, failed medication was doo personnel that had and to ensure a pre- left unattended by o Findings include: R14 was observed nursing assistant (N medication patch to R14. The medication licensed practical n 7/13/16. NA-B state lidocaine patch. NA patch were LPN-A's was not a trained m LPN-A had left the for her to apply. NA medication patch w nursing assistant to R14's physician ord an order for icy hot back topically one t times a day as nee R14's medication a dated 7/16, identified the person who adm medication patch a for the nursing assi	docaine patch by licensed staff d to ensure a prescribed cumented by the licensed administered the medication escribed medication was not qualified medication staff. on 7/13/16, at 7:02 a.m., when NA)-B was observed to apply a b the middle lower back of on patch had the initials of urse (LPN)-A and the date of ed the medication patch was a N-B confirmed the initials on the s initials. NA-B confirmed she nedication aide. NA-B stated medication patch in the room N-B stated typically the vas left in the room for the o apply. ders, dated 7/14/16, identified pad five percent, apply to low ime a day for pain and two	F 4	.25	Pine Haven Care Center provides pharmaceutical services (including procedures that ensures the accurate acquiring, receiving, dispensing, and administering of all drugs and biologica to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutis services within the facility and to guide development and implementation of pharmaceutical services and procedur Persons authorized to administer medications must meet related state a federal requirements. The medication administration policies and procedures have been reviewed a found appropriate. The Consultant Pharmacist routinely provides training the nursing staff on medication administration procedures and techniques. The next training session the pharmacist is scheduled for September 22, 2016. During the August 15, 2016 mandatory meeting, the nurses and trained medication aides will be instructed that only authorized staff can administer medication, that the nurse/trained medication must document its administration, that the person initialing skin patch must be the person who applies it, and that medications are no be left unattended with the resident un the appropriate assessments, clinician	eals) ical e res. and s and to by y at	

Facility ID: 00148

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'	TIPLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY IPLETED
		245359	B. WING			4.4/004.0
	PROVIDER OR SUPPLIER	240009	D: WING _	STREET ADDRESS, CITY, STATE		14/2016
	VEN CARE CENTER	INC		210 NORTHWEST 3RD STRE PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 425	apply the patch. LF applied by the nurs worked at the facili stated she would in planned that way b always been done. On 7/13/16, at 8:18 trained medication initialed for R14's is stated I did that bee patch out for LPN-// On 7/13/16, at 8:25 (DON) stated the p had to be a trained administer medication was the person initi be the person adm On 7/13/16, at 12: expected medication unless the resident to self-administer to stated R14 was no medications. The facility policy of Administration Ger medications do so properly orientated distribution system	PN-A stated the patch had been sing assistants since she had ty for 1 and ½ years. LPN-A nagine it would be care because that was how it has	F 42	<ul> <li>25</li> <li>self-administration of r been completed. The ordered for resident ne applied by staff author medications.</li> <li>To monitor compliance Manager will observe application of the lcy F resident number 14 ar resident with an order over-the-counter analg noncompliance is note observations and staff done.</li> <li>Compliance will be rev monthly Quality Assura Assessment Committe October 2016 quarterl and Improvement Cor</li> </ul>	Icy Hot patch umber 14 will be ized to administer e, the Clinical for correct Hot patch for hd for any other for an gesic patch. If ed additional training will be viewed at the ance and ee meeting and the y Quality Assurance	

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		AND HUMAN SERVICES				FORM	08/10/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245359	B. WING			<b>07</b> / <sup>-</sup>	14/2016
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425 F 431 SS=E	pharmacy or other plaws and regulation medications. B. Adu who prepares the d person who adminis are allowed to self-a specifically authoriz and in accordance -administration of m Documentation (ind individual who adm records the adminis directly after the med 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is a reconciled. Drugs and biologica labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer	personnel authorized by state as to prepare and administer ministration 7) The person lose for administration is the sters the dose. 14) Residents administer medications when zed by the attending physician with procedures for self nedications. D. cluding electronic) 1) The inisters the medication dose stration on the resident's MAR edication is given. DRUG RECORDS, BUGS & BIOLOGICALS mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to	F 4	125			8/21/16

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CENTER STATEMENT AND PLAN C NAME OF F PINE HA	RS FOR MEDICARE	-	A. BUILE B. WING				08/10/2016 APPROVED 0938-0391 SURVEY PLETED
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri quantity stored is m be readily detected This REQUIREMEN by: Based on observation interview facility fail medications were p proper outdates. Findings include: Observation: Observation of medi room on the 600 wi 07/11/16, 5:00 p.m. (TMA)-A. Upon obse found a bottle of Se with the directions of g-tube daily as nee 4/2016, Loperamid ml per J (jejunostor and 10 ml after with Senna tablets prese	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can	F	43	1         Regulation 483.60(b, d, e) F431 –         Labeling of Drugs and Biologicals         Pine Haven Care Center provides         pharmaceutical services to meet the         needs of each resident. The facility         contracts with a licensed consultant         pharmacist who collaborates with fac         staff to coordinate pharmaceutical         services and guide the development         implementation of related         policies/procedures to ensure the         accurate acquiring, receiving, dispension         storing and administering of all drugs         biologicals.         In accordance with State and federal         the facility policy requires that drugs	cility and sing, s and I law,	
	medication room re medication, Aplisol injection 1 ml which lot #772984 that ha outdated 30 after o	/2016. Upon observation of efrigerator found facility stock (a tuberculin derivative) h was 1/4 of the way full with a id an open date of 5/27/16 and pening or June 26, 2016. at was prescribed to (R22) 650			biologicals are labeled in accordance currently accepted professional princ and standards and that all drugs and biologicals are stored in a secure, loc location with access only by authorize personnel. Outdated and expired dru and biologicals are routinely discarde	ciples cked ed igs	

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PRINTED: 08/10/2016 FORM APPROVED

TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION		E SURVEY PLETED
		245359	B. WING _		07/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 431		•	F 43			
		sert one suppository per ours as needed with an		according to accepted p	ractice standards.	
	expiration date of 4 prescribed to (R50)	l/2016 and Bisacodyl ) suppository 10 mg		The medication related p procedures were review	ed and found	
	needed with an exp Observation of me	bine suppository rectally daily as biration date of 4/2016. dication cart and medication		appropriate. According to if there is a change in ma administration instruction	edication ns, an adhesive	
	at 5:29 p.m. with lic	ing was completed on 7/11/16, censed practical nurse cervation found Quetiapine		sticker stating "Direction To Chart" will be applied container to alert the sta	to the medication	
	which was prescrib expiration date of 5 (R14) give two tabl	bed to (R47) 50 mg with an 5/22/15, Tylenol prescribed to ets by mouth three times daily		medication administratio changes and 2) expiratio checked before administrational	on dates are to be	
	Ultram prescribed	expiration date of 12/2015, to (R14) 1 tablet by mouth four ded with an expiration date of		medications/biologicals.	eeting August 15,	
		dication cart and medication		2016, the nurses and tra assistants will be reinstru	ucted on 1) the	
	at 6:00 p.m. with tra	ing was completed on 7/11/16, ained medication aide servation found a stock		importance of medicatio and the procedure for at notification labels to the	taching	
	Nitrostat 0.4 mg wi	th an expiration date of 7/2015. as administered to (R60) on		there is an order change check expiration dates b	e 2) the need to	
	Robitussin prescrib every six hours as	to facility documents. bed to (R49) 5 ml by mouth needed with an expiration date		administering medication the policy for disposing of medications/biologicals	of outdated as well as those	
	date of 5/2016. Mill	upply of Tums with expiration k of Magnesia prescribed to y mouth daily as needed with		that have unreadable lab mislabeled/unlabeled.		
	an expiration date to (R29) place one minutes for three d	of 4/2016, Nitrostat prescribed tab under tongue every five oses with an expiration date of		The labels of all medicat were checked for expira completeness and reada	tion dates, ability. Continued	
	units subcutaneous an open date of 6/1	rescribed to (R17) inject 10 s per sliding scale which had 11/2016 and artificial tears		compliance with the disp outdated medications/bid those that are mislabeled	ologicals and d/unlabeled will	
	a day with an expir medication bottles	) one drop in left eye four times ation date of 2/2015. Found including Vitamin B12 and 42) that had no resident		be monitored monthly b Nurses/designee - staff authorized to administer the consultant pharmaci	member medications and	

Facility ID: 00148

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				()(0)			<u>. 0938-039</u>
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         PINE HAVEN CARE CENTER INC       210 NORTHWEST 3DD STREET         IVAI ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         F 431       Continued From page 41 identifier label and the expiration date had rubbed off on the label. Upon observation of medication room found Maalox prescribed for (R25) 80 ml by mouth three times a day before meals and at bedtime as needed with an expiration date of 3/2016.       F 431         Observation on 7/12/16, at 9:21 a.m. of medication administration with registered nurse (RN)-C showed a Levernir pen prescribed to (R34) with a label identifying to inject 24 units in the morning. MAR identified 40 units to be administered on the given was based off of what percentage of the meal was eaten, which at that time R34 required 22 units. Lantus pen for R34 with label identifying to inject 45 units in the morning. MAR identified 40 units to be administered in the morning. MAR identified 40 units to be administered in the morning. MAR identified 40 units to be administered in the morning, MAR identified 40 units to be administered in the morning, the needed on top. RN-C then turned the pen dial to 40. RN-C approached resident room, knocked and entered ther room preparing to administer the medication. At that time asked to speak with RN-C in the hallway and asked about the manufacturer's guidelines related to priming the insulin pen. RN-C stated, yes I usually			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
PINE HAVEN CARE CENTER INC         210 NORTHWEST 3RD STREET PINE ISLAND, NM 55963           (PA) D PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         D PREFX TAG         PROVERS' PLAN OF CORRECTION (EACH DERICENT OF AUXIENT BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         PROVERS' PLAN OF CORRECTION (EACH DERICENT OT THE PROPORIATE DEFICIENCY)           F 431         Continued From page 41 (identifier label and the expiration date had rubbed off on the label. Upon observation of medication room found Maalox prescribed for (R25) 30 ml by mouth three times a day before meals and at bedime as needed with an expiration date of 3/2016.         F 431           Compliance with proper administration record. (RN)-C showed a Levernir pen prescribed to (R34) with a label identifying to inject 24 units in the morning. IMA B identified to units to be administration record. If noncompliance is noted, additional monitoring and staff education will be done.         Compliance will be reviewed at the monitoring and staff education will be done.           Compliance from page 41 (identified the amount to be given was based off of what percentage of the meal was eaten, which at that time R34 required 22 units. Lantus pen for R34 with a label identifying to inject 45 units in the morning. MAR identified 40 units to be administered in the morning. Humalog vial for R34 with label to administer 10 units in the morning. MAR identified to administer registruct room, knocked and entered the room preparing to administer the medication. At that time asked to speak with RN-C in the hallway and asked about the manufacturer's guidelines related to priming the insulin pen. RN-C stated, yes I usually do that I forogot. RN-C was asked to			245359	B. WING _			14/2016
PINE HAVEN CARE CENTER INC         PINE ISLAND, MN 55963           (xx) D PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAST DE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         D PREFIX Continued From page 41 (dentifier label and the expiration date had rubbed off on the label. Upon observation of medication room found Maalox prescribed for (R25) 30 ml by mouth three times a day before meals and at bedtime as needed with an expiration date of 3/2016.         F 431         Compliance with proper administration of insulin using a pen, random observations of nurses administering insulin will be done. To monitor the accuracy of insulin vial/pen labels, a licensed nurse will compare all current insulin vial/pen labels with the emedication administration record (MAR) identified the amount to be given was based off of what percentage of the meal was eaten, which at that time R34 required 22 units. Lantus pen for R34 with a label identifying to inject 45 units in the morning, MAR identified 40 units to be administer of inthe morning. Humalog vial for R34 with a label identifying to inject 45 units in the morning, MAR identified to administer the medication. At that time asked to speak with RN-C in the hallway and asked about the manufacturer's guidelines related to priming the insulin pen. RN-C stated, yes I usually do that I forgot. RN-C was asked to demonstrate. RN-C turned the dial back to zero and then turned the dial to two. RN-C removed the outer cap of the needle but the inner pink cap was still present on	NAME OF F	PROVIDER OR SUPPLIEF	1			CODE	
PREFX TAGLEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFX TAGCecho CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)F 431Continued From page 41 identifier label and the expiration date had rubbed off on the label. Upon observation of medication room found Maalox prescribed for (R25) 30 ml by mouth three times a day before meals and at bedtime as needed with an expiration date of 3/2016.F 431Observation on 7/12/16, at 9:21 a.m. of medication administration right he medication administration record (MAR) identified the amount to be given was based off of what percentage of the meal was eaten, which at that time R34 required 22 units. Lantus pen for R34 with label identifying to inject 42 wints in the morning, MAR identified 40 units to be administered in the morning. Humalog vial for R34 with label to administer eight units in the morning, MAR identified to administer lisulin pien by wiping the top of the pen with an alcohol wipe, then placing the needle on top. RN-C then turned the pen dial to 40. RN-C approached resident room, knocked and entered the room preparing to administer the medication. At that time asked to speak with RN-C in the Halway and asked about the manufacturer's guidelines related to priming the insulin pen. RN-C removed the domostrate. RN-C turned the dial back to zero and then turned the dial to two. RN-C removed the outer cap of the needle but the inner prink cap was still present onPrefix TAG	PINE HA	VEN CARE CENTER	INC				
identifier label and the expiration date had rubbed off on the label. Upon observation of medication room found Maalox prescribed for (R25) 30 ml by mouth three times a day before meals and at bedtime as needed with an expiration date of 3/2016. Observation on 7/12/16, at 9:21 a.m. of medication administration with registered nurse (RN)-C showed a Levemir pen prescribed to (R34) with a label identifying to inject 24 units in the morning, the medication administration record (MAR) identified the amount to be given was based off of what percentage of the meal was eaten, which at that time R34 required 22 units. Lantus pen for R34 with label identifying to inject 45 units in the morning, MAR identified 40 units to be administered in the morning, MAR identified 40 units to be administered in the morning. MAR identified 40 units to be administered in the morning full in the morning, MAR identified to administer 10 units in the morning, MAR identified to administer 10 units in the morning, MAR identified to administer eight units in the morning. RN-C prepared Lantus insulin pen by wiping the top of the pen with an alcohol wipe, then placing the needle on top. RN-C then turned the pen dial to 40. RN-C approached resident room, knocked and entered the room preparing to administer the medication. At that time asked to speak with RN-C in the hallway and asked about the manufacturer's guidelines related to priming the insulin pen. RN-C stated, yes I usually do that I forgot. RN-C removed the outer cap of the needle but the inner pink cap was still present on	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
the cap on. Stopped RN-C at that time and again asked about manufacturer's guidelines related to priming the insulin pen. RN-C removed the cap and primed the pen with two units of lantus.	F 431	identifier label and off on the label. Up room found Maalo mouth three times bedtime as neede 3/2016. Observation on 7/ medication admini (RN)-C showed a (R34) with a label the morning, the n (MAR) identified th based off of what eaten, which at tha Lantus pen for R3 inject 45 units in th units to be adminis vial for R34 with la morning, MAR ide in the morning. RN by wiping the top of then placing the ne the pen dial to 40. room, knocked an administer the me speak with RN-C i the manufacturer's the insulin pen. RN I forgot. RN-C was turned the dial bac dial to two. RN-C n needle but the innu- the needle. RN-C the cap on. Stoppe asked about manu- priming the insulin and primed the pen	The expiration date had rubbed bon observation of medication ox prescribed for (R25) 30 ml by a day before meals and at d with an expiration date of 12/16, at 9:21 a.m. of istration with registered nurse Levemir pen prescribed to identifying to inject 24 units in nedication administration record ne amount to be given was percentage of the meal was at time R34 required 22 units. 4 with a label identifying to ne morning, MAR identified 40 stered in the morning. Humalog abel to administer 10 units in the ntified to administer eight units N-C prepared Lantus insulin pen of the pen with an alcohol wipe, eedle on top. RN-C then turned RN-C approached resident d entered the room preparing to dication. At that time asked to n the hallway and asked about s guidelines related to priming N-C stated, yes I usually do that s asked to demonstrate. RN-C ck to zero and then turned the removed the outer cap of the er pink cap was still present on started to prime the pen with ed RN-C at that time and again ufacturer's guidelines related to pen. RN-C removed the cap	F 4:	<ul> <li>compliance with proper ad insulin using a pen, randor of nurses administering insudone. To monitor the accur vial/pen labels, a licensed compare all current insulin with the medication admini If noncompliance is noted, monitoring and staff education done.</li> <li>Compliance will be reviewed monthly Quality Assurance Assessment Committee m October 2016 quarterly Quality Quality</li></ul>	n observations sulin will be racy of insulin nurse will vial/pen labels stration record. additional tion will be ed at the and eeting and the ality Assurance	

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 08/10/2016 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		245359	B. WING _		07/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 42	F 43	31		
	Interview with TMA verified expiration of stated if an expired be removed from the room, would be re-on nursing (DON) would Interview with LPN- verified expiration of that another LPN on be going through all rooms looking for everified that if an ex- it should be removed cart/medication roor residents. Interview with TMA- verified expiration of verified missing res- stated that all media resident name and label should not be expired medications and placed in a bin well as the DON sh TMA-C verified that not be administered Interview with RN-C verified the labels of were incorrect. RN- changed by the door should have been p as soon as the order	A on 7/11/16, at 5:00 p.m. lates of medications. TMA-A medication is found it would be medication cart/medication ordered and the director of ld be informed. B on 7/11/16, at 5:29 p.m. lates of medication and stated in the night shift is supposed to I the carts and medication xpired medications. LPN-B spired medication is found that ad from the medication m so that it isn't given to any -C on 7/11/16, at 6:00 PM lates of medications and ident identifying labels and cations should be labeled with that any medications without a given. TMA-C stated the s should have been removed in the medication room as ould have been notified. expired medications should d. C on 7/12/16, at 9:21 a.m. in the insulin pens and vials C stated when an order is ctor that a label change sticker blaced over the existing label				

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		AND HUMAN SERVICES				FORM	08/10/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245359	B. WING			07/ <sup>.</sup>	14/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	medications every t medications and the expired medications circulation, placed i to pharmacy, reorde DON verified that la placed immediately DON verified that n training on the prop reported that staff r a year related to ins Record Review: DON provided the s was presented to n of insulin pen admin documentation titler identifies, "it is poss to collect in the cart avoid injecting air, a before each injectio units. Hold the pen the push-button all selector shows 0. Y insulin at the tip of t list of nursing staff v the proper use of in documented to hav 12/30/2015. Manufacturer's guid Insulin was provide guidelines identify t injecting insulin. Th a test dose of 2 uni pointing up and light the air bubbles rise	time they are administering e expectation when finding s is that they are pulled out of in medication room, sent back ered, notify family if needed. abel change stickers should be r once the order has changed. tursing staff had received ber use of insulin pens. DON eceived training at least once sulin pen usage.	F 4	.31			

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	RS FOR MEDICAR	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245359	B. WING _		07	7/14/2016
NAME OF I	PROVIDER OR SUPPLIEF	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 431	Continued From p	age 44	F 43	1		
		n all the way in and check to mes out of the needle.				
F 441 SS=F	policy dated Febru expiration date on administering any Ordering and Rec dated February of physicians's direct is inaccurate, the changed-refer to of indicating there is Resident-specific that are not labele the manufacturer's identified with the storage in the facil 2015 identifies tha immediately removial will check the expi- before administer be administered to medications will be supply and destroy 483.65 INFECTIO SPREAD, LINENS The facility must e Infection Control F safe, sanitary and	N CONTROL, PREVENT stablish and maintain an Program designed to provide a comfortable environment and development and transmission	F 44	1		8/21/16
	(a) Infection Contr The facility must e Program under wh	stablish an Infection Control				

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	ripl	E CONSTRUCTION		0938-0391 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245359	B. WING			07/-	14/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET		
				Р	INE ISLAND, MN 55963		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	``	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		DATE
	1		1		DEFICIENCE		
F 441	Continued From pa	ae 45	F 4	/1			
		ntrols, and prevents infections	1 -				
	in the facility;						
		ocedures, such as isolation,					
		o an individual resident; and or incidents and corrective					
	actions related to in						
	(b) Drayanting Core	ad of Infantion					
	(b) Preventing Spre (1) When the Infect	ion Control Program					
	determines that a re	esident needs isolation to					
		of infection, the facility must					
	isolate the resident. (2) The facility must	t prohibit employees with a					
	communicable dise	ase or infected skin lesions					
		with residents or their food, if					
	direct contact will tr	ansmit the disease. t require staff to wash their					
		rect resident contact for which					
	hand washing is inc						
	professional practic	e.					
	(c) Linens						
	Personnel must har	ndle, store, process and					
	transport linens so infection.	as to prevent the spread of					
		JT is not mot as suideneed					
	by:	NT is not met as evidenced					
	Based on interview	and record review, facility			Regulation 483.65 Tag F441 – Infe	ection	
		an infection control program			Control		
		lysis of collected data to ions to prevent the spread of			Pine Haven Care Center has estab	lished	
		the potential to affect all 51			and maintains an infection control		
	residents who resid				program designed to provide a safe		
	Findings include:				sanitary, and comfortable environm and to prevent the development of	ent	
					disease and infection. The facility h	as an	

Facility ID: 00148

If continuation sheet Page 46 of 51

PRINTED: 08/10/2016

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245359	B. WING _			<b>07</b> /1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 441	was asked how the to help detect unust and to determine the prevention and com- that this information quality assurance (( and that they go over to try and correlate resident infections. monthly reports of r and are tracking an infections and are a tests that have com- that the only place to documented was in minutes. When ask monitoring for trend that it is all in QA are anything formal in p consultant that com- helping and that she when she has the ti facility monitors for RN-G reported, "I d that in place right ne sort of form that is f done." RN-G stated that she documents infection, what sym- infection and with th date of the antibiotic doesn't know if the antibiotic on that dat	m. registered nurse (RN)-G facility conducts data analysis ual or unexpected outcomes be effectiveness of infection trol practices. RN-G stated is reviewed at the facility QA) meetings every month er resident and staff infections any possible staff infections to RN-G also stated they have resident and staff infections tibiotic use for different asking for cultures even on the back negative. RN-G stated this information was the facility QA meeting ed how the facility is is in infections RN-G reported that they don't have blace. RN-G stated there is a thes into the facility who is the has been trying to work on it me. When asked how the the resolution of an infections on't really know, we don't have ow but there should be some filled out when the antibiotic is a in the infection control log which resident has an ptoms associated with the the doctor order start and end c. RN-G stated that she resident actually finishes the tte since she isn't notified, she	F 44	41	infection control program that 1) investigates, controls, and prevents infections in the facility 2) determine appropriate procedures, if any, that implemented (such as isolation) for resident with an infectious disease a maintains a record of incidences of infections and tracks any alternative actions taken related to infection contr tracks the resident, room, infection causative organism (if cultured), an antibiotic treatment dates. To furthe analyze collected data, charts will b to compare the number of infections the current quarter with the previous quarter and the previous year. The infection control nurse has reviewed infection control regulations with a f on the requirements for infection surveillance and analysis. A comprehensive infection control res manual is available for reference. Infection control practices and infect control data are discussed during the monthly infection control logs are summarized and presented during the quarterly Quality Assurance and Improvement Committee meetings. Identified trends and prevention techniques are routinely discussed. Compliance with regulatory requirer and facility policies for an infection	es the will be each and 3) entrol. rol log type, d r e used s for s d the ocus cource tion ne Data the ments	
	infection, what sym infection and with th date of the antibiotic doesn't know if the antibiotic on that da	ptoms associated with the ne doctor order start and end c. RN-G stated that she resident actually finishes the			Improvement Committee meetings. Identified trends and prevention techniques are routinely discussed.	ments control irector	

Facility ID: 00148

If continuation sheet Page 47 of 51

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED
		245359	B. WING _		07/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA		INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 441 F 465 SS=B	infection control log facility which had co These were marked a specific infection the infection contro what infection, sym antibiotics. No cultu Requested to view related to conductin but none was provi Policy: Requested p control practices bu 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pr sanitary, and comfor residents, staff and	control logs. Included in the gs were map layouts of the olor coded infection tools. d on the map indicating where was located. Also present in I log was a list of residents, ptoms, start and end dates of ures were identified. any facility documentation ng data analysis of infections ded. policy related to infection ut none was provided. AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for the public.	F 44	months through a review of the im control tracking data. If noncompli- noted, additional training and audi- be done. Compliance will be reviewed durin October 2016 quarterly Quality As and Improvement Committee mea- ongoing.	ance is ting will og the surance	8/21/16
	by: Based on observative review, the facility for sanitary environme all meals were prepared affect residents which the facility and not the the facility. In additive maintain the clean livents for 3 of 6 shares wing of the facility.	NT is not met as evidenced tion, interview, and document ailed to ensure a clean and nt for the facility kitchen where bared. This had the potential to o resided in the older wings of the newly renovated wing of on, the facility failed to iness of the bathroom ceiling ared bathrooms on the 200 This had the potential to affect ag on the 200 wing unit.		Regulation 483.70(h) Tag F465 – Sanitary, Comfortable Environment It is the policy of Pine Haven Care to provide a safe, functional, sanit comfortable environment for resid staff, and the public. As part of an ongoing process to p a pleasant, homelike environment Haven Care Center has a schedu routine cleaning, repairs, and	e Center ary and ents, provide , Pine	

Facility ID: 00148

	RS FOR MEDICARE	AND HUMAN SERVICES			0	RINTED: 08/10/2016 FORM APPROVED MB NO. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		245359	B. WING			07/14/2016
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •
PINE HA	PINE HAVEN CARE CENTER INC				10 NORTHWEST 3RD STREET VINE ISLAND, MN 55963	
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 465	Continued From pa	ge 48	F4	465		
	Findings include: During the initial kit p.m., DA-B agreed further stated the m cleaned the identifie following soiled are aide (DA)-B: Thirteen out of fifter above walkways in debris, and/or bugs The gas stove hood soiled with thick du Seven of seven cei were coated with du Thirty ceiling tiles h Dry food storage ro covered with dust a significant dust Large ceiling vent s hallway outside of t dust around the edu Long white pipe un sink was covered w Seven of ten sprink covered with dust During the kitchen f the dietary manage areas. The DM stat for the Monday AM vents and dish roor was to write out a m clean it. The DM ve lacked ceilings, ligh vents, and sprinkled	During the initial kitchen tour on 7/11/16, at 12:05 p.m., DA-B agreed the areas were soiled. DA-B further stated the maintenance department cleaned the identified kitchen areas. The following soiled areas were observed with dietary aide (DA)-B: Thirteen out of fifteen ceiling light fixtures, located above walkways in kitchen, were soiled with dust, debris, and/or bugs The gas stove hood vent screens were heavily soiled with thick dust Seven of seven ceiling exhaust vents in kitchen were coated with dust; Thirty ceiling tiles heavily soiled with debris Dry food storage room had 2 of 2 light fixtures covered with dust and the exhaust vent with significant dust Large ceiling vent screen, located in kitchen hallway outside of the dry food storage room, with dust around the edges Long white pipe under the three compartment sink was covered with dust and debris			maintenance of the facility. All staff members are expected to report environmental concerns to the app administrative/supervisory staff. During the mandatory meetings Au 15, 2016, the staff will be reminded observe for equipment/furnishings/structures th need to be repaired, cleaned, or re The procedures for reporting work to the Maintenance Director will be reviewed. The soiled kitchen ceiling light fixtu stove hood vent screens, ceiling ex- vents, ceiling tiles, ceiling vent scre and sprinkler heads were cleaned. maintenance staff will be responsite ongoing cleaning of ceiling exhaus ventilation screens, sprinkler heads fixtures and tiles. These tasks have added to the maintenance cleaning list and will be checked quarterly an cleaned as needed. During the August 4, 2016 meeting dietary staff were instructed to be observant for areas that need clean and were informed of the cleaning schedule for the stove hood vent st and water pipes. The dietary staff v inform the maintenance staff of any that need attention between the roor maintenance checks. Due to a major addition to the facilit	ropriate gust I to nat placed. items rres, khaust een, The ble for t vents, s, light e been g task nd , the ning creens vill y areas utine
	stove hood screens	s were last cleaned 2/17/15. e invoices provided were for			during the week of the survey the residents in the 200 wing were in the	

Facility ID: 00148

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PRINTED: 08/10/2016 FORM APPROVED

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245359	B. WING _		07/*	07/14/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (			
PINE HAVEN CARE CENTER INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE	
F 465	stove hood was sol 7/15/16. The DM ve department had no soiled areas prior to Document review of identified hood clear review of invoice da ceiling and floors of During interview on of nursing verified a prepared from the f Document review of Cleaning Schedule weekly Monday AM and dish room vent cleaning assigned f sprinklers, pipe und sink, or for ceiling of The facility policy d Schedules, reveale Department will be sanitary condition. cleaning tasks liste department and cle timely and appropri During an observat room 206 and 208 ceiling vent in the b collected balls of da	hen. The DM stated the gas heduled to be cleaned on erified the maintenance t been notified to clean the o the initial tour. of invoice dated 2/17/15, aning completed. Document ated 8/2/15, identified cleaning ompleted. n 7/14/16, at 7:00 a.m., director all 51 residents ate food facility kitchen. of the facility Dietary Daily dated revised 7/4/14, revealed A cook to check hood vents ts. There was no other for ceilings, light fixtures, der the three compartment exhaust vents. ated 9/12/12, Cleaning ed "The Foodservice maintained in a clean and Cleaning schedules, with all d, will be provided in the eaning tasks completed in a	F 46	<ul> <li>process of being relocated. and bath rooms in the 200 process of being deep cleat painting and rewaxing floor preparation for residents be back to the 200 wing. The k vents/ducts in all resident be checked for dust build up.</li> <li>Compliance will be monitor Maintenance Director throug of ceiling fixtures/tiles and r maintenance cleaning logs dietary supervisor through of the stove hood vent screen the kitchen cleaning task sh</li> <li>Compliance will be reviewer monthly Quality Assurance Assessment Committee me October 2016 quarterly Qua and Improvement Committee</li> </ul>	wing are in the ned including s in eing moved pathroom athrooms were ed by the gh observation eview of and by the observation of s and audits of neets. d at the and eeting and the ality Assurance		

If continuation sheet Page 50 of 51

		AND HUMAN SERVICES				FORM	08/10/2016 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245359	B. WING			07/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	•	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HAVEN CARE CENTER INC					10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	Continued From pa	ge 50	F4	465			
	During an observat 209 and 211 on 7/1 vent in the bathroor collected balls of du During an environm maintenance direct the joint bathroom of have collected balls ceiling vent. The mathe the facility did not re vents in the bathroo cleaned on a regular	ion of the shared bathroom of 1/16 at 2:57 p.m., the ceiling m was noted to contained ust in the grating of the vent. nental tour with the or on 7/14/16 at 12:41 p.m., of 210 and 212 was noted to s of dust in the grating of the aintenance director stated that egularly monitor the ceiling oms to ensure that they were					

Facility ID: 00148

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		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	6359126	FORM	08/12/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245359	B, WING		07/1	13/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HAVEN CARE CENTER INC				210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	К 0	00		
	FIRE SAFETY					
	Minnesota Departm Fire Marshal Divisio time of this survey, found in substantia requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),				
-8	a partial basement. at 3 different times. constructed in 1964 Type II(111) constru- constructed to the I determined to be of 1991, another addi Wing and was deter Because the origina are of the same type construction type a the facility was surve The building is fully fire alarm system we detection and space	center is a 1-story building with The building was constructed The original building was 4 and was determined to be of action. In 1970, addition was North Wing that was f Type II(111) construction. In tion was added to the West trmined to be Type II (111). al building and the 2 additions be of construction and meet the llowed for existing buildings, yeyed as one building.		EPO	2	
	notification. The facility has a c	apacity of 70 beds and had a time of the survey.				
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Flectron	hically Signed					08/10/2016

**Electronically Signed** 

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00148

		AND HUMAN SERVICES			FORM	): 08/12/2016 APPROVED ). 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DA CO	(X3) DATE SURVEY COMPLETED 07/13/2016		
		245359	B WING		07			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE		
K 000	Continued From pa	age 1	K 00	0				
	The requirement a MET.	t 42 CFR, Subpart 483.70(a) is						
			ii ii					
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:0BBR	21	Facility ID: 00148	If continuation st	neet Page 2 o		

		AND HUMAN SERVICES & MEDICAID SERVICES		Ŧ	5359026	FORM	08/12/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - PINE HAVEN CARE CENTER			(X3) DATE SURVEY COMPLETED			
		245359	B. WING			07/*	13/2016		
	NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
K 000	INITIAL COMMENT Citation Text for Ta	۲S g 0000, Regulation K302 Bld	ĸ	000					
	KINGSLEY, ROY FIRE SAFETY								
	by the Minnesota D State Fire Marshal survey, (Pine Have substantial complia participation in Mec Subpart 483.70(a), 2000 edition of Nat Association (NFPA)	Initial Survey was conducted epartment of Public Safety - Division. At the time of this n Care Center) was found in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection ) Standard 101, Life Safety er 18 New Health Care.							
	constructed in 2016 Type V(111) constru				EPOC				
	system. The facility full corridor smoke spaces open to the	ected by a full fire sprinkler has a fire alarm system with detection, resident rooms and corridors that are monitored epartment notification.							
K 018 SS=D	found NOT in subs	urvey the 34 bed addition was tantial compliance. FETY CODE STANDARD	ĸ	018			7/14/16		
	constructed to resis Clearance between covering is not exc impediment to the devices that releas	orridor openings shall be at the passage of smoke. In bottom of door and floor eeding 1 inch. There is no closing of the doors. Hold open e when the door is pushed or d. Doors shall be provided with							
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE		
Electron	ically Signed						08/10/2016		

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.

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
ND PLAN C	D PLAN OF CORRECTION IDENTIFICATION NUMBER: 245359		A, BUILDING	02 - PINE HAVEN CARE CENTER		
					07/1	3/2016
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC			s 2 F			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETIC DATE
K 018	18.3.6.3.6 are peri prohibited. 18.3.6.3 This STANDARD Doors protecting constructed to res Clearance betwee covering is not exc impediment to the devices that releas pulled are permitte positive latching h 18.3.6.3.6 are peri prohibited. 18.3.6.3 On facility tour bet on July 12, 2016, reviewed revealed	age 1 ardware. Dutch doors meeting mitted. Roller latches shall be is not met as evidenced by: corridor openings shall be ist the passage of smoke. In bottom of door and floor ceeding 1 inch. There is no closing of the doors. Hold open se when the door is pushed or ed. Doors shall be provided with ardware. Dutch doors meeting mitted. Roller latches shall be tween 09:00 AM and 1:00 PM observation and documentation I that both sets of the smoke not close when tested.	K 018	Tag K018 Life Safety Survey The contractor responsible for the installation of the fire doors in the occupied new addition was notifie need to adjust the door to allow co closure. The doors were adjusted 2016. The Maintenance Director is resp for monitoring compliance. Completion date: July 14, 2016	recently d of the omplete July 14,	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted August 1, 2016

Mr. Steven Ziller, Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5359026

Dear Mr. Ziller:

The above facility was surveyed on July 11, 2016 through July 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute

Pine Haven Care Center Inc August 1, 2016 Page 2

after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697 Pine Haven Care Center Inc August 1, 2016 Page 3 Pine Haven Care Center Inc August 1, 2016 Page 4

## PRINTED: 08/10/2016 FORM APPROVED

Minnesc	Minnesota Department of Health								
-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00148	B. WING		07/14/2016				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
PINE HAVEN CARE CENTER INC			THWEST 3RI AND, MN 55						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE			
2 000	Initial Comments		2 000						
	****ATTE	NTION*****							
	NH LICENSING	CORRECTION ORDER							
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been							
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.							
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are							
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 08/10/16			

Electronically Signed

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If continuation sheet 1 of 61

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
		00148	B. WING	0	07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
VINE HA	VEN CARE CENTER		THWEST 3RE AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	Department's staff the following correc Please indicate in y correction that you	& 14, 2016, surveyors of this visited the above provider and ction orders are issued. /our electronic plan of have reviewed these orders, e when they will be completed				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		8/21/16	
	comprehensive pla objectives and time long- and short-tern and mental and psy identified in the cor assessment. The of must include the in	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on interview failed to develop a the diagnosis of de	ent is not met as evidenced and record review the facility comprehensive care plan for pression for 1 of 5 residents unnecessary medications.		Comprehensive Care Plans Pine Haven Care Center uses the result of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The		

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC.	THWEST 3R AND, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLET DATE
2 560	Continued From pa	age 2	2 560			
2 560	R44's physician or an order for citalop 40 milligrams once progress note date diagnosis of major R44's medication r R44's depressive s R44's PHQ-9 (deprindicated score NA indicated a score of address the diagno specific symptoms On 7/14/16, at 9:35 services (DSS)-A s monitoring the use DSS-A reviewed R depression was no stated R44 had bee admission and she physician progress Celexa. On 7/14/16, at 10:1 stated that it was vi use of an antidepre The facility policy F Usage, dated 1/23/ monitoring of all tat assist in the assess relationship of psyce	ders dated 7/14/16, identified aram (Celexa) (anti-depressant) a day. R44's physician d 4/4/16, identified the depression and indicated egimen included Celexa for symptoms. ression test) dated 4/6/16, and the one dated 6/30/16, of 7. R44's care plan failed to osis of major depression and and interventions. 5 a.m., the director of social stated she was responsible for pf psychotropic medications. 44's care plan and stated t care planned for R44. DSS-A en on the Celexa since was not sure what R44's notes stated about the 11 a.m., the director of nursing ery important to care plan the		<ul> <li>individualized care plan 1) incl measurable objectives and tim meet the resident's needs as i the comprehensive assessme describes the services that are furnished to attain or maintain resident's highest practicable mental, and psychosocial well 3) recognizes the residents' rig cares/services.</li> <li>The care plan related policies/ and the staff responsibilities for development and revision of th comprehensive plans of care of reviewed and found appropriat</li> <li>During the August 15, 2016, m meeting, the staff will be 1) rent the facility policies for care plan implementation/reviews/updat reminded that the residents' care must be current at all times and instructed that care plans must depression and related interver residents with a diagnosis of d</li> <li>The social worker has reviewed of care for resident number 44 revised it to include the diagno depression and related goals, and interventions.</li> <li>To monitor compliance, the so will audit the care plans of all re</li> </ul>	etables to dentified in nt 2) to be the ohysical, being and ght to refuse procedures r ne were te. nandatory minded of n es 2) are plans id 3) t address entions for epression. ed the plan c and has oses of treatments, cial worker	
	was requested but			with the diagnosis of depression that mood symptoms, goals, a interventions are appropriately	on to assure nd	
	director of nursing	(DON) or designee could o ensure care plans		Care plans will be revised as r As part of the quarterly care of	necessary.	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (	X3) DATE S COMPL	
		00148	B. WING		07/14/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VINE HA			THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLET DATE
2 560	Continued From pa	ige 3	2 560			
	resident. The DON all appropriate emp DON or designee of system to ensure of	epresent the individual or designee could in-service ployees on that system. The could develop a monitoring ngoing compliance. R CORRECTION: Twenty-one		process, the interdisciplinary team v continue to review the care plans fo completeness, accuracy, and releva Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting an October 2016 quarterly Quality Assu and Improvement Committee meeting	r ancy. Id the urance	
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care I personnel involved in the t.	2 565			8/21/16
	by: Based on observative review, the facility for the fac	ent is not met as evidenced ion, interview and record ailed to follow the care plan for esidents (R43) reviewed for rs for 1 of 3 residents (R14) nsferred; for monitoring target ly for the use of anti-psychotic 5 residents (R44) reviewed for cations; 1 of 1 resident (R45) sleep late into the a.m. as for nail care for 1 of 3 served for nail care. plan, indicated R43 required ing and was to have a sponge ly MDS dated 6/8/16, indicated y intact and required assist of		Services by Qualified Personnel per Plan Pine Haven Care Center provides c and services that meet professional standards of quality and are delivered appropriately qualified persons (e.g. licensed, certified) in accordance wite each resident's written plan of care. interdisciplinary care planning team uses an assessment process to dev an individualized care plan for each resident that supports the highest practicable level of function and wel 2) implements procedures and practicas as outlined in the plan 3) reviews the at least quarterly and with significant changes in condition and 4) makes	are ed by th The 1) velop Il-being tices e plan	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER		THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	one staff for bathin	g.		modifications as necessary.		
	The facility bath schedule sheet dated 7/7/16, identified R43 was scheduled for a tub bath or shower on Tuesdays for the day shift. On 7/13/16, at 11:26 a.m., R43 stated she was supposed to have her bath on 7/12/16 but did not receive it. R43 did not know why her bath was not provided. "I am just assuming they were busy."			The facility has policies and pro- for developing individualized pla and communicates the resident needs to the direct care givers b the "pocket care plan" (PCP). Th are routinely updated to reflect r the interdisciplinary plan of care	ns of care s care by use of ne PCPs evisions in	
	(NA)-D stated the labath was 7/5/16. N morning report whe	2 a.m., nursing assistant- ast day documented for R43's IA-D stated she had received on she came on duty and she R43 had not received a bath		During the August 15, 2016, ma meetings, the nursing staff will b reminded/instructed 1) that the p care must be followed 2) that jol performance expectations includ aware of and following the resid of care with a focus on nail care frequency, assisting with transfe	be blans of b be being ent's plan , bathing	
	(DON) stated if R4: the bath needed to possible. The DON to follow the care p	-		respecting sleep/wake preference of the need for monitoring/document target behaviors. The orientation employees will continue to address importance of respecting the respecting the respecting the respecting the respective preferences and following the respective preferences and the respective preferences and following the respective preferences and following the respective preferences and the respective preferences and the respective preferences and the respective preferences and th	ces and 3) menting n for new ess the sident's the	
	assistance for trans another related to o back pain with inter persons contact gu using the EZ stand			resident's individualized plan of Resident number 43 – The resid plan for bathing was reviewed a appropriate. The direct care stat informed that the resident's assid day is Saturday morning. If the b	dent's care nd found if was gned bath path is not	
	be transferred by n R14's bed into R14 EZ stand mechanic failed to transfer R <sup>2</sup> care plan indicated			given on Saturday, the charge n be notified. Resident number 14 – The resid ability to transfer has been rease the resident continues to require to assist with the EZ stand lift. T	lent's sessed; e two staff he direct	
		a.m., NA-B stated R14 was to ne or two assist using the EZ		care staff have been informed o continuing need for two person a		

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	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3F AND, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 5	2 565			
		ted it depended on R14's staff assist was used to		transfers. The care plan was r found to appropriately address transferring.		
	On 7/13/14, at 8:25 a.m., the DON st was to be transferred using the EZ st two assist.			Resident number 44 – The readiagnosis of frontotemporal de delusional thoughts. The resid nearly continual string pulling/	ementia with lent exhibits hand rolling	
	adverse side effect medications after th history of psychosis Evaluate effectiven medications for pos	plan, indicated potential for s due to use of antipsychotic raumatic brain injury, long s. Interventions included: ess and side effects of ssible decease/ elimination of periodically and observe		motions related to parasitosis. though the behavior is exhibite frequently and seems normal resident, the direct care staff h informed that the behavior mu documented on every shift that observed.	ed very for the nave been ist be	
		behaviors. The care plan vior of hallucinations, pulling at		Resident number 45 – As add the care plan, the resident has pattern of going to bed late at	s a life long	
	R44 was sitting in h was observed to be forth constantly and his hand of throwin R44 was observed	p.m., observation revealed his wheelchair in his room. R44 e moving his hands back and d then made the motion with g something. At 5:42 p.m., wheeling his wheelchair with		sleeping late in the morning. T assistants have been instructe the resident to awake naturally nursing assistant PCP has be accordingly.	he nursing ed to allow y; the	
	his feet in the hallw and forth.	ay and moving his hands back		Resident number 53 – The re- grooming plan of care was rev		
	be sitting in his whe	a.m., R44 was observed to eelchair in the dining room fast. R44's right hand was ption.		found appropriate. The direct are aware of the need to provi as part of the resident's routin grooming/bathing procedures.	care staff de nail care e	
	dining room and his rolling motion.	2 a.m., R44 was sitting in the s hands were moving in a		Compliance will be monitored auditing/observations of the for one month: 1) resident bathing transfers-observations to be a	llowing for g and assigned by	
	and NA-J stated R4	p.m., nursing assistant (NA)-C 44 had a hallucination behavior ut R44 had not had that		the Director of Nurses/designed care-observations to be done Enrichment staff 3) document	by the Life	

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STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00148	B. WING		07/1	07/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3R AND, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 6	2 565				
	<ul> <li>2 565 Continued From page 6</li> <li>behavior today. NA-C and NA-J stated they document in the computer system under the behavior of hallucination when they observe R44 displaying the behavior. R44's hallucination documentation in the computer system revealed no documented behaviors for the dates of 7/1/16 through 7/13/16.</li> <li>On 7/14/16, at 10:11 a.m. the DON stated she expected staff to document every time staff observed R44 having the hallucination behavior of pulling strings.</li> <li>The facility policy dated 1/23/06, Psychotropic Medication Monitoring, indicated Monitoring</li> </ul>			target behaviors—audits to by the Social Worker. 4) interdisciplinary team will monitor the resident's PCI related to the comprehens noncompliance is noted a monitoring and staff trainin Compliance will be review monthly Quality Assurance Assessment Committee n October 2016 quarterly Qu and Improvement Commit	The review and Ps for accuracy sive care plan. If dditional ng will be done. ved at the e and neeting and the uality Assurance		
	Guidelines: III. Wh initiated, the reside the effectiveness o presence of advers	en anti-psychotic therapy is ent is monitored to determine f the medication and the se reactions. Nurse reviews the and summarizes on weekly					
	requested and not R45 has a diagnos hemiparesis follow left non-dominant s Heartland Hospice R45 care plan date 6/2/16, identified th get up near noon, a her normal pattern she gets up. Reviewed progress 7/12/16, which sho behaviors including breakfast, refusing morning, refusing r morning baths, pin	enting the care plan was provided. is of hemiplegia and ing cerebral infarction affecting side. Resident was started on services on 2/17/16. ed with last review date of hat R45 likes to sleep late, will and decline breakfast, this was at home, offer food drink when is notes from 5/27/16 to wed an increase in R45 g being combative, refusing to get out of bed in the morning medications, refusing ching and biting a staff ogress notes were written					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING.	· · · · · · · · · · · · · · · · · · ·		
		00148	B. WING		07/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	when R45 as well a facility that she is n of progress notes t notes including from conference, which to facility staff that morning and cares in the afternoon ho During observation					
	•	in beauty shop, smiling.				
	7/13/16, 7:06 a.m.	asleep in bed.				
	entered R45 room asked R45 if she c which R45 replied told R45 what time don't care. NA-G si and then you can r R45 responded, I c told R45 that she w NA-G stated, I'll ch otherwise she'll get 7/13/16, at 7:34 a.r her bedroom and a NA-G stated why d changed and bega upset and stated, c juice or coffee and After this, began ra	m. nursing assistant (NA)-G and offered juice and coffee, ould get her up for the day to I don't get up right away. NA-G it was and R45 responded, I tated, can I get you dressed est and I'll come back to which don't like to be bothered. NA-G vould be back in 10 minutes. eck back in 10 minutes t in a bad mood. m. NA-G re-approached R45 in again R45 declined to get up. Ion't you let me get you n lifting the bed. R45 became don't do that. NA-G offered asked to open R45 curtains. aising the bed again and R45 ist want to lay here for a while.	1			
	7/13/16, 8:50 a.m.	in bed asleep.				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
			A. DOILDING.				
		00148	B. WING		07/	07/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
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2 565	Continued From pa	age 8	2 565				
	7/12/16, at 3:10 p.r become aware of a on 7/11/16. LSW st made aware of this staff not checking t are documenting th Interview with nurs 7/13/16, at 7:13 a.r wake R45 up arour minutes until she's state that she gets in the morning. On stated R45 had aga fed her in her room Interview with NA-C stated she knows h pocket care plan (F areas including din living (ADL) which a requiring the assis pericare BID and P grooming. PCP ide bladder, transfer, a sensory, skin care, comments. Under of daily, change bed I Hospice, Female C nothing noted abou bed until noon. NA- the care plan and s copies of the PCP NA-G stated these had access to. NA- behaviors when we usually once she is Interview with R45 9:28 a.m. stated, R	sed social worker (LSW)-B on m. identified that she had just an increase in R45 behaviors tated that she hadn't been s prior to 7/11/16 due to floor the 24 hour note text when they heir progress notes. ing assistant (NA)-G on m. stated that she starts to nd 6 am and will go in every 15 ready to get up. Continued to up anywhere between 6 and 8 7/13/16, at 8:52 a.m. NA-G ain refused to get up so we jus and we will try again later. G on 7/13/16, at 9:09 a.m. how to care for R45 from her PCP). PCP identified care ing needs, activities of daily specifically identified R45 at of 1 for dressing, bathing and PRN. Partial assist of 1 for entified care for bowel and mbulation, devices, orientation dentures, activities and comments it states, make bed inens weekly, Heartland Caregivers only. There was at R45 preference to stay in -G stated she has access to showed a binder which had in the 600 wing nurse's station were the only care plans she -G stated R45 usually has a get her up in the morning but a up she is better. family (F)-A on 7/13/16, at 45 had never been a morning ways like to stay up late into the state of stay up late into the	/ t				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00148	B. WING		07/	07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 565	Continued From pa	age 9	2 565				
	(RN)-B on 7/13/16, unaware that the c stay in bed until no R45 family say tha mornings are a "tel does better in the a she doesn't do the registered nurse (F and then RN-1 give	stered nurse case manager , at 12:00 p.m. stated she was are plan identified R45 should on and she had never heard t. RN-B went on to state rrible idea" for R45 as she afternoon. RN-B also stated care plans that another RN)-1 handles the care plans es the information to the stant (AA)-F to complete the e staff.					
	stated care plans a and she updates s gets new informatic comes to her first a responsible for upo staff utilize when ca has "never been a	1 on 7/13/16, at 12:36 p.m. are triggered off of the MDS ections of the MDS when she on. The new information and then the AA-F is dating the PCP that direct care aring for residents. Stated R45 morning person, it has always maybe it was removed by					
	Hospice when they Interview with AA-F stated she gets the PCP from RN-B. A information from th from Hospice if cha	v started working with her". on 7/13/16, at 1:43 p.m. information to update the lso stated she gets direct the therapy department and anges need to be made. AA-F ion was on the PCP but					
	information had be therapy was workin Interview with direc 7/13/16, at 2:29 p.r reflection of the co	en changed when occupationang with her at meal times. otor of nursing (DON) on m. stated the PCP should be a mprehensive care plan and the what is in the care plan would					
nesota D	Interview with occu	upational therapy assistant at 8:21 a.m. stated [R45] was					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00148	B. WING		07/	07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
ΟΝΕ ΗΔ			THWEST 3RD				
		PINE ISL	AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	ige 10	2 565				
	but policy was not r Based on observati review, the facility f bathing for 1 of 3 re choices; for transfe observed being tran behaviors accurate medication for 1 of unnecessary medic was not allowed to care planned; and f	by on 1/29/16. a policy concerning care plans					
	Findings include:						
	assistance for bath bath. R43's quarter	plan, indicated R43 required ing and was to have a sponge ly MDS dated 6/8/16, indicated y intact and required assist of g.					
	5	hedule sheet dated 7/7/16, scheduled for a tub bath or /s for the day shift.					
	supposed to have h receive it. R43 did r	6 a.m., R43 stated she was her bath on 7/12/16 but did not hot know why her bath was not assuming they were busy."					
	(NA)-D stated the la bath was 7/5/16. N morning report whe	2 a.m., nursing assistant- ast day documented for R43's IA-D stated she had received on she came on duty and she R43 had not received a bath					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00148	B. WING		07/	07/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	On 7/13/16, at 12:4 (DON) stated if R43 the bath needed to possible. The DON to follow the care pl R14's current care assistance for trans another related to c back pain with inter persons contact gu using the EZ stand On 7/13/16, at 7:02 be transferred by n R14's bed into R14 EZ stand mechanic failed to transfer R1 care plan indicated On 7/13/16, at 8:09 be transferred by o stand lift. NA-B stat mood if one or two transfer R14. On 7/13/14, at 8:25 was to be transferret two assist. R44's current care adverse side effect medications after tr history of psychosis Evaluate effectiven medications for pos psychotropic drugs resident mood and	<ul> <li>1 p.m., the director of nursing</li> <li>3 had not received her bath, be made up as soon as stated she would expect staff an for bathing.</li> <li>plan, indicated R14 required sferring form one position to leconditioning related to low vention of provide two idance and physical assist mechanical lift.</li> <li>a.m., R14 was observed to ursing assistant (NA)-B from 's wheelchair. NA-B used the al lift to transfer R14. NA-B</li> <li>4 with two assist as per R14's</li> </ul>					

Minnesota Department of Health STATE FORM

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 12	2 565			
	R44 was sitting in I was observed to be forth constantly and his hand of throwin R44 was observed	) p.m., observation revealed his wheelchair in his room. R44 e moving his hands back and d then made the motion with ng something. At 5:42 p.m., wheeling his wheelchair with vay and moving his hands back				
	be sitting in his who	) a.m., R44 was observed to eelchair in the dining room (fast. R44's right hand was otion.				
		2 a.m., R44 was sitting in the s hands were moving in a				
	and NA-J stated R- of pulling strings, b behavior today. NA document in the co behavior of hallucir displaying the beha documentation in t	p.m., nursing assistant (NA)-C 44 had a hallucination behavio but R44 had not had that A-C and NA-J stated they computer system under the nation when they observe R44 avior. R44's hallucination he computer system revealed haviors for the dates of 7/1/16				
	expected staff to d	11 a.m. the DON stated she ocument every time staff ing the hallucination behavior				
	Medication Monitor Guidelines: III. Wh initiated, the reside	lated 1/23/06, Psychotropic ring, indicated Monitoring en anti-psychotic therapy is ent is monitored to determine of the medication and the				

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00148	B. WING		07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 13	2 565			
		se reactions. Nurse reviews the and summarizes on weekly				
	A policy for implem requested and not	enting the care plan was provided.				
	Director of Nursing review, and/or revise ensure care plans The Director of Nur educate all approprise procedures. The Director of Nur	THOD OF CORRECTION: The or designee could develop, se policies and procedures to are followed for all residents. rsing or designee could riate staff on the policies and rsing or designee could g systems to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			8/21/16
	receive nursing can custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	a general. A resident must re and treatment, personal and a supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14	4/2016
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	EN CARE CENTER		HWEST 3R AND, MN 55			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	by: Based on observative review, the facility for related skin injury for reviewed for non-propriad dition, the facility resident (R45) recersion of the spice agency who direct care staff. Findings include: R53 was observed a skin tear on the resident tear on the resident of the Admission Recersion admitted to the facility one centimeter, noted. R53 stated for the significant chara dated 4/7/16, noted required limited assembility and transfer for walking in room locomotion on the team of the significant on the resident of the significant chara dated 4/7/16, noted required limited assembility and transfer for walking in room locomotion on the team of the significant of t	ent is not met as evidenced ion, interview, and document ailed to identify a non-pressure or 1 of 3 residents (R53) ressure related skin. In failed to ensure that 1 of 1 eiving hospice services had a f care between facility and ich was communicated to on 7/11/16, at 3:27 p.m., with ight wrist, approximately one open to air and no drainage ne bumped into something. cord identified R53 was lity with diagnoses that nellitus and atrial fibrillation. nge Minimum Data Set (MDS) d R53 to have intact cognition, sistance of one staff for bed er, supervision with set up help , walking in hall and unit, and required extensive or toilet and personal bygiene		<ul> <li>Provide Care/Services for Well-being</li> <li>Pine Haven Care Center president with the necessar services to attain or maintapracticable physical, ment psychosocial well-being, in with the comprehensive pl</li> <li>The interdisciplinary care the each resident at the time of quarterly, with significant of condition, and more often condition indicates. The re- including end-of-life care as services as well as cares the integrity and treat skin pro- identified and a plan of car- implemented, routinely re- revised as necessary base assessments.</li> <li>The policies and procedur- identifying, reporting, inves- monitoring and communicar areas and other skin lesion</li> </ul>	provides each ry care and ain the highest al, and n accordance lan of care. team assesses of admission, changes in as the resident's esidents' needs and hospice to preserve skin blems are re developed, evaluated, and ed on continuing	
	R53's care plan data alteration in skin int deficit, cognitive im jejunostomy tube, c anticoagulant thera to observe for char	or toilet and personal hygiene. ted 1/2/15, identified a risk for tegrity related to nutritional pairment, presence of former diabetes and received upy. Interventions included staff nges in skin integrity daily with e nurse as needed, and nurse ated.		areas and other skin lesion reviewed and found appro licensed nurse evaluates t skin condition on a weekly Residents with open skin a reviewed weekly by the int care team; the nurse pract is notified of concerns regan nonhealing or worsening of	priate. A the resident's v basis. areas are terdisciplinary titioner/physician arding	
	·	a.m., licensed practical nurse		On August 4, 2016, the Dia and the Heartland Hospice		

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	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00148	B. WING		07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	HWEST 3R			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLET DATE
2 830	Continued From pa	ge 15	2 830			
	(LPN)-A stated R53 the former jejunostic stated there were in R53. On 7/12/16, at 11:4 (NA)-B stated she fic cares and identified On 7/13/16, at 12:1 bed, feeding himse wound was approxi an open, dry wound without a dressing a p.m., the right outer uncovered. R53 stat denied pain. On 7/14/16, at 8:25 wound had two ster wound had a dark to or drainage. On 7/14/16, at 8:40 (DON) verified a wo R53. The DON stat concerning skin this staff and had all res	B received wound treatment to omy tube sight. LPN-A further o other wound treatments for 0 a.m., nursing assistant had assisted R53 with morning I R53 had no skin issues. 3 p.m., R53 sat on the edge of If lunch. The right outer wrist mately two centimeters with d bed. The skin tear was and had no drainage. At 2:25 r wrist wound remained ated he bumped himself and a.m., R53's right outer wrist ri-strip tapes in place. The prown surface with no redness a.m., the director of nursing bund to the outer right wrist of ed after questions arose s week, she trained all nursing sidents re-assessed for skin R53's wrist wound was		coordinator addressed the currer procedures for coordination of or between the facility and the host as well as implementation and documentation of the coordinate Options for notifying the facility which hospice staff will visit the when the visits will occur, and w cares/services will be provided the process for notifying the face changes in the hospice staff visits schedule were discussed. During the August 15, 2016 main nursing staff meeting, instruction include the need to observe for lesions and the importance of appropriately identifying, report documenting, monitoring and tr lesions. Procedures related to t will be reviewed as well as devec care plans to monitor/treat/prev pressure related and other skin Instruction will be provided to the assistants on the need to be all injuries/lesions and to immediat the findings to the licensed nurs Observing and reporting the resisting the	care pice staff ed efforts. staff about resident, <i>t</i> hat as well as ility of itation ndatory n will skin ng, eating skin he above eloping ent lesions. e nursing ert to skin rely report se. sident's	
		6 with the skin re-assessment. le expected staff to report skin lt away.		the nursing assistant's bathing p During the August 15, 2016 me	eting, the	
	review dated 5/4/09 Skin Integrity. Skin cares done by the r concerns are noted immediately to the	f facility Skin Ulcer policy b, revealed "D. Monitor will be observed daily during hursing assistant. If any skin l, they are to be reported designated nurse. hospice services on 2/17/16.		staff will also be informed of the for coordinating care between the and hospice staff including the procedures for notifying the faci (Nurse, CNA, Social Worker, et visiting the resident, when the v made, and what care/services t staff will provide as well as how	he facility hospice lity of who c.) will be isits will be he hospice	

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TATEMENT OF D ND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14	4/2016
AME OF PROVID	ER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
		210 NORT	HWEST 3R	D STREET		
INE HAVEN C	ARE CENTER	NC	ND, MN 55			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830 Cont	inued From pa	ge 16	2 830			
Acco	rding to the Ac	Imission Record, R45 has a		in the schedule will be com	nmunicated.	
follow non-or- multi R45's ident that r signif with servi intero notes with comf be m On 7 aide at the R45 HHA form facilit eithe regis day of On 7 aide at the regis day of On 7 state ident state acce	ving a cerebra dominant side, ple systems fa s care plan wit ified comfort c no longer wish ficant change i the hospice ag ces to resident disciplinary cars in hard copy each hospice v ort, notify hosp ade. /12/16, at 1:30 (HHA)-I indica e facility twice a and a nurse w -I stated follow for the care pr y. HHA-I state r the licensed tered nurse (R of her visit. /12/16, at appr cation aid (TM on hospice bea plan (PCP). The hospice was acility. /12/16, at appr d there was a ified when hosp d the hospice	h a revision date of 6/2/16, are guidelines for resident's to be hospitalized for a n condition. In collaboration ency will provide hospice t and family. Refer to hospice e plan and documentation of chart for current updates visit. Treatments as ordered for bice/MD/NP if changes need to p.m. the hospice home health ted a hospice aid was present a week to provide showers for as present twice a week. ing her visits she filled out a ovided and left a copy with the d she communicated with practical nurse (LPN) or N) who was in charge on the roximately 1:45 p.m. trained A)-D stated she knew R45 cause it was on the pocket MA-D stated she found out coming when they arrived at roximately 1:50 p.m. LPN-C calendar in R45's room that pice was coming. LPN-C care plan and notes were Click care (facility		Resident number 53 – A lia assessed the resident's sk at which time a 1.5 cm skii identified on the resident's strips were applied. A July nurse's note stated that the healed. The care plan was revised to reflect history of skin tears. Resident number 45 – The Nursing and the resident's care coordinator have disc coordination services betw and hospice staff. The resi coordinated plan of care in describing the types of ser be provided by the hospice the schedule for the service staff will be providing the s nurse, social worker, etc.). agency will notify the faciliti changes in the visitation set which will then be communistaff. The care plan was re- found appropriate. To monitor compliance with schedules, a random audit hospice residents will be d weeks to determine if the w the documented schedule whether the facility staff was change. If noncompliance hospice agency administra notified and additional aud done.	sin July 12, 2016 In tear was right wrist; steri 18, 2016 e skin tear was a reviewed and and risk for e Director of hospice nurse cussed the veen the facility ident has a n his record vices that will e agency staff, tess, and what ervice (aide, . The hospice ty of any chedule/plans nicated to the eviewed and h hospice visit t of records of lone for two visits followed and, if not, as notified of the is noted, the ative staff will be	

Iinnesota Depa TATEMENT OF DEF ND PLAN OF CORR	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00148	B. WING		07/14/2	
AME OF PROVIDEF	OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
			ORTHWEST 3R			
INE HAVEN CA	RE CENTER	INC	SLAND, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830 Contin	ued From pa	age 17	2 830			
pocket dining which is perican partial identifi ambula care, o comme change caregiv what c hospic the can nurse's NA-G is had ac On 7/1 registe stated hard cl (ADL) The ho facilitie schedu chart. followin times. notify t On 7/1 really k be at the RN-B v front o hospic vecks ac	care plan (F needs, activi- stated assist or BID (twice assist of 1 for ed care for b ation, device entures, active entures, active ents the PCF e bed linens vers only. The ares were pre- e agency. No- re plan throu station whice stated these cess to. 3/16, at 10:1 red nurse pat- there was a nart that lister hospice care plan. Je was locat This was the ng when inst of changes whe he facility of 3/16, at 12:0 canew when the facility, bu- verified the he f R45's hard e aid was at and the RN of the rest of the rest of the rest of the rest of the rest of the rest of the rest of t	by to care for R45 from her PCP). The PCP identified: ities of daily living (ADL's) of 1 for dressing, bathing an e daily) and PRN (as needed) or grooming. The PCP bowel and bladder, transfer, s, orientation sensory, skin ivities and comments. Under P stated make bed daily, weekly, hospice, and female here was nothing noted about rovided to R45 from the A-G stated she had access to gh a binder at the 600 wing ch had copies of the PCP. were the only care plans she 19 a.m. the hospice agency atient care coordinator (RN)-care plan in the front of R45 ed what activities of daily livin responsible for on their visite plan was integrated into the RN-J stated the hospice ted in the front of R45's hard e schedule the facility should ructing their staff of visiting vere made, hospice would these changes. 00 p.m. RN-B stated she neve he hospice nurse was going fut it was usually Thursday. tospice schedule was in the chart which identified the the facility on Monday of each e was dated 2/17/16, which	, t o J s g s. be	To monitor compliance wi identification of new skin p licensed nurse will observ skin condition weekly. The Nurses/designee will revie reports for seven days to appropriate follow up to a there is evidence that skin not identified in a timely m appropriate follow up is no additional auditing and sta done. Compliance will be review monthly Quality Assuranc Assessment Committee m October 2016 quarterly Q and Improvement Commi	problems, a re the resident's e Director of ew the skin audit assure cute problems. If n problems are nanner, or if ot documented, aff training will be wed at the e and neeting and the uality Assurance	

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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•	
	VEN CARE CENTER	INC	THWEST 3RD			
		PINE ISL	AND, MN 5596			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	nurses as well as h their visit notes in t there was a nurse's weekly for the past On 7/13/16, at 2:29 (DON) stated hosp care nurse and nur facility. Any change added to the pocket further stated when member of the dire passed on to the cl would pass informa shift change. The D morning there was members of the int gave a verbal repo the last 24 hours as into the PointClick hours. The undated facility Resident Receiving care is provided by hospice and the nur responsible for dev care guiding both p needs and goals. T identify which provivarious aspects of State, local and Fe did not address how communicated to c	unicated their visit with floor nerself. They also left a copy of he hard chart. RN-B verified is note in R45's hard chart 30 days. 9 p.m. the director of nursing ice spoke directly to the direct rse manager when in the es hospice made should be et care plan (PCP). The DON information was relayed to a fact care staff this should be harge nurse. The charge nurse ation along in daily reports at DON went on to state that each report at 9:00 a.m. for rerdisciplinary team. The nurse rt of any new information from s well as any notes entered care system for the last 24-72 y policy for Coordination of a g Hospice Services stated, "If the hospice in the facility, the trying home are jointly veloping a coordinated plan of providers based on assessed The coordinated care plan will ider is responsible for the care and updated according to deral regulations". The policy w the information would be direct care staff within the				
	responsible for resi	could in-service all staff ident cares on the need to ure related skin concerns and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED	
		00148	B. WING	07/	07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
PINE HA		INC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
2 830	Continued From pa	age 19	2 830			
	provide palliative ca monitor for complia	ares as care planned. Then ince.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 860	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 F. Adequate and re; Hands-Feet	2 860		8/21/16	
	proper care. The c adequate and prop E. per care and att	or determining adequate and riteria for determining er care include: tention to hands and feet. mails must be kept clean and				
	by: Based on observat	ent is not met as evidenced ion, interview, and document ailed to ensure 1 of 2 residents	6	Activities of Daily Living Care		
	(R53) reviewed rec Findings include:	eived nail care.		Pine Haven Care Center provides the necessary services to maintain good nutrition, grooming, personal care and ora	I	
		to the facility with diagnoses tes mellitus according to Record.		hygiene for residents who are unable to carry out activities of daily living independently. Based on the comprehensive resident assessment, the staff provides cares which assist the		
	dated 4/7/16, revea required extensive hygiene which inclu R53's care plan dat required assistance	ted 1/2/15, identified R53		resident to maintain and enhance his/her self-esteem and self-worth including assistance nail care as outlined in the plan of care. The residents' need for assistance with personal hygiene is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary.		
	Observations on 7/	11/16, at 3:26 p.m., revealed		During the mandatory meeting August 15,		

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	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00148	B. WING		07/1	4/2016
AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
INE HA	VEN CARE CENTER	INC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLET DATE
2 860	Continued From pa	age 20	2 860			
	registered nurse (F extensive assistant During interview or stated the finger na During interview or director of nursing long and soiled. Sh staff to provide R53 SUGGESTED MET director of nursing systems to ensure the assistance nee or her designee co staff. The DON or of monitoring systems compliance.	n 7/13/16, at 9:48 a.m., RN)-A verified R53 required ce with personal hygiene. n 7/14/16, at 8:25 a.m., R53	,	<ul> <li>2016, the nursing staff will be 1) reinstructed on the facility's policies providing personal hygiene to the residents 2) reminded that their job description requires knowledge of a responsibility for following the reside plan of care and 3) instructed on the importance of providing nail care. The description requires as necessar improve/enhance the residents' appearance, comfort, and dignity we emphasized.</li> <li>The grooming plan of care for reside number 53 was reviewed and foun appropriate in addressing the reside personal care needs. The direct care aware of the need to provide nas part of the routine grooming/bat procedures.</li> <li>The Life Enrichment Director/desige be responsible for monitoring comp by randomly checking residents' fir nails for appropriate length and cleanliness for two weeks. If noncompliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting a October 2016 quarterly Quality Assand Improvement Committee meeting and staff training will be compliance will be reviewed at the monthly Quality Assand Improvement Committee meeting and staff training and the monthly Quality Assand Improvement Committee meeting a October 2016 quarterly Quality Assand Improvement Committee meeting and the provement Committ</li></ul>	and dent's ne The y to vill be dent d lent's ure staff ail care hing gnee will oliance nger	
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			8/21/16
		sores. Based on the sident assessment, the director				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DATE SURVEY COMPLETED	
		00148	B. WING		07/14/2016	
	PROVIDER OR SUPPLIER	STREET A	DDRESS. CITY.	STATE, ZIP CODE		
		210 NOF	THWEST 3R			
PINE HA	VEN CARE CENTER	PINE ISL	AND, MN 55	5963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLE E DATE	
2 900	Continued From pa	ige 21	2 900			
		must coordinate the ursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview and document ailed to treat identified pressure further pressure ulcers from 1 resident (R62).	9	Prevent/Heal Pressure Sores Based on the comprehensive assessm Pine Haven Care Center staff ensure t		
	that the resident ha and a fracture of th	cord, dated 3/15/16, indicated d diagnoses of repeated falls e upper end of the left e running from the shoulder to		residents who enter the facility without pressure sores do not develop pressur sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necess treatment and services to promote healing, prevent infection, and prevent	re sary	
	resident was at risk integrity related to l incontinence. There interventions provid R62 would maintain	e were a number of led with the goal in mind that n her skin integrity.		new pressure areas from developing. Based on the comprehensive skin assessment, care plans are developed address and minimize risks of skin breakdown. The plans focus on service that maintain skin integrity, prevent pressure sores, and provide treatment prescribed.	es	
		sessment (CAA), dated 7/8/16 esident currently had a	3	The policies and procedures for		

NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
	00148	B. WING		07/1	4/2016
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	NC 210 NORT	HWEST 3R	D STREET		
	PINE ISLA	AND, MN 55	5963		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLET DATE
Continued From pa	ge 22	2 900			
pressure ulcer. It st a special mattress R62's progress not through 7/14/16, int to the facility with p as well as both hee progress notes indi multiple stage one area which were re survey. R62's medication re indicated that the p supplement or a ma times a day with me loss. On 7/13/16 at 7:04 back in bed. At 7:17 (NA)-H entered R60 resident if she woul expressed a desire "so stiff". During thi was off so R62 was mattress. NA-H not plugged in. She tur was working, but th The air mattress wa in it. R62 stated she on at all, she stated it was. At 8: 48 a.m brought R62's brea The breakfast tray cream of wheat, to juice, a cup of coffe water at her table. I	ated that the resident needed to reduce or relieve pressure. es, reviewed from 3/15/16 dicated the resident admitted ressure ulcers on her coccyx ds. Further review of the cated that R62 developed pressure ulcers on her coccyx solved at the time of the eview report, dated 4/12/2016, hysician had ordered a house agic cup to be given three eals for the indication of weight a.m., R62 was lying flat on her 7 a.m., nursing assistant 2's room and asked the Id like to get up. The resident to get up and stated she felt s observation, the air mattress a resting directly on the red that the air mattress was ned it on and the air mattress en NA-H turned it off again. as again noted to have no air e did not want the air mattress I that the bed was fine the way ., nursing assistant (NA)-D kfast to her room on a tray. consisted of pudding, a bowl of ast, a cup of milk, a cup of NA-D stated this was all that		skin condition and risk factor: reviewed and found appropri- evaluation of the resident's s skin risk factors, and tissue to continue to be completed at ta admission, readmission from quarterly, and with significant condition. A licensed nurse of residents' skin condition wee physician and dietary manage notified of open lesions and to care is revised to reflect related interventions. Open lesions at and measured on a routine biphysician is notified of worsening/nonhealing wound care staff routinely inform the nurse of any skin problems in cares. Observation of skin or the body is part of the bathing The system for notifying the open skin areas was reviewed changes were indicated. During the August 15, 2016 m meeting, the nursing staff will reinstructed on the facility's s policies and procedures. Disc include the need to 1) completed monitoring and documentation the healing/nonhealing of open implement skin-related nursin and clinician ordered intervent monitor the effectiveness and acceptance of the intervention will be reminded to notify the manager if the resident choo	s were ate. An kin condition, olerance will the time of the hospital, t changes in bserves the kly. The ger are he plan of ted are monitored asis and the ds. The direct e charge oted during n all areas of g protocol. dietary staff of d; no nandatory l be kin related cussion will ete weekly on describing en lesions 2) ng practices ntions and 3) d resident ns. The staff clinical ses not to	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa pressure ulcer. It st a special mattress R62's progress not through 7/14/16, int to the facility with p as well as both hee progress notes indi multiple stage one area which were re survey. R62's medication re indicated that the p supplement or a ma times a day with me loss. On 7/13/16 at 7:04 back in bed. At 7:17 (NA)-H entered R62 resident if she woul expressed a desire "so stiff". During thi was off so R62 was mattress. NA-H not plugged in. She tur was working, but th The air mattress wa in it. R62 stated she on at all, she stated it was. At 8: 48 a.m brought R62's brea The breakfast tray of cream of wheat, toa juice, a cup of coffe water at her table. I was served for R62	NT OF DEFICIENCIES IOF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00148       00148         PROVIDER OR SUPPLIER       STREET AD 210 NORT PINE ISLA         VEN CARE CENTER INC       210 NORT PINE ISLA         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 22         pressure ulcer. It stated that the resident needed a special mattress to reduce or relieve pressure.       R62's progress notes, reviewed from 3/15/16 through 7/14/16, indicated the resident admitted to the facility with pressure ulcers on her coccyx as well as both heels. Further review of the progress notes indicated that R62 developed multiple stage one pressure ulcers on her coccyx area which were resolved at the time of the survey.         R62's medication review report, dated 4/12/2016, indicated that the physician had ordered a house supplement or a magic cup to be given three times a day with meals for the indication of weight loss.         On 7/13/16 at 7:04 a.m., R62 was lying flat on her back in bed. At 7:17 a.m., nursing assistant (NA)-H entered R62's room and asked the resident if she would like to get up. The resident expressed a desire to get up and stated she felt "so stiff". During this observation, the air mattress was off so R62 was resting directly on the mattress. NA-H noted that the air mattress was plugged in. She turned it on and the air mattress was working, but then NA-H turned it off again. The air mattress was again noted to have no air in it. R62 stated she did not want the air mattress was working, but then NA-H turned it off again. The air mattress was again noted to have no air in it. R62 stated she did not want the air mattres	NT OF DEFICIENCIES (OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIP A. BUILDING 00148         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, 210 NORTHWEST 3R PINE ISLAND, MN 52         VEN CARE CENTER INC       210 NORTHWEST 3R PINE ISLAND, MN 52         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 22       2 900         pressure ulcer. It stated that the resident needed a special mattress to reduce or relieve pressure.       2 900         R62's progress notes, reviewed from 3/15/16 through 7/14/16, indicated the resident admitted to the facility with pressure ulcers on her coccyx as well as both heels. Further review of the progress notes indicated that R62 developed multiple stage one pressure ulcers on her coccyx area which were resolved at the time of the survey.         R62's medication review report, dated 4/12/2016, indicated that the physician had ordered a house supplement or a magic cup to be given three times a day with meals for the indication of weight loss.         On 7/13/16 at 7:04 a.m., R62 was lying flat on her back in bed. At 7:17 a.m., nursing assistant (NA)-H entered R62's room and asked the resident if she would like to get up. The resident expressed a desire to get up and stated she felt "so stiff". During this observation, the air mattress was off so R62 was resting directly on the mattress. NA-H noted that the air mattress was off so R62 was resting directly on the mattress. NA-H noted that the bed was fine the way it was. At 8: 48 a.m., nursing assistant (NA)-D brought R62's breakfast to her room on a tray. The breakfast tray c	NT OF DEFICIENCIES INFORMATION       (X1) PROVIDERINGER-SUPPLIENCIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         00148       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         VEN CARE CENTER INC       210 NORTHWEST 3RD STREET PINE ISLAND, NM 55863         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISTE PERFECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)       PRETX 7AG         PREVIDERS PLAN OF COR (EACH DEFICIENCY MISTE PERFECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)       PRETX 7AG         Continued From page 22       2 900         Continued From page 22       2 900         Continued From page 22       2 900         R62's progress notes, reviewed from 3/15/16 through 7/14/16, indicated the resident admitted to the facility with pressure ulcers on her coccyx area which were resolved at the time of the survey.       comprehensively assessing 1 examplement or a magic cup to be given three survey.         On 7/13/16 at 7:04 a.m., R62 was lying flat on her back in bed. At 7:17 a.m., nursing assistant (NA)+ H ored R62's rom and asked the resident if she would like to get up. The resident expressed a desire to get up and stated she felf ros stiff. During this observation, the air mattress was pulgaed in. She turned it on and the air mattress was pulgaed in. She turned it on and the air mattress was pulgaed in. She turned it on and the air mattress was pulgaed in. She turned it on and the air mattress was pulgaed in. She turned it the bed was fine the way it was. At 8: 48 a.m., nursing assistant (NA)-D brought R62's treak at the bed	UT OF DEFICIENCIES       (X1) PROVIDERSUPPLIER       (X2) PATER       (X2) PATER       (X2) PATER         OPTONDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       07/1.         VEN CARE CENTER INC       210 NORTHWEST 3RD STREET       PROVIDERS PLAN OF CORRECTION         VEN CARE CENTER INC       210 NORTHWEST STR STREET         VEN CARE CENTER INC       210 NORTHWEST STR STREET         SUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCY       ID         SUMMARY STATEMENT OF DEFICIENCY       ID         Continued From page 22       2 900         Continued From page 22       2 900         Continue to be completed ath the resident admitted to the facility with pressure ulcers on her coccyx area which were resolved at the time of the survey.       completed ather resident skin condition, A licensed nurse observes the resident's skin condition weight locs.         R62's medication review report, dated 4/12/2016, indicated that the physician had ordered a house supplement or a magic cup to be given three staff routiney inform the charge nurse of any skin problems noted during reas das skin the abf folt 'so stiff'. During this observation, the air mattress was ofts oRC was resting assistant the mattress was again noted tha the air mattress on at all, she stated that the

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14/2016	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 900	interventions were recurrence of press stated R62 was giv She stated that the R62's coccyx area stiffness when she that it looked like th but R62 had a care 6/22/16 and the res the air mattress. Re LPN-D stated that the be tried to alleviate When interviewed of trained medication supplements were assistants and nurs it had been served identified where the supplements off in were then to be del explained that the of label on each supple the supplements in revealed that R62 of her name on it.	hurse (LPN)-D was asked what in place to prevent the sure ulcers for R62. LPN-D ren the air mattress on 6/21/16. air mattress was initiated for and R62 complained of a lot of went to bed. LPN-D stated he mattress was started then e conference meeting on sident was very upset about 62 did not want to use it. maybe something else should		Resident number 62 – Recent s assessments indicate intact skii occasional blanchable redness The resident's air mattress has discontinued at her request; use wheelchair ROHO pressure red cushion continues. The residen receiving a dietary supplement of weight loss. The care plan ha reviewed and revised. Compliance will be monitored b Administrator/designee by 1) au orders for supplements to assur dietary department is aware of t and is delivering the ordered su to the nursing care area and 2) the use of pressure reduction m to assure proper use/function a acceptance. Compliance will be reviewed at monthly Quality Assurance and Assessment Committee meetin October 2016 quarterly Quality and Improvement Committee m	n with on coccyx. been e of a uction t is due to risk is been y the diting the re that the he order pplement reviewing attresses nd resident the g and the Assurance	
	order to provide a s Practical Nurse (LF break in communic and dietary. The die received the order	ated they never received an supplement to R62. Licensed PN)-A verified there had been a sation between the nursing staff etary department never to provide the supplement. on 7/13/16 at 1:49 p.m. LPN-D				
		dent developed a pressure				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER		DRESS, CITY, S		077	14/2016
		210 NOB	THWEST 3RD			
PINE HA	VEN CARE CENTER I	INC:	AND, MN 559			
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2 900	Continued From pa	ge 24	2 900			
	nurse manager woo on a weekly basis a new interventions in LPN-D stated she w from R62's bed as mattress was not b When interviewed of dietary manager sta an order from the n was to receive a su When interviewed of registered nurse (R been a breakdown resulted in R62 not supplement with me tried an air mattress order to try and pre later they held a ca stated she did not li explained to R62 th couple more days t mind. RN-B explain report back to her t been turned on as When interviewed of director of nursing of expected the nursir resident had been of mattress on her been expected the dietar been notified in ord supplement with mo Review of the faciliti Skin Ulcers, advise	on 7/14/16 at 8:41 a.m., the ated that she never received uursing department that R62 pplement with meals. on 7/14/16 at 9:49 a.m., iN)-B stated that there had in communication which receiving the ordered eals. RN-B further stated they s on R62's bed in June in vent pressure ulcers. A day re conference and the resident ike the air mattress. RN-B hat she wanted her to try it for a o see if she changed her hed the nursing staff did not hat the air mattress had not R62 did not want to use it. on 7/14/16 at 1:23 p.m. the (DON) stated she would have ng staff to be notified that the declining the use of the air d. The DON further stated she y department would have er to provide R62 with the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (	X3) DATE S COMPL	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I		THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 25	2 900			
	Director of Nursing review, and/or revis ensure residents re ulcer treatment and The Director of Nur educate all appropr The Director of Nur develop monitoring compliance.	sing or designee could				
21330	MN Rule 4658.072 Routine & Emerger	5 Subp. 2 A&B Providing ncy Oral Health Ser	21330			8/21/16
	must be referred fo unless the resident examination within admission. B. After the ini nursing home mus resident wants to se any necessary help at least an annual b annual dental check one year from the examination or with	ental visit. ays after admission, a resident r an initial dental examination has received a dental the six months before tial dental examination, a t ask the resident if the ee a dentist and then provide to make the appointment, on basis. This opportunity for an kup must be provided within date of the initial dental in one year from the date of ne within the six months				
	by:	ent is not met as evidenced		Routine/Emergency Dental Care		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
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PINE HA	VEN CARE CENTER	INC	HWEST 3R AND, MN 55			
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PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLE <sup>-</sup> DATE
21330	Continued From pa	age 26	21330			
	review the facility fa were offered for 2 of reviewed for dental concerns. Findings include: R53 had diabetes re facility Admission F Observations on 7/ R53 had missing te lower left of his mo seen a dentist for y of nursing (DON) v Document review of Data Set (MDS) da cognition was intact assist of one staff f included brushing te tooth fragments, no broken teeth, no ble difficulty chewing. If assessment dated exam was many yet teeth. R53's care plan rev R53 required assiss interventions include	ailed to ensure dental services of 3 residents (R53, R47) services and who had oral mellitus, according to the		Pine Haven Care Center rou the residents in obtaining rou emergency dental services. assists the resident in makin appointments and arranging transportation to and from th office. The family is notified of damaged dentures and resid referred to a dentist as approx The policies and procedures dental assessments and refe been reviewed and revised. assessment form will be imp The need/desire for a dental be routinely discussed during care conferences and more there are complaints of mou chewing problems. The optic contracting with Apple Tree I provide on-site dental care is explored. During the August 15, 2016 of staff meeting, the following w discussed: 1) any resident w difficulty chewing or complai pain or other dental related p should be assessed to deter for referral to the physician of the implementation of the ref	utine and The facility of for e dentist's of lost or dent is opriate. The facility of e dentist's opriate. The facility opriate. The facility opriate of the annual frequently if th pain or on of Dental to s being mandatory vill be who has ns of mouth or oblems mine the need or dentist 2)	
	refer to dentist as r hygiene at least two	to set up dental appointments, needed and staff provide oral o times a day and as needed.		assessment form and 3) the a dental referral at least ann Resident number 53 – The r	ually. esident is	
	nursing assistant (I morning cares afte	n 7/12/16, at 11:40 a.m., NA)-B stated R53 preferred r breakfast and oral care one ne. NA-B stated R53 brushed		receiving hospice services; t been no complaints of mouth difficulty chewing. During the July 20, 2016 care conference	n pain or e resident's	

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3F AND, MN 5			
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21330	Continued From pa	age 27	21330			
	his own teeth at be During interview or assistant (NA)-D st one staff to set up a stated R53 brushed During interview or registered nurse (F evidence of offering missing teeth. R47's admission re the resident had a b Lewy bodies. R47's annual minin 5/5/16, indicated th impaired cognitively On 7/12/16 at 9:32 were beginning to o decay. He stated it had been to the de was noted to have upper right side of had not offered him R47's last oral asse it was unknown wh dental exam was. I referral to a dental R47's medical reco been to a dentist on	dtime. n 7/14/16, at 1:30 p.m., nursing rated R53 required assist of supplies for oral care. NA-D d his own teeth. n 7/14/16, at 1:30 p.m., RN)-B verified the lack of g R53 dental services for ecord, dated 2/24/14, indicated diagnosis of dementia with num data set (MDS), dated the resident was moderately y. a.m., R47 stated his teeth deteriorate and starting to had been over a year since he ntist. Upon observation, R47 multiple missing teeth on the his mouth. R47 stated the staff n a dental appointment. essment, dated 5/4/16, stated en the last time he had a t recommended no immediate professional. ssessment, dated 6/14/2016,		declined an offer for a dental r stating that they want a dentis appointment only if there is an care plan has been updated a Resident number 47 – An oral assessment was completed b registered nurse August 5, 20 resident had no complaints of problems chewing. The reside not wish to see a dentist –"tee paining me." The resident's or be discussed with his wife; a c referral will be addressed. Th has been reviewed and revise To monitor compliance, any re- indicates mouth pain on the M assessment will be reassesse need for a referral to the phys dentist. The need for a dental other residents will be address resident's next routine care co Compliance will be reviewed a monthly Quality Assurance an Assessment Committee meet October 2016 quarterly Qualit and Improvement Committee	t issue. The ccordingly. y a 16. The pain or ent did/did th aren't al status will lental e care plan d. esident who IDS d for the ician or referral for sed at the onference. at the d ing and the y Assurance	

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IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE. ZIP CODE		14/2010
	VEN CARE CENTER	INC 210 NOF	THWEST 3RD	STREET		
		PINE ISL	AND, MN 559			
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21330	Continued From pa	age 28	21330			
	R47's progress notes did not indicate that he had been offered a routine dental appointment. On 7/13/16, at 11:48 a.m. licensed practical nurse (LPN)-A stated that dental services were offered at the annual care conference meetings. She stated this should be documented.					
			•			
	stated residents re assessment. If the offered a dental ap issues were not bro conference. If som problem the physic	B a.m., registered nurse (RN)-A ceived an annual oral y had problems they would be pointment. She stated dental ought up at every care eone was noted to have a sian would be notified. She o request an appointment ould come up.				
	(DON) stated that	p.m., the director of nursing she expected nursing staff to intment at least every six				
	Assessment, it stat	ument dated 1/13/06, ted that oral assessments on admission and quarterly.				
	director of nursing develop systems to dental services per individualized asse designee could edu members on this p	THOD OF CORRECTION: The (DON) or her designee could o ensure residents receive r recommendations from essments. The DON or her ucate all appropriate staff rocess. The DON or her velop monitoring systems to mpliance.	•			
	TIME PERIOD FO days	R CORRECTION: Twenty-one				

STATEMEI	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUR COMPLETI	
		00148	B. WING		07/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA		INC:	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE CO	(X5) OMPLET DATE
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375		8/2	21/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on interview failed to implement which included and determine intervent infection. This had residents who resid Findings include: Interview: 07/14/16, at 9:11 a. was asked how the to help detect unus and to determine th prevention and con that this information quality assurance ( and that they go ov to try and correlate resident infections. monthly reports of a and are tracking an infections and are a tests that have com that the only place of documented was in minutes. When ask	ent is not met as evidenced and record review, facility an infection control program lysis of collected data to tions to prevent the spread of the potential to affect all 51 led in the facility. m. registered nurse (RN)-G facility conducts data analysis ual or unexpected outcomes the effectiveness of infection trol practices. RN-G stated is reviewed at the facility QA) meetings every month er resident and staff infections to RN-G also stated they have resident and staff infections tibiotic use for different asking for cultures even on the back negative. RN-G stated this information was the facility QA meeting ted how the facility is ds in infections RN-G reported		<ul> <li>Infection Control</li> <li>Pine Haven Care Center has estable and maintains an infection control program designed to provide a safe sanitary, and comfortable environm and to prevent the development of and infection. The facility has an in control program that 1) investigates controls, and prevents infections in facility 2) determines the appropria procedures, if any, that will be implemented (such as isolation) for resident with an infectious disease maintains a record of incidences of infections and tracks any alternativ actions taken related to infection con- tracks the resident, room, infection causative organism (if cultured), ar antibiotic treatment dates. To furthe analyze collected data, charts will be to compare the number of infection the current quarter with the previou quarter and the previous year. The infection control nurse has reviewe infection control regulations with a on the requirements for infection</li> </ul>	e, hent disease fection s, the te r each and 3) f e ontrol. rol log type, hd er be used is for is	

Iinnesota Departm TATEMENT OF DEFICIE ND PLAN OF CORRECT	NCIES (X1) PRO	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
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INE HAVEN CARE	CENTER INC		HWEST 3R			
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	From page 30	hay dan't haya	21375	survoillance and analysis		
anything f consultan helping ar when she facility mo RN-G rep that in pla sort of for done." RN that she d infection a date of the doesn't kr antibiotic of just goes for end da Reviewed infection of facility wh These we a specific the infecti what infect antibiotics Requeste related to but none w Policy: Re control pra	that comes into d that she has be has the time. Wh nitors for the rese orted, "I don't rea ce right now but t m that is filled out- G stated in the i ocuments which what symptoms a nd with the docto e antibiotic. RN-G ow if the residen on that date since of the residen on the since of the residen of the residen	N-G stated there is a the facility who is een trying to work on it ien asked how the olution of an infections lly know, we don't have here should be some t when the antibiotic is infection control log resident has an associated with the or order start and end a stated that she t actually finishes the e she isn't notified, she octor's order indicates logs. Included in the map layouts of the ed infection tools. map indicating where ated. Also present in s a list of residents, start and end dates of e identified. lity documentation analysis of infections lated to infection was provided. F CORRECTION: The r her designee could on control systems		surveillance and analysis. A comprehensive infection contr manual is available for referer Infection control practices and control data are discussed du monthly infection control meet from the infection control logs summarized and presented du quarterly Quality Assurance an Improvement Committee mee Identified trends and prevention techniques are routinely discu Compliance with regulatory re and facility policies for an infer analysis will be monitored by of Nursing/designee for the ner months through a review of th control tracking data. If nonco noted, additional training and a be done. Compliance will be reviewed of October 2016 quarterly Quality and Improvement Committee ongoing.	infection ring the ings. Data are uring the ad tings. on ssed. quirements ction control the Director ext three e infection mpliance is auditing will luring the y Assurance	

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00148	B. WING		07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER		THWEST 3RI AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLET DATE
21375	Continued From pa	age 31	21375			
	staff. The DON or o	or designee could educate all designee could develop s to ensure ongoing				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			8/21/16
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines id States Centers for Disease ntion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.				
	This MN Requirem by: Based on interview facility failed to ens	ent is not met as evidenced and document review the ure 5 of 5 residents (R26, 0) and 5 of 5 employees (E-A,		State Statute 144A.04 Tuberculosis Prevention and Con	trol	

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		00148	B. WING		07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VINE HA	VEN CARE CENTER	INC	THWEST 3R			
			AND, MN 55	PROVIDER'S PLAN OF CORR		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 32	21426			
	<ul> <li>E-B, E-C, E-D, E-E) received tuberculin skin testing (TST) with both induration and interpretation readings; in addition the facility failed to ensure a second step TST was read within 48 to 72 hours after administration for 1 of 5 residents (R60.) This had the potential to effect all 51 residents in the facility, staff, and visitors.</li> <li>Findings Include:</li> <li>R26 was admitted to the facility on 5/31/16 according to the Admission Record. R26's Medication Administration Record (MAR) for June 2016 indicated "results of 1st mantoux [TST]" on 6/2/16 was read at 4:41 p.m. with a 0 mm reading</li> </ul>			Pine Haven Care Center has a comprehensive tuberculosis in control program in accordance most current federal and state The program includes a tuber infection control plan that cove and unpaid employees, contra students, residents, and volun During the mandatory meeting 2016, the licensed nurses wer to document whether the resu Mantoux tests are interpreted "negative" or "positive" as well amount of induration. The TB	nfection e with the guidelines. culosis ers all paid actors, teers. g August 15, re instructed lts of the as as the	
	and "results of 2nd read at 3:37 p.m. w lacking interpretation	mantoux" on 6/23/16 was vith a 0 mm reading; both on.		forms have been updated to in positive/negative interpretation Resident number 60 has been	nclude the n.	
	according to the Ad Medication Adminis 2016 indicated "res 6/9/16 was read at	to the facility on 6/7/16 dmission Record. R35's stration Record (MAR) for June sults of 1st mantoux [TST]" on 5:41 p.m. with a 0 mm reading d mantoux" on 6/30/16 was		administered a second Manto August 5, 2016. The results of be read within 48 and 72 hour administration. The results of be documented in the residen	of the test will s after the test will	
	read at 12:43 p.m. lacking interpretation R54 was admitted according to the Act Medication Administ 2016 indicated "re	with a 0 mm reading; both on. to the facility on 5/20/16 dmission Record. R54's stration Record (MAR) for May sults of 1st mantoux [TST] "		Compliance will be monitored Infection Control nurse throug the reports of TB test results f 30 days. If noncompliance is r additional auditing and staff tra done.	h audits of or the next noted, aining will be	
	reading and R26 ' "results of 2nd mar	ad at 5:19 p.m. with a 0 mm s MAR for June 2016 indicated ntoux" on 6/12/16 was read at ) mm reading; both lacking		Compliance will be reviewed a monthly Quality Assurance an Assessment Committee meet October 2016 quarterly Quality and Improvement Committee	d ing and the y Assurance	
		to the facility on 5/24/16 dmission Record. R70's				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00148	B. WING		07/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA		INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 33	21426			
	Medication Administration Record (MAR) for May 2016 indicated "results of 1st mantoux [TST]" on 5/27/16 was read at 12:16 a.m. with a 0 mm reading and R70's MAR for June 2016 indicated "results of 2nd mantoux" on 6/16/16 was read at 10:43 p.m. with a 0 mm reading; both lacking interpretation.					
	according to the Ad Medication Adminis February 2016 indie [TST]" on 2/3/16 w mm reading. R60's administered on 2/2 on 2/24/16 at 3:13	23/16 at 12:49 a.m. and read p.m. [38 hours and 25 minutes ı] with a 0 mm reading; both				
		administered on 6/28/16 with 7/1/16 at 9:35 p.m. with a 0 g interpretation.				
		Γ administered on 5/31/16 with 6/2/16 at 1:30 p.m. with a 0 g interpretation.				
		T administered on 6/2/16 with 6/5/16 at 10:55 a.m. with a 0 g interpretation.				
		T administered on 5/9/16 with 5/11/16 at 4:15 p.m. with a 0.1 g interpretation.				
	2/9/16 with the resu a.m. with a 0 mm re E-E received a step	o-one TST administered on ults read on 2/12/16 at 9:00 eading; lacking interpretation. o-two TST administered on sults read on 3/18/16 at 11:40				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER		THWEST 3RD			
	SUMMARY ST		AND, MN 559	PROVIDER'S PLAN OF C		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET DATE
21426	Continued From pa	age 34	21426			
	a.m. with a 0 mm reading; lacking interpretation.					
	On 7/14/16 at 1:09 p.m. the director of nursing (DON) stated, the facility read TST's from induration only and did not document the interpretation of positive or negative.					
	date 7/14, reads; ' [tuberculosis] skin trained nurse via s within 48-72 hours a. TB skin tests are nurse's initials, and	ontrol Plan-Residents, review '7. Five U.S. units of TB testing is administered by a ub dermal injection and read 13. Documentation includes: e documented by date, site, d the manufacturer and lot TB skin test results are read in				
	date 1/13, reads; ' be documented in	Center Policies and ontrol Plan-Employees, review '12. A. Mantoux tests should millimeters of induration and and lot number recorded."				
	Tuberculosis Contr Settings, A guide for infection control reg July 2013.	nent of Health, Regulations for rol in Minnesota Health Care or implementing tuberculosis gulation in your facility, dated				
	General principles, include the date of the number of milli induration, docume	g Health Care Workers, "TST documentation should the test (i.e. month, day, year), meters of induration (if no ent "0" mm) and interpretation				
	"An employee may after a negative TE negative IGRA or T	gative). Baseline TB screening, begin working with patients symptom screen and a ST (i.e., first step) dated within				
nnesota D	90 days before hire Page 23, Screenin epartment of Health	e. g Residents, General				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA			RTHWEST 3RD LAND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ige 35	21426			
	72 hours of admiss admissionTST do should include the the number of millin induration, docume (i.e., positive or neg Page 28, Baseline Residents Template	ing should be initiated within ion or 90 days prior to ocumentation for residents date (i.e., month, date, year), meters of induration (if no ent "0" mm), and interpretation gative). TB Screening Tool for e, Tuberculin Skin Testing sults (read between 48-72	1			
	The director of nurs review tuberculosis MDH and CDC rec designee could edu to the tuberculosis director of nursing of	THOD OF CORRECTION: sing (DON) or designee could screening standards meet th ommendations. The DON or ucate all licensed nursing staff screening systems. The could develop monitoring ongoing compliance.	e			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9			
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535			8/21/16
	must be free from u unnecessary drug i A. in excessive	al. A resident's drug regimen unnecessary drugs. An s any drug when used: e dose, including duplicate dru	g			
	D. in the prese which indicate the o discontinued.	e duration; quate indications for its use; c nce of adverse consequence dose should be reduced or rug regimen review required i	S			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER		THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21535	Continued From pa with provisions in the Code of Federal Re 483.25 (1) found im Operations Manua Long-Term Care Fe Department of Hea Health Care Finand This standard is ind available through the system and the Sta subject to frequent This MN Requirem by: Based on observative review the facility fa specific symptoms anti-depressant me (R44) reviewed for addition, the facility assessment prior to medication for 1 of unnecessary medica Finding include: R44's quarterly Min 4/6/16, indicated R	age 36 he Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change. ent is not met as evidenced tion, interview and record ailed to identify and monitor for the use of an edication for 1 of 5 residents unnecessary medications. In <i>r</i> failed to complete a sleep o the initiation of a hypnotic 5 residents (R47) reviewed for cations.	21535	Unnecessary Drugs Pine Haven Care Center staff ense each resident's drug regime is fre unnecessary drugs. The resident' regime is reviewed by the interdis care team, physician and consulta pharmacist to assure that medica not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indic or in the presence of adverse consequences which indicate the should be reduced or the drug	ure that e from s drug ciplinary ant tions are tate cations, dose	
	medication. R44's physician or an order for citalop 40 milligrams (mg) 4/23/14. R44's phy	ders dated 7/14/16, identified oram (Celexa) (anti-depressant) once a day with start date of sician progress note, dated		discontinued. An effort is made to the lowest effective dose of psych medications and to discontinue th psychotropic medications whenev possible. Pine Haven Care Center staff ens	otropic e use of er	
	and indicated R44' Celexa for R44's d	iagnosis of major depression s medication regimen included epressive symptoms. R44's stration record dated 7/16,		<ol> <li>residents who have not used psychotropic drugs are not given to drugs unless psychotropic drug the necessary to treat a specific cond</li> </ol>	erapy is	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	HWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLET DATE
21535	Continued From pa	age 37	21535			
	prescribed. R44's PHQ-9 (dep	receiving the medication as ression test) dated 4/6/16, and PHQ-9 dated 6/30/16, f 7.		diagnosed and documented in the record and 2) residents who use psychotropic drugs receive gradua reductions with attempts to manage behaviors using nonpharmacologic interventions.	/ho use /e gradual dose to manage	
	major depression. specific symptoms diagnosis of depression On 7/14/16, at 9:35 services (DSS)-A s monitoring the use DSS-A reviewed R was no depression stated R44 had be admission and she physician progress Celexa. DSS-A state scores was becaus a little bit, and indic DSS-A stated she f in R44. On 7/14/16, at 10:1 (DON) stated it was the use of an antid	5 a.m., the director of social stated she was responsible for pf psychotropic medications. 44's care plan and stated there care plan for R44. DSS-A en on the Celexa since was not sure what R44's notes stated about the ted the increase in PHQ-9 se R44 said he felt depressed cated he slept too much. had not seen a mood change		Medications are reviewed by the consultant pharmacist monthly an attending physician/nurse practitic during their routine 30/60 day visit more often as indicated. Based or resident's comprehensive assess Pine Haven Care Center staff rou- identify target behaviors and moo symptoms that justify the use of psychotropic medications. At the time of the quarterly care conference and more often if need residents receiving psychotropic medications are reassessed by lic nurses and the social worker. The medication type/dose, behavior/m symptoms, and other related infor are reviewed to assure that the re continues to reflect adequate indic for use, that related target behaviors symptoms are identified and mon	ded, censed cord cations ior/mood itored,	
	needed to be a mo medications. The facility policy d Medication Usage, monitoring of all tar assist in the assess relationship of psyc	and believed there are thorough review of lated 1/23/06, Psychotropic indicated consistent rget symptoms will be done to sment of the risk/benefit chotropic drug therapy.		and that assessments are completed indicated. On August 2, 2016, the Consultant Pharmacist, Director of Nursing, at Social Workers met to review the regulations related to the use of psychotropic medications. The pot and procedures related to the administration of psychotropic met and medications used to treat inst	nt and licies edications	

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TATEMEN	a Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED
		00148	B. WING	07	/14/2016
AME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY,	STATE, ZIP CODE	
INE HAV	EN CARE CENTER		HWEST 3R	D STREET 5963	
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
21535	Continued From pa	age 38	21535		
	that the resident ha Lewy bodies.	d a diagnosis of dementia with		were reviewed and revised.	
	Lewy boules.			The daily behavior log will continue to be	
	R47's medication re	eview report, dated 2/15/16,		used to track 1) target behaviors justifying	9
	indicated the reside	ent had been prescribed		the use of antipsychotic medications 2)	
		pressant) for insomnia. He was		interventions to modify behavior and 3) th	е
	to receive 50 mg (n	nilligrams) at bedtime.		effectiveness of the interventions. Mood	
	B17's care plan da	ated 10/23/15, indicated that		symptoms related to the use of antidepressant medications will be	
		buble sleeping, staying asleep,		addressed in the care plan and discussed	4
		d getting back to sleep. The		at least quarterly at the resident's care	•
		to establish a calm, quiet and		conference.	
		ent prior to an established			
		ew the resident regarding what		During the mandatory meetings on Augus	
		nome to establish a restful		15, 2016, the licensed nursing staff will be	9
		be incorporated in to the care		instructed on 1) the documentation	
	•	R47 was to take medications ote sleep. The staff were to		procedures for tracking target behaviors as well as related interventions and their	
		sleep log while on medication		effectiveness 2) addressing target	
	and as needed. The			behaviors/mood symptoms in the care	
		eriodic sleep assessment by		plan and 3) the new procedures for	
	licensed staff.	, , ,		tracking sleep/wake patterns, conducting	
				sleep assessments and documenting	
		p assessment, identified he		nighttime sleep habits. The direct care	
		nored. The bottom of the		staff will be reminded of the importance of	f
		the resident had symptoms		being observant for behavior/mood	
		ited to sleep apnea. In entation, it stated the resident		symptoms and reporting symptoms to the charge nurse in a timely manner.	•
		sionally, and he had days and		charge nuise in a unley manner.	
		cording to R47's former facility.		Resident number 44 – The care plan has	
	0	J		been updated to address the diagnosis	
	R47's 24 hour sleep	p log, dated 6/4/16 through		and symptoms of depression. The Social	
		days that were not completed.		Worker will complete a depression screen	ו
		ays, two nights showed R47		questionnaire every 90 days and with a	
		ne night and went back to		significant change in condition. The	
	sleep.			physician will be contacted if there is an	4
	When interviewed	on 7/14/16 at 10:17 a.m.,		increase in symptoms of depressed mood The care plan will be reviewed and revise	
		RN)-B stated the facility did a 7		as necessary.	ч
		pnitor sleep. She stated that			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE	
21535	Continued From pa	age 39	21535			
	upon admission to information taken fr assessment was pr R47's sleep log rev 7/16, stated the res slept all night. R47 stated he did have for an hour or two a	hly do a sleep assessment the facility. She stated that rom the original sleep ut into a monthly sleep log. riew notes, from 2/16 through sident was awake all day and slept a majority of the night. It a period where he was awake at night but able to get back to ted he napped a few times		Resident number 47 – The sleep/wake patterns will be three days after which a re- will review the data and con assessment. A licensed nu continue to document on th sleep quality/patterns week practitioner/physician will b ongoing problems with inso resident's care plan has be and updated accordingly.	e tracked for gistered nurse mplete a sleep irse will ne resident's kly. The nurse e notified of any omnia. The een reviewed	
	<ul> <li>When interviewed on 7/14/16 on 10:42 a.m., the consultant pharmacist stated nursing staff should be completing the 7 day sleep logs.</li> <li>When interviewed on 7/14/16 at 1:20 p.m., the director of nursing (DON) stated staff did monitor hypnotic medications to determine whether it was working or not. She stated she understood about the need for a sleep assessment prior to the initiation of a hypnotic medication.</li> </ul>			Nurses/designee will review residents receiving medica insomnia to ensure approp tracking/assessments have completed. The Medical Re Coordinator will review the admissions for next 90 day admission sleep tracking lo assessments are complete manner.	w the records of tions to treat riate sleep e been ecord records of new rs to assure ogs and	
	Insomnia Assessm the cause of insom hypnotic sleeping n assessment and sl upon admission, sl complaints of insor ordered sleeping m discontinuing sleep log would be docur charting.	ty document dated 4/22/09, ent, advised staff to assess nia before initiating the use of nedications. It stated a sleep eep log would be completed eep pattern change or nnia, pre administration of nedications, and 7 days after o medication. The 3 day sleep nented according to acute		To further monitor complian Workers will audit the care residents with the diagnosit to ensure that depression a mood indicators are addret the consultant pharmacist's medication audits and the o planning process, the resid medication regimen will con reviewed to assure that me to manage mood and insor appropriate and are monitor Compliance will be reviewed	plans of all s of depression and related essed. During s monthly quarterly care lents' ntinue to be edications used mnia are ored.	
	The director of nurs	sing (DON) or designee could o ensure resident medication		monthly Quality Assurance Assessment Committee m October 2016 quarterly Qu	and eeting and the	

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Minneso	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00148	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	HWEST 3R			
040 15		PINE ISLA	AND, MN 55			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 40	21535			
	could educate all ap unnecessary medic could develop a mo ongoing compliance Quality Assurance (	ations. The DON or designee nitoring system to ensure and report the findings to the		and Improvement Committee mee	ting.	
21555	Medications Staff d Subp. 2. Staff des medications. A nur personnel, as descu be designated as re	ignated to administer se or unlicensed nursing ribed in part 4658.1360, must	21555			8/21/16
	by: Based on observati review the facility fa medication was adr personnel; failed to medication was doo personnel that had and failed to ensure not left unattended 1 of 7 residents (R1 administration. Findings include: On 7/13/16, at 7:02 (NA)-B was observed	ent is not met as evidenced on, interview and record iled to ensure a prescribed ninistered by licensed ensure a prescribed cumented by the licensed administered the medication a prescribed medication was by the licensed personnel for 4) observed for medication a.m., nursing assistant ed to apply a medication patch back of R14. The medication		Pharmacy Services Pine Haven Care Center provides pharmaceutical services (including procedures that ensures the accur acquiring, receiving, dispensing, a administering of all drugs and biolo to meet the needs of each residen licensed pharmacist collaborates w facility staff to coordinate pharmace services within the facility and to g development and implementation pharmaceutical services and proce Persons authorized to administer medications must meet related stafederal requirements.	rate nd ogicals) t. A vith veutical uide of edures.	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00148	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
	VEN CARE CENTER	INC.	THWEST 3R			
		PINE ISL	AND, MN 5	5963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLE DATE
21555	Continued From pa	ige 41	21555			
21333	patch had the initia (LPN)-A and the da medication patch w confirmed the initia initials. NA-B confir medication aide. Na medication patch in NA-B stated typical left in the room for R14's physician ord an order for icy hot back topically one t times a day as need R14's medication a dated 7/16, identifie the person who adr medication patch. On 7/13/16, at 8:05 was the person who medication patch a for the nursing assi we usually have the patch, as R14 likes apply the patch. LP applied by the nurs worked at the facilit	Is of licensed practical nurse te of 7/13/16. NA-B stated the vas a lidocaine patch. NA-B ls on the patch were LPN-A's med she was not a trained A-B stated LPN-A had left the the room for her to apply. If the medication patch was the nursing assistant to apply. ders, dated 7/14/16, identified pad five percent, apply to low ime a day for pain and two		The medication administra and procedures have beer found appropriate. The Co Pharmacist routinely provid the nursing staff on medica administration procedures The next training session b pharmacist is scheduled for 22, 2016. During the August 15, 2010 meeting, the nurses and tr medication aides will be in only authorized staff can a medications, that the nurse medication aide who admin medication must documen administration, that the per skin patch must be the per applies it, and that medica be left unattended with the the appropriate assessment orders, and care planning self-administration of medi been completed. The Icy H ordered for resident numbo applied by staff authorized medications.	a reviewed and nsultant des training to ation and techniques. by the or September 6 mandatory ained structed that dminister e/trained nisters the t its rson initialing a rson who tions are not to or resident unless nts, clinician for cations have lot patch er 14 will be	
	always been done. On 7/13/16, at 8:18 trained medication initialed for R14's ic stated I did that bed	ecause that was how it has a.m., NA-A, who was a aide, confirmed she had by hot medication patch. NA-A cause I got the medication		To monitor compliance, the Manager will observe for c application of the lcy Hot p resident number 14 and fo resident with an order for a over-the-counter analgesic noncompliance is noted ac	orrect atch for r any other an c patch. If dditional	
		A and put the patch on.		observations and staff train done.	ning will be	

ND PLAN OF CORRECTION IDENTIFICATION NUMBE			LE CONSTRUCTION		SURVEY
	00148	B. WING		07/1	4/2016
ME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NE HAVEN CARE CENTER	INC	THWEST 3R AND, MN 55			
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21555 Continued From p	age 42	21555			
had to be a trained administer medica medications were assistant. The DO was the person ini be the person adm On 7/13/16, a t 12 expected medicati unless the residen to self-administer	bolicy of the facility was staff d medication aide or a nurse to tion. The DON stated not to be applied by a nursing N stated the policy of the facility tialing for the medication was to ninistering the medication. :45 p.m., the DON stated she ons were never left unattended t had been assessed to be able the medication. The DON of able to self-administer		Compliance will be review monthly Quality Assuranc Assessment Committee r October 2016 quarterly Q and Improvement Commi	urance and ittee meeting and the erly Quality Assurance	
Administration Gen medications are ad accordance with g practices and only to do so. Personne medications do so properly orientated distribution system are prepared only pharmacy or other laws and regulatio medications. B. Ad who prepares the person who admin are allowed to self specifically authori and in accordance -administration of Documentation (in individual who adm	cluding electronic) 1) The ninisters the medication dose istration on the resident's MAR				
SUGGESTED ME	THOD OF CORRECTION: The				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		00148	B. WING	07	7/14/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
PINE HA			THWEST 3R AND, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21555	director of nursing develop systems to self administration staff is administerin designee could edu these systems. The develop monitoring compliance.	age 43 (DON) or designee could ensure, other than residents as appropriate, only qualified ag medications. The DON or ucate all appropriate staff on e DON or designee could systems to ensure ongoing R CORRECTION: Twenty-one	21555		
21620	MN Rule 4658.134 Drugs used in the r in accordance with	nursing home must be labeled	21620		8/21/16
	by: Based on observati interview facility fail medications were p proper outdates. Findings include: Observation: Observation of med room on the 600 wi 07/11/16, 5:00 p.m. (TMA)-A. Upon obs found a bottle of Se with the directions to g-tube daily as nee 4/2016, Loperamid ml per J (jejunostor and 10 ml after with Senna tablets pres- by mouth three time	ent is not met as evidenced ion, record review and led to ensure that all properly labeled and within dication cart and medication ing was completed on with trained medication aid servation of medication cart enna syrup prescribed to (R50) to give 10 ml (milliliters) per ded with an expiration date of e also prescribed for (R50) 20 my) tube for first loose stool n expiration date of 6/2016. cribed to (R45) give one tablet es daily as needed with v/2016. Upon observation of		Labeling of Drugs and Biologicals Pine Haven Care Center provides pharmaceutical services to meet the needs of each resident. The facility contracts with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of related policies/procedures to ensure the accura acquiring, receiving, dispensing, storing and administering of all drugs and biologicals. In accordance with State and federal law the facility policy requires that drugs and biologicals are labeled in accordance wit currently accepted professional principle	te , h

Innesota Department of Hericiencies ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLE	
	00148	B. WING		07/14/2	2016
AME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	210 NOR	THWEST 3R	DSTREET		
INE HAVEN CARE CENTER	PINE ISLA	AND, MN 55	5963		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
21620 Continued From pa	age 44	21620			
medication room re medication, Apliso injection 1 ml which lot #772984 that has outdated 30 after of Acetaminophen that mg suppository, insert rectum every six he expiration date of 4 prescribed to (R50 (milligram), insert of needed with an exp Observation of me room on the 300 w at 5:29 p.m. with lid (LPN)-B. Upon obs which was prescribe expiration date of 5 (R14) give two table as needed with an Ultram prescribed times daily as need 8/2015. Observation of me room on the 500 w at 6:00 p.m. with tr (TMA)-C. Upon ob Nitrostat 0.4 mg wi This medication wa 6/27/16 according Robitussin prescrib every six hours as of 3/2016, Stock su date of 5/2016. Mil (R37) give 30 ml b an expiration date to (R29) place one minutes for three of	age 44 efrigerator found facility stock (a tuberculin derivative) n was 1/4 of the way full with a ad an open date of 5/27/16 and opening or June 26, 2016. at was prescribed to (R22) 650 sert one suppository per burs as needed with an 4/2016 and Bisacodyl ) suppository 10 mg one suppository rectally daily as biration date of 4/2016. dication cart and medication ing was completed on 7/11/16, censed practical nurse servation found Quetiapine bed to (R47) 50 mg with an 5/22/15, Tylenol prescribed to ets by mouth three times daily expiration date of 12/2015, to (R14) 1 tablet by mouth four ded with an expiration date of dication cart and medication ing was completed on 7/11/16, ained medication aide servation found a stock th an expiration date of 7/2015. as administered to (R60) on to facility documents. bed to (R49) 5 ml by mouth needed with an expiration date upply of Tums with expiration k of Magnesia prescribed to tab under tongue every five loses with an expiration date of rescribed to (R17) inject 10		and standards and that all drugs a biologicals are stored in a secure location with access only by author personnel. Outdated and expired and biologicals are routinely disca according to accepted practice st The medication related policies a procedures were reviewed and for appropriate. According to facility p if there is a change in medication administration instructions, an ad sticker stating "Directions Change To Chart" will be applied to the m container to alert the staff to refer medication administration record changes and 2) expiration dates a checked before administering medications/biologicals. During the mandatory meeting Au 2016, the nurses and trained med assistants will be reinstructed on importance of medication label ac and the procedure for attaching notification labels to the containen there is an order change 2) the ne check expiration dates before administering medications/biologi the policy for disposing of outdates medications/biologicals as well as that have unreadable labels or ar mislabeled/unlabeled. The labels of all medications/biologi were checked for expiration dates completeness and readability. Co- compliance with the disposition o outdated medications/biologicals	, locked orized drugs arded andards. nd ound oolicy 1) hesive ed Refer edication to the for are to be ugust 15, dication 1) the occuracy rs when eed to icals 3) ed s those e	

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		00148	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		210 NOR1	THWEST 3R	D STREET		
	VEN CARE CENTER	PINE ISLA	AND, MN 55	5963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	ige 45	21620			
	an open date of 6/1 prescribed to (R32) a day with an expira medication bottles Bone builder for (R identifier label and off on the label. Up room found Maalox mouth three times bedtime as needed 3/2016. Observation on 7/1 medication adminis (RN)-C showed a L (R34) with a label in the morning, the m (MAR) identified the based off of what p eaten, which at that Lantus pen for R34 inject 45 units in the units to be adminisi vial for R34 with lat morning, MAR iden in the morning. RN- by wiping the top of then placing the ne the pen dial to 40. F room, knocked and administer the med speak with RN-C in the manufacturer's the insulin pen. RN I forgot. RN-C was turned the dial back dial to two. RN-C re needle but the inne the needle. RN-C s the cap on. Stopper	1/2016 and artificial tears one drop in left eye four times ation date of 2/2015. Found including Vitamin B12 and 42) that had no resident the expiration date had rubbed on observation of medication a prescribed for (R25) 30 ml by a day before meals and at with an expiration date of 2/16, at 9:21 a.m. of stration with registered nurse evemir pen prescribed to dentifying to inject 24 units in edication administration record e amount to be given was ercentage of the meal was t time R34 required 22 units. with a label identifying to e morning, MAR identified 40 tered in the morning. Humalog bel to administer 10 units in the tified to administer eight units -C prepared Lantus insulin pen if the pen with an alcohol wipe, edle on top. RN-C then turned RN-C approached resident I entered the room preparing to lication. At that time asked to the hallway and asked about guidelines related to priming -C stated, yes I usually do that asked to demonstrate. RN-C k to zero and then turned the emoved the outer cap of the r pink cap was still present on tarted to prime the pen with d RN-C at that time and again facturer's guidelines related to		monitored monthly by Direct Nurses/designee - staff mem authorized to administer med the consultant pharmacist. To compliance with proper admi insulin using a pen, random of of nurses administering insul done. To monitor the accurad vial/pen labels, a licensed nu compare all current insulin vi with the medication administ If noncompliance is noted, ad monitoring and staff education done. Compliance will be reviewed monthly Quality Assurance a Assessment Committee mee October 2016 quarterly Quali and Improvement Committee	aber dications and o monitor nistration of observations in will be cy of insulin rse will al/pen labels ration record. dditional on will be at the nd sting and the ity Assurance	

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	age 46	21620			
		pen. RN-C removed the cap n with two units of lantus.				
	Interviews:					
	verified expiration stated if an expired be removed from t	A-A on 7/11/16, at 5:00 p.m. dates of medications. TMA-A d medication is found it would he medication cart/medication ordered and the director of uld be informed.				
	verified expiration of that another LPN of be going through a rooms looking for e verified that if an e it should be remov	-B on 7/11/16, at 5:29 p.m. dates of medication and stated on the night shift is supposed to all the carts and medication expired medications. LPN-B xpired medication is found that ed from the medication om so that it isn't given to any				
	verified expiration of verified missing resistated that all med resident name and label should not be expired medication and placed in a bin well as the DON sh	A-C on 7/11/16, at 6:00 PM dates of medications and sident identifying labels and ications should be labeled with t that any medications without a given. TMA-C stated the as should have been removed in the medication room as hould have been notified. It expired medications should d.				
	verified the labels of were incorrect. RN changed by the do	C on 7/12/16, at 9:21 a.m. on the insulin pens and vials I-C stated when an order is ctor that a label change sticker placed over the existing label er was changed.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
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21620	Continued From pa	age 47	21620			
	stated that staff she medications every medications and th expired medication circulation, placed to pharmacy, reord DON verified that la placed immediately DON verified that r training on the prop	I on 7/13/16, at 2:24 p.m. ould be checking for expired time they are administering the expectation when finding is is that they are pulled out of in medication room, sent back lered, notify family if needed. abel change stickers should be y once the order has changed. hursing staff had received ber use of insulin pens. DON received training at least once sulin pen usage.				
	Record Review:					
	was presented to n of insulin pen admi documentation title identifies, "it is pos- to collect in the car avoid injecting air, before each injectio units. Hold the pen the push-button all selector shows 0. V insulin at the tip of list of nursing staff the proper use of in	staff training information that nursing staff on the proper use inistration. Training ed, "Insulin Pen Administration" sible for small amounts of air tridge with normal use. To an "airshot" is performed on. Turn the dose selector to 2 pointing the needle up, press the way in until the dose fou should see a drop of the needle. DON provided a who had received training on nsulin pen and RN-C is ve received training on				
	Insulin was provide guidelines identify injecting insulin. Th a test dose of 2 un	delines for Long-Acting Lantus ed by the DON. Manufacturer's to perform a safety test prior to his test is performed by dialing its. Hold pen with the needle htly tap the insulin reservoir so				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			
		00148	B. WING		07/	14/2016
AME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
INE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	THE APPROPRIATE	COMPLE DATE
21620	Continued From pa	age 48	21620			
	will help you get the the injection button	e to the top of the needle. This e most accurate dose. Press a all the way in and check to mes out of the needle.				
	policy dated Februa expiration date on administering any r Ordering and Rece dated February of 2 physicians's directi is inaccurate, the n changed-refer to cl indicating there is a Resident-specific n that are not labeled the manufacturer's identified with the n storage in the facili 2015 identifies that immediately remov will check the expir before administerin be administered to	n Administration Procedures ary of 2015 states check package/container before medication. Medication eiving from Pharmacy policy 2015 identifies If the ons for use change or the label nurse may place a "directions hart" label on the container a change in directions for use. nonprescription medications d by the pharmacy are kept in original container and resident's name. Medication ity policy dated February of t outdated medications are red from inventory. The nurse ration date of each medication ing it. No expired medication will a resident. All expired e removed from the active red in the facility.				
	director of nursing systems to ensure monitored for expir designee could edu DON or designee of	THOD OF CORRECTION: The (DON) or designee develop medication is regularly ration dates. The DON or ucate all appropriate staff. The could develop monitoring ongoing compliance.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/14/2016	
		00148	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE		
PINE HA			HWEST 3R			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21685	Continued From pa	ige 49	21685			
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			8/21/16
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation lealth, comfort, safety, and esidents according to a written be and repair program.				
	by: Based on observative review, the facility for sanitary environme all meals were preparted for the facility and not for the facility. In additive maintain the clean of the facility. In additive maintain the clean of the facility. The facility and not for the facility. In additive for 3 of 6 shares wing of the facility. The facility all residents residents residents for the facility. The facility all residents residents residents for the facility. The facility and not for the facility and not for the facility. The facility and not for the facility and not for the facility and not for the facility. The facility and not for the facility. The facility and not for the facility. The facility and not for the facility. The facility and the facility. The facility and t	ent is not met as evidenced ion, interview, and document ailed to ensure a clean and nt for the facility kitchen where bared. This had the potential to o resided in the older wings of the newly renovated wing of on, the facility failed to iness of the bathroom ceiling ared bathrooms on the 200 This had the potential to affect og on the 200 wing unit.		Safe, Sanitary, Comfortable Env It is the policy of Pine Haven Can to provide a safe, functional, san comfortable environment for resist staff, and the public. As part of an ongoing process to pleasant, homelike environment Haven Care Center has a sched routine cleaning, repairs, and ma of the facility. All staff members a expected to report environmenta concerns to the appropriate administrative/supervisory staff. During the mandatory meetings 15, 2016, the staff will be remind observe for equipment/furnishings/structures need to be repaired, cleaned, or The procedures for reporting wo to the Maintenance Director will reviewed.	re Center itary and idents, o provide a , Pine ule for aintenance are il August led to s that replaced. rk items	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE : COMPL	
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA		INC:	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21685	Continued From pa	ige 50	21685			
	soiled with thick du Seven of seven cei were coated with du Thirty ceiling tiles h Dry food storage ro covered with dust a significant dust Large ceiling vent s hallway outside of t dust around the ed Long white pipe un sink was covered w Seven of ten sprink covered with dust During the kitchen t the dietary manage areas. The DM stat for the Monday AM vents and dish roor was to write out a n clean it. The DM ve lacked ceilings, ligh vents, and sprinkle stove hood screens The DM verified the cleaning in the kitch stove hood was sch 7/15/16. The DM ve department had no soiled areas prior to Document review of identified hood clear review of invoice da	st ling exhaust vents in kitchen ust; eavily soiled with debris oom had 2 of 2 light fixtures and the exhaust vent with screen, located in kitchen he dry food storage room, with ges der the three compartment <i>i</i> th dust and debris der the daily cleaning schedule cook included checking hood n vents, and if soiled, dietary naintenance slip for them to erified the cleaning schedules at fixtures, ceiling exhaust rs. The DM further stated the swere last cleaned 2/17/15. The DM stated the gas neduled to be cleaned on erified the maintenance t been notified to clean the po the initial tour. of invoice dated 2/17/15, uning completed. Document ated 8/2/15, identified cleaning		The soiled kitchen ceiling lig stove hood vent screens, co vents, ceiling tiles, ceiling version sprinkler heads were cleaned maintenance staff will be re- ongoing cleaning of ceiling ventilation screens, sprinkle fixtures and tiles. These tas added to the maintenance of list and will be checked qua- cleaned as needed. During the August 4, 2016 r dietary staff were instructed observant for areas that nee and were informed of the cl schedule for the stove hood and water pipes. The dietar inform the maintenance sta that need attention betweer maintenance checks. Due to a major addition to t during the week of the surver residents in the 200 wing we process of being relocated. and bath rooms in the 200 ving preparation for residents be back to the 200 wing. The b vents/ducts in all resident b checked for dust build up.	eiling exhaust ent screen, and ed. The sponsible for exhaust vents, er heads, light sks have been cleaning task arterly and meeting, the I to be ed cleaning eaning d vent screens y staff will ff of any areas n the routine he facility, ey the ere in the The rooms wing are in the ned including s in ping moved pathroom athrooms were ed by the	
	of nursing verified a	ompleted. 7/14/16, at 7:00 a.m., director all 51 residents ate food facility kitchen.		Maintenance Director throu of ceiling fixtures/tiles and r maintenance cleaning logs dietary supervisor through o the stove hood vent screen	eview of and by the observation of	

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
	00148	B. WING		07/14/2016	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VEN CARE CENTER I					
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 51	21685			
Document review of Cleaning Schedule weekly Monday AM and dish room vent cleaning assigned f sprinklers, pipe und sink, or for ceiling e The facility policy d Schedules, reveale Department will be sanitary condition. cleaning tasks listed department and cle timely and appropri During an observat room 206 and 208 of ceiling vent in the b collected balls of du During an observat 210 and 212 on 7/1 vent in the bathroor collected balls of du During an observat 209 and 211 on 7/1 vent in the bathroor collected balls of du During an environm maintenance direct the joint bathroom of have collected balls	f the facility Dietary Daily dated revised 7/4/14, revealed l cook to check hood vents s. There was no other for ceilings, light fixtures, der the three compartment exhaust vents. ated 9/12/12, Cleaning d "The Food service maintained in a clean and Cleaning schedules, with all d, will be provided in the eaning tasks completed in a ate manner." ion of the shared bathroom of on 7/11/16 at 5:54 p.m. the athroom was noted to contain ust in the grating of the vent. ion of the shared bathroom of 2/16 at 10:07 a.m., the ceiling m was noted to contain ust in the grating of the vent. ion of the shared bathroom of 1/16 at 2:57 p.m., the ceiling m was noted to contain ust in the grating of the vent.		Compliance will be reviewe monthly Quality Assurance Assessment Committee m October 2016 quarterly Qu	ed at the and eeting and the ality Assurance	
	OF CORRECTION PROVIDER OR SUPPLIER VEN CARE CENTER I SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Document review of Cleaning Schedule weekly Monday AM and dish room vent cleaning assigned f sprinklers, pipe und sink, or for ceiling e The facility policy d Schedules, reveale Department will be sanitary condition. cleaning tasks liste department and cleaning tasks liste department and cleaning tasks liste department and cleaning tasks lister department in the be collected balls of du During an observat 210 and 212 on 7/1 vent in the bathroom collected balls of du During an environm maintenance direct the joint bathroom of have collected balls of du	AT OF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00148         PROVIDER OR SUPPLIER       STREET AD         VEN CARE CENTER INC       210 NOR PINE ISL.         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 51         Document review of the facility Dietary Daily Cleaning Schedule dated revised 7/4/14, revealed weekly Monday AM cook to check hood vents and dish room vents. There was no other cleaning assigned for ceilings, light fixtures, sprinklers, pipe under the three compartment sink, or for ceiling exhaust vents.         The facility policy dated 9/12/12, Cleaning Schedules, revealed "The Food service Department will be maintained in a clean and sanitary condition. Cleaning schedules, with all cleaning tasks listed, will be provided in the department and cleaning tasks completed in a timely and appropriate manner."         During an observation of the shared bathroom of room 206 and 208 on 7/11/16 at 5:54 p.m. the ceiling vent in the bathroom was noted to contain collected balls of dust in the grating of the vent.         During an observation of the shared bathroom of 210 and 212 on 7/12/16 at 10:07 a.m., the ceiling vent in the bathroom was noted to contain collected balls of dust in the grating of the vent.         During an observation of the shared bathroom of 209 and 211 on 7/11/16 at 2:57 p.m., the ceiling vent in the bathroom was noted to contain collected balls of dust in the grating of the vent.         During an environmental tour with the maintenance director on 7/14/16 at 12:41 p.m., the joint bathroom of 210 and 212 was noted t	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         00148       B. WING	OP CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:         00148       E. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         VEN CARE CENTER INC       210 NORTHWEST 3RD STREET         Continued From page 51       21685         Document review of the facility Dietary Daily Cleaning Schedule dated revised 7/4/14, revealed weekly Monday AM cook to check hood vents and dish room vents. There was no other cleaning assigned for ceilings, light fixtures, sprinklers, pipe under the three compartment sink, or for ceiling exhaust vents.       Compliance will be reviewe monthly Quality Assurance         The facility Dolicy dated 9/12/12, Cleaning Schedules, revealed "The Food service       Compliance will be r	OF DEFICIENCIES       (X1) PROVIDERSUPPLIERCULA       (De2) MULTIPLE CONSTRUCTION       (X3) DATE         OP CORRECTION       00148       B.WING       (D) OP CONSTRUCTION         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       (D) OP CONSTRUCTION NUMBER:       (D) OP CONSTRUCTION         VEN CARE CENTER INC       210 NORTHWEST 3ND STREET       PROVIDERS PLAN OF CORRECTION       (EACH CORRECTIVE ACTION SOLID DE         SUMMARY STATEMENT OF DEFICIENCIES       (EACH CORRECTIVE ACTION SOLID DE       (EACH CORRECTIVE ACTION SOLID DE         IED CONTINUE OF DEFICIENCIES       (EACH CORRECTIVE ACTION SOLID DE       (EACH CORRECTIVE ACTION SOLID DE         Continued From page 51       21685       (EACH CORRECTIVE ACTION SOLID DE         Document review of the facility Dietary Daily       Cleaning assigned for ceilings, light fixtures, sprinklers, pipe under the three compartment sink, or for ceiling exhaust vents.       Compliance will be reviewed at the monthly Quality Assurance and and sanitary condition. Cleaning schedules, with all cleaning tasks isted, will be provided in the department will be maintained in a clean and sanitary condition. Cleaning schedules, with all cleaning tasks isted, will be provided in the grating of the vent.         During an observation of the shared bathroom of 210 and 212 on 7/11/16 at 15:54 p.m., the ceiling vent in the bathroom was noted to contain collected balls of dust in the grating of the vent.         During an observation of the shared bathroom of 209 and 211 on 7/111/16 at 12:41 p.m., the joint bathroom vas noted to c

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		07/	14/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
PINE HA	VEN CARE CENTER	INC	RTHWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	age 52	21685			
		have a policy that addressed g of resident bathrooms.				
	administrator or de to ensure the facilit comfort, safety, an administrator or de appropriate staff or administrator or de	THOD OF CORRECTION: The signee could develop systems ty is well maintained for d cleanliness. The signee could educate all n what those systems are. The signee could develop s to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one				
21830	MN St. Statute 144 Residents of HC F	.651 Subd. 10 Patients & ac.Bill of Rights	21830			8/21/16
	Subd. 10. Partici notification of famil	pation in planning treatment; y members.				
	in the planning of the includes the opport alternatives with incorportunity to requi- care conferences, family member or of both. In the event present, a family member chosen by the resident conferences. (b) If a resident of unconscious or con- communicate, the efforts as required	Il have the right to participate heir health care. This right tunity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be nember or other representative dent may be included in such who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify nber or a person designated in				

	ta Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00148	B. WING		07/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	VEN CARE CENTER I	210 NOR	FHWEST 3RD	STREET		
	VEN CARE CENTER I	PINE ISL	AND, MN 559	63		
(X4) ID			ID			(X5) COMPLET
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		DATE
				DEFICIENCY	() )	
21830	Continued From pa	ge 53	21830			
		-				
		ent as the person to contact in the resident has been				
		lity. The facility shall allow the				
		articipate in treatment				
		e facility knows or has reason				
		ent has an effective advance				
	directive to the cont	trary or knows the resident has				
		that they do not want a family				
		n treatment planning. After				
		ember but prior to allowing a				
		articipate in treatment				
		/ must make reasonable				
		vith reasonable medical ne if the resident has				
		ce directive relative to the				
		e decisions. For purposes of				
		asonable efforts" include:				
		e personal effects of the				
	resident;					
		e medical records of the				
		session of the facility;				
		ny emergency contact or				
		tacted under this section It has executed an advance				
		er the resident has a				
		the resident normally goes for				
	care; and	the resident hermany gees for				
		e physician to whom the				
		oes for care, if known,				
		nt has executed an advance				
		y notifies a family member or				
		ncy contact or allows a family				
		ate in treatment planning in				
		s paragraph, the facility is not				
		r damages on the grounds that he family member or				
		or the participation of the				
		s improper or violated the				
	patient's privacy rig					

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		
		00148	B. WING			
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VINE HA	VEN CARE CENTER	INC	HWEST 3R			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLET DATE
21830	Continued From pa	age 54	21830			
	family member or of the facility shall atter members or a desi examining the pers and the medical re- possession of the f to notify a family m emergency contact admission, the faci social service agen agency that the res the facility has bee member or design county social service enforcement agence identifying and noti designated emerge service agency or I that assists a faciliti subdivision is not Ii damages on the gr	asonable efforts to notify a designated emergency contact, empt to identify family gnated emergency contact by sonal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the lity shall notify the county tocy or local law enforcement sident has been admitted and n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in fying a family member or ency contact. A county social ocal law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper ent's privacy rights.				
	by:	ent is not met as evidenced		Self-Determination/Participation		
	failed to provide ch	oices for frequency of bathing (R42, R43) reviewed for		Pine Haven Care Center staff res residents' rights to 1) choose act	ivities,	
	Findings include:			schedules, and health care consi his or her interests, assessments plans of care and 2) make choice	s, and	
	4/14/16, indicated I	num Data Set (MDS) dated R42 was cognitively intact and one staff for bathing. R42's		aspects of his or her life in the fa are significant to the resident. Th recognizes the right of the reside	cility that e facility	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
		210 NORT	HWEST 3R	D STREET		
	VEN CARE CENTER I	PINE ISLA	ND, MN 55	963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP! DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21830	Continued From pa	ige 55	21830			
	current care plan, ir assistance for bath The facility bath sch identified R42 was Fridays for the day On 7/11/16, at 5:11 chose the bath for h it." R42 stated she on Friday. R43's quarterly MD was cognitively inta staff for bathing. R4 indicated R43 requi was to have a spon However, the facilit 7/7/16, identified R4 bath or shower on On 7/11/16, at 1:28 allowed to choose t R43 further stated s week but would pre On 7/12/16, at 1:38 (NA)-E stated staff know when a reside	ndicated R42 required ing and preferred showers. hedule sheet dated 7/7/16, scheduled for a tub bath on shift. p.m., R42 stated facility staff her and she "went along with received a bath once a week S dated 6/8/16, indicated R43 ict and required assist of one 43's current care plan, ired assistance for bathing and	2.000	resident representative to make choices about care and treatme including the right to determine bathing schedule, frequency, an bath. The residents are encoura participate to the greatest exten in the care planning process and assists them in exercising their discussing with the resident (or resident's representative) the re condition, treatment options, pe preferences, and any potential consequences of accepting or re recommended treatment. A policy for determining the resi bathing preferences has been d the related procedures reviewed revised. As part of the admissio residents are asked about prefe and the importance of choosing wear, type of bath, snack availa locking up personal belongings, arise/bedtime, having reading m available, listening to favorite m keeping up with the news, partic religious services/practices, etc. are made to follow preferences and services to the greatest extr possible. The resident's preferences	nt his/her d type of iged to t possible d the staff rights by the sident's rsonal efusing the dents' rafted and d and n process, rences what to bility, choosing laterial usic, cipating in Attempts for cares ent ed bathing	
	determined the resident's bath day upon admission. On 7/12/16, at 2:04 p.m., registered nurse (RN)-B stated she was responsible for the nursing admission process of residents. RN-B stated upon admission one bath a week was provided for residents. RN-B further stated short term residents let staff know how many baths a week			of bath (tub/shower/sponge/bed be addressed and his/her prefer included in the individualized pla The resident/legal representativ asked about satisfaction with cares/services during the quarter conferences, with significant char more often if indicated.	rences an of care. e will be erly care	

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00148	B. WING		07/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3F AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21830	Continued From pa	age 56	21830			
	they prefer. Short to their rooms which r accommodate the did not ask resident baths a week the re- social services ask upon admission. R long term residents preferred. On 7/12/16, at 3:18 services (DSS)-A s ask about resident preference. On 7/12/16, at 3:25 RN-B was unable to process for resident staff usually assign admission and adm assigned which day bath. RN-A stated a of bathing was not ever asked upon at the resident's initial within five days of a resident if they war of care. RN-A stated frequency of bathin On 7/12/16, at 3:35 responsible for the stated she schedul bath unless they wa her know if a reside bathing. On 7/13/16, at 8:36 (DON) stated resid	erm residents have showers in		During the mandatory meeting 2016, the nursing staff will be the residents' right to make ch regarding heath care services with his/her interests, assess plans of care including the right their bathing preferences resp Resident number 42 - The RN manager will interview the ress regarding her preferred bathin frequency. The resident's plan the nursing assistants' care re cards will be reviewed and up necessary to reflect her bathin preferences. The social worke continue to ask the resident a satisfaction with cares during one-to-one visits; the resident satisfaction with cares will also discussed during the quarterly conferences. Resident number 43 – The re currently in the hospital. Upon to the facility, the resident will interviewed by RN clinical mai regarding her preferred bathin frequency. The resident's plan the nursing assistants' care re cards will be reviewed and up necessary to reflect bathing p The social worker will continue resident about her satisfaction during their one-to-one visits; resident's satisfaction with car be discussed during the routin conferences.	informed of noice consistent nents, and ht to have bected. I clinical ident ig type and n of care and of care and of care and of care and of care and of care and of care ang er will bout her their 's o be r care sident is her return be nager ng type and n of care and of care and of care and ference dated as references. e to ask the n with cares the res will also ne care	

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00148	B. WING		07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA		NC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21830	Continued From pa	ge 57	21830			
	they wanted one m A policy regarding t bathing was reques the DON stated the	<ul> <li>self-determine and participate in health care decisions as well as their satisfact with cares will be monitored by the Soc Workers during one-on-one interviews, during the choice of bathing.</li> <li>self-determine and participate in health care decisions as well as their satisfact with cares will be monitored by the Soc Workers during one-on-one interviews, during the routine care conferences, ar through feedback from Resident Count meetings. The Life Enrichment staff will continue to ask the resident about the</li> </ul>		satisfaction the Social erviews, ences, and nt Council t staff will		
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could development and implement policies and procedures to ensure all residents are offered choices in their daily routines. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could monitor to ensure ongoing compliance.			importance of choosing the typ part of the minimum data set of process. Any care concerns with communicated to the appropriate department manager/supervise Compliance will be reviewed at monthly Quality Assurance and Assessment Committee meetin October 2016 quarterly Quality and Improvement Committee re	e of bath as ompletion II be ate or. t the d ng and the Assurance	
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21870	MN St. Statute 144 Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870			8/21/16
	residents shall have	nsive service. Patients and e the right to a prompt and se to their questions and				
	by: Based on observati	ent is not met as evidenced on, interview and document		- Resident and Family Groups		
	council grievances and social service of to the facility by the	ailed to resolve resident in regards to nursing, dietary department concerns reported resident council. This had the esidents who needed		Pine Haven Care Center respe promotes the existence of the Council. The concerns and recommendations of the famili residents are reviewed and tak	Resident es and	

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STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		210 NOB	THWEST 3F			
PINE HA	VEN CARE CENTER	INC PINE ISL	AND, MN 5	5963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULD BE	(X5) COMPLET DATE
				DEFICIENCY)		
21870	Continued From pa	age 58	21870			
	Findings include: On 7/11/16, at 6:45 p.m., R14 stated the facility			consideration during decision-m the development of policies and procedures affecting resident se The facility attempts to accomm	ervices. odate the	
	raised during reside council made sugg	r follow up on grievances ent council. When the resident estions/raised concerns,		Councils' recommendations to t greatest extent possible.		
	resident that made			The Resident Council meetings routinely attended by interdiscip team department managers and	linary care I the	
	revealed the follow			administrator. The Life Enrichm Director/designee facilitates the writes the meeting minutes, ens	meetings, ures that	
	indicated nursing d taking too long to g	council meeting minutes epartment concerns included et ready for bed, overbed table in reach, not obtaining a nurse		the appropriate department man notified of resident concerns, ar resolution of the concerns.		
	bathroom, call light overall poor call light staff stating the will	ng too long to use the time too long in the morning, ht response times including be right back and do not decided that the nurse		The polices and procedures for conducting the Resident Counci were reviewed and revised. The agenda and minutes will be exp routinely include action plans ar	meeting anded to	
	change to get this r	eet with staff today at shift matter addressed quickly and e place to see if it improved.		up to resident concerns. During the August 3, 2016 mont Assurance and Assessment me		
	indicated dietary co	council meeting minutes oncerns included a resident not on assisted, mostly cold food at		importance of responding to res concerns and the procedures for addressing resident concerns w	ident or	
	lunch, wanted soup pizza, Sundays wei	b/none puree, request for re always beef and mashed ents would like something		reviewed with the department m As discussed, the department n will continue to address/investig resident concerns; the resolutio	anagers. nanagers ate n/findings	
	indicated nursing corresident communic	council meeting minutes oncerns included nursing and ation about tests/prep, dietary requests for more variety on		will be reported during the next Council meeting. The minutes of four Resident Council meetings reviewed to ensure that the resi concerns/comments were addre	f previous were dents'	
	Sundays, one resid	lent requested he receive a les not just egg salad, and		the findings/resolution communi documented. Dave Christiansor	cated and	

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00148	B. WING		07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER		THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21870	Continued From pa	age 59	21870			
21870	social services con concerns which wo 5/24/16 - Resident identified nursing co about resident deat stated they learned newspaper. Reside family here and wo and families too. Th and a plan made for 6/28/16 - resident of indicated nursing co the assistance of a would follow up on nursing staff. Resident council m include documenta concerns identified On 7/13/16, at 11:1 stated the manager supposed to take c back to AD-C with s documented in the resident council min to all managers by back to her. AD-C s documented in the the resolution was On 7/13/16, at 2:15 when grievances w council meeting, ea	age 59 cerns included privacy uld be addressed with staff. council meeting minutes oncerns including questions th notification. Residents of a resident death in the ents further stated were a uld like to support each other here would be a team formed or resident notification of death. council meeting minutes oncerns related to obtaining nurse. The nurse manger communication between eeting minutes failed to tion of follow up for the from 2/23/16 through 6/28/16. 1 a.m., activity director (AD)-C rs assigned concerns were are of it. Managers were to get solutions which would be minutes. AD-C stated the nutes are sent out every month email with a reminder to get stated if no resolution was minutes in the last six months "probably not there."		Long-term Care Ombudsman, guest speaker at the July 26, Resident Council meeting and the residents' rights including to care and services that meet pro- practice standards. During the mandatory meeting 2016, the staff will be reminde resident's right to have concer and addressed in a timely man the expectation that the care w provided in a timely manner as the plan of care. Resident righ tips/suggestions to improve th care and quality of life are inclu- monthly staff newsletter. To monitor compliance, the Administrator/Designee will au Resident Council minutes for three months to assure that re concerns are being addressed manner and that resolutions/re are being reported to the Resi and/or specific residents as ap Compliance will be reviewed a monthly Quality Assurance and Assessment Committee meeti October 2016 quarterly Quality and Improvement Committee	2016 reviewed the right to rofessional August 15, d of the ns reported oner and of vill be s outlined in ts and e residents' uded in the the next sidents' I in a timely esponses dent Council opropriate. t the d ing and the y Assurance	
	went back and worl email should be the	ked on the concern. AD-C's e second reminder of erns to be addressed. Staff				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OF CORRECTION			E SURVEY PLETED
		00148			07/14/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		07/14/2018	
		210 NOF	RTHWEST 3RD			
PINE HA	VEN CARE CENTER	INC	AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21870	Continued From pa	age 60	21870			
	meeting by each d resolve the concer concerns were bro resolution would put The administrator practice to docume to be reviewed late The facility policy F indicated minutes concerns and sugg response to sugge SUGGESTED ME The administrator revise policies and grievances and res residents/families a The administrator staff on the proces designee could de ensure ongoing co monitoring results Committee.	Resident Council, dated 4/7/09, of the council would reflect all gestions addressed and facility	Ð			