DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0BBR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245359**

2. STATE VENDOR OR MEDICAID NO. (L2) **664240300**

3. NAME AND ADDRESS OF FACILITY
(L3) **PINE HAVEN CARE CENTER INC**
(L4) **210 NORTHWEST 3RD STREET**
(L5) **PINE ISLAND, MN** (L6) **55963**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **08/29/2016**

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	66			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 09/6/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 9/6/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **11/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

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,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245359 Y1	A. Building B. Wing Y2	8/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	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 Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
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(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(l)	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		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	9/6/2016	10160	8/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245359	A. Building 02 - PINE HAVEN CARE CENTER B. Wing	8/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 07/14/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 9/6/2016	**SIGNATURE OF SURVEYOR** 37008	**DATE** 8/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/13/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0BBR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245359**

2. STATE VENDOR OR MEDICAID NO. (L2) **664240300**

3. NAME AND ADDRESS OF FACILITY
(L3) **PINE HAVEN CARE CENTER INC**
(L4) **210 NORTHWEST 3RD STREET**
(L5) **PINE ISLAND, MN** (L6) **55963**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/14/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	66			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Justin Main, HFE NE II 08/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/19/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **11/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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
Email: gary.nederhoff@state.mn.us
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide choices for frequency of bathing for 2 of 3 residents (R42, R43) reviewed for choices. Findings include: R42's annual Minimum Data Set (MDS) dated 4/14/16, indicated R42 was cognitively intact and required assist of one staff for bathing. R42's	F 242	Tag F242 Self-Determination/Participation Pine Haven Care Center staff respect the 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 resident.	8/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 242	Continued From page 1 current care plan, indicated R42 required assistance for bathing and preferred showers. The facility bath schedule sheet dated 7/7/16, identified R42 was scheduled for a tub bath on Fridays for the day shift. On 7/11/16, at 5:11 p.m., R42 stated facility staff chose the bath for her and she "went along with it." R42 stated she received a bath once a week on Friday. R43's quarterly MDS dated 6/8/16, indicated R43 was cognitively intact and required assist of one staff for bathing. R43's current care plan, indicated R43 required assistance for bathing and was to have a sponge bath. However, the facility bath schedule sheet dated 7/7/16, identified R43 was scheduled for a tub bath or shower on Tuesdays during the day shift. On 7/11/16, at 1:28 p.m., R43 stated she was not allowed to choose the frequency of her bathing. R43 further stated she received a bath once a week but would prefer a bath twice a week. On 7/12/16, at 1:38 p.m., nursing assistant (NA)-E stated staff reference the bath sheet to know when a resident is scheduled to receive a bath. NA-E stated somebody "higher up" 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	F 242	The facility recognizes the right of the resident or resident representative to make informed choices about care and treatment including the right to determine his/her bathing schedule, frequency, and type of bath. The residents are encouraged to participate to the greatest extent possible in the care planning process and the staff assists them in exercising their rights by discussing with the resident (or the resident's representative) the resident's condition, treatment options, personal preferences, and any potential consequences of accepting or refusing the recommended treatment. A policy for determining the residents' bathing preferences has been drafted and the related procedures reviewed and revised. As part of the admission process, residents are asked about preferences and the importance of choosing what to wear, type of bath, snack availability, locking up personal belongings, choosing arise/bedtime, having reading material available, listening to favorite music, keeping up with the news, participating in religious services/practices, etc. Attempts are made to follow preferences for cares and services to the greatest extent possible. The resident's preferred bathing schedule, frequency of bathing, and type of bath (tub/shower/sponge/bed bath) will be addressed and his/her preferences included in the individualized plan of care. The resident/legal representative will be asked about satisfaction with cares/services during the quarterly care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 242	Continued From page 2 residents let staff know how many baths a week they prefer. Short term residents have showers in their rooms which makes it easier to accommodate the preference. RN-B stated she did not ask residents upon admission how many baths a week the resident would like. RN-B stated social services asked about bathing preference upon admission. RN-B stated she did not ask long term residents how many baths a week they preferred. On 7/12/16, at 3:18 p.m., director of social services (DSS)-A stated social services did not ask about resident preference for bathing preference. On 7/12/16, at 3:25 p.m., RN-A stated when RN-B was unable to complete the admission process for residents she filled in. RN-A stated staff usually assigned one bath a week upon admission and administrative assistant (AA)-F assigned which day the resident would receive a bath. RN-A stated asking the resident frequency of bathing was not a formal question she had ever asked upon admission. RN-A stated during the resident's initial care conference, usually within five days of admission, staff asked the resident if they wanted any changes in their plan of care. RN-A stated we are not documenting the frequency of bathing unless there is a concern. On 7/12/16, at 3:35 p.m., AA-F stated she was responsible for the scheduling of baths. AA-F stated she scheduled new admissions a weekly bath unless they want more. AA-F stated staff let her know if a resident requested a change in bathing. On 7/13/16, at 8:36 a.m., the director of nursing	F 242	conferences, with significant change and more often if indicated. During the mandatory meeting August 15, 2016, the nursing staff will be informed of the residents' right to make choice regarding heath care services consistent with his/her interests, assessments, and plans of care including the right to have their bathing preferences respected. Resident number 42 - The RN clinical manager will interview the resident regarding her preferred bathing type and frequency. The resident's plan of care and the nursing assistants' care reference cards will be reviewed and updated as 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. Resident number 43 – The resident is currently in the hospital. Upon her return to the facility, the resident will be interviewed by RN clinical manager regarding her preferred bathing type and frequency. The resident's plan of care and the nursing assistants' care reference cards will be reviewed and updated as necessary to reflect 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 242	Continued From page 3 (DON) stated residents were asked about bathing preferences. The residents are assigned a bath once a week unless they specifically requested they wanted one more often. A policy regarding the choice for frequency of bathing was requested. On 7/14/6, at 7:20 a.m., the DON stated the facility did not have a policy for the choice of bathing.	F 242	be discussed during the routine care conferences. Respect for the resident's right to self-determine and participate in health care decisions as well as their satisfaction with cares will be monitored by the Social Workers during one-on-one interviews, during the routine care conferences, and through feedback from Resident Council meetings. The Life Enrichment staff will continue to ask the resident about the importance of choosing the type of bath as part of the minimum data set completion process. Any care concerns will be communicated to the appropriate department manager/supervisor. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting. Completion date: August 21, 2016	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 244	Regulation 483.15(c)(6) Tag F244 –	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 244	Continued From page 4 review, the facility failed to resolve resident council grievances in regards to nursing, dietary and social service department concerns reported to the facility by the resident council. This had the potential to effect residents who needed assistance with activities of daily living. Findings include: On 7/11/16, at 6:45 p.m., R14 stated the facility did not consistently follow up on grievances raised during resident council. When the resident council made suggestions/raised concerns, facility staff did not consistently get back to the resident that made the complaint. Review of the Resident Council meeting minutes revealed the following grievances: 2/23/16 - Resident council meeting minutes indicated nursing department concerns included taking too long to get ready for bed, overbed table or call light not within reach, not obtaining a nurse upon request, waiting too long to use the bathroom, call light time too long in the morning, overall poor call light response times including staff stating the will be right back and do not come back. It was decided that the nurse manager would meet with staff today at shift change to get this matter addressed quickly and follow up would take place to see if it improved. 3/22/16 - Resident council meeting minutes indicated dietary concerns included a resident not being fed right when assisted, mostly cold food at lunch, wanted soup/none puree, request for pizza, Sundays were always beef and mashed potatoes and residents would like something different.	F 244	Resident and Family Groups Pine Haven Care Center respects and promotes the existence of the Resident Council. The concerns and recommendations of the families and residents are reviewed and taken into consideration during decision-making and the development of policies and procedures affecting resident services. The facility attempts to accommodate the Councils' recommendations to the greatest extent possible. The Resident Council meetings are routinely attended by interdisciplinary care team department managers and the administrator. The Life Enrichment Director/designee facilitates the meetings, writes the meeting minutes, ensures that the appropriate department managers are notified of resident concerns, and tracks resolution of the concerns. The polices and procedures for conducting the Resident Council meetings were reviewed and revised. The meeting agenda and minutes will be expanded to routinely include action plans and follow up to resident concerns. During the August 3, 2016 monthly Quality Assurance and Assessment meeting, the importance of responding to resident concerns and the procedures for addressing resident concerns were reviewed with the department managers. As discussed, the department managers will continue to address/investigate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 244	Continued From page 5 4/26/16 - Resident council meeting minutes indicated nursing concerns included nursing and resident communication about tests/prep, dietary concerns included requests for more variety on Sundays, one resident requested he receive a variety of sandwiches not just egg salad, and social services concerns included privacy concerns which would be addressed with staff. 5/24/16 - Resident council meeting minutes identified nursing concerns including questions about resident death notification. Residents stated they learned of a resident death in the newspaper. Residents further stated were a family here and would like to support each other and families too. There would be a team formed and a plan made for resident notification of death. 6/28/16 - resident council meeting minutes indicated nursing concerns related to obtaining the assistance of a nurse. The nurse manger would follow up on communication between nursing staff. Resident council meeting minutes failed to include documentation of follow up for the concerns identified from 2/23/16 through 6/28/16. On 7/13/16, at 11:11 a.m., activity director (AD)-C stated the managers assigned concerns were supposed to take care of it. Managers were to get back to AD-C with solutions which would be documented in the minutes. AD-C stated the resident council minutes are sent out every month to all managers by email with a reminder to get back to her. AD-C stated if no resolution was documented in the minutes in the last six months the resolution was "probably not there."	F 244	resident concerns; the resolution/findings will be reported during the next Resident Council meeting. The minutes of previous four Resident Council meetings were reviewed to ensure that the residents' concerns/comments were addressed and the findings/resolution communicated and documented. Dave Christianson, Long-term Care Ombudsman, was a guest speaker at the July 26, 2016 Resident Council meeting and reviewed the residents' rights including the right to care and services that meet professional practice standards. During the mandatory meeting August 15, 2016, the staff will be reminded of the resident's right to have concerns reported and addressed in a timely manner and of the expectation that the care will be provided in a timely manner as outlined in the plan of care. Resident rights and tips/suggestions to improve the residents' care and quality of life are included in the monthly staff newsletter. To monitor compliance, the Administrator/Designee will audit the Resident Council minutes for the next three months to assure that residents' concerns are being addressed in a timely manner and that resolutions/responses are being reported to the Resident Council and/or specific residents as appropriate. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 244	Continued From page 6 On 7/13/16, at 2:15 p.m., the administrator stated when grievances were expressed at the resident council meeting, each department manager there at the time of the meeting took the information went back and worked on the concern. AD-C's email should be the second reminder of grievances or concerns to be addressed. Staff was to follow up at the next resident council meeting by each department what they did to resolve the concern. The administrator stated concerns were brought up in the meeting and any resolution would probably be verbal, not written. The administrator stated it was not facility practice to document resolution to the concerns to be reviewed later with residents. The facility policy Resident Council, dated 4/7/09, indicated minutes of the council would reflect all concerns and suggestions addressed and facility response to suggestions.	F 244		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 279	Continued From page 7 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive care plan for the diagnosis of depression for 1 of 5 residents (R44) reviewed for unnecessary medications. Findings include: R44's physician orders dated 7/14/16, identified an order for citalopram (Celexa) (anti-depressant) 40 milligrams once a day. R44's physician progress note dated 4/4/16, identified the diagnosis of major depression and indicated R44's medication regimen included Celexa for R44's depressive symptoms. R44's PHQ-9 (depression test) dated 4/6/16, indicated score NA and the one dated 6/30/16, indicated a score of 7. R44's care plan failed to address the diagnosis of major depression and specific symptoms and interventions. On 7/14/16, at 9:35 a.m., the director of social services (DSS)-A stated she was responsible for monitoring the use pf psychotropic medications. DSS-A reviewed R44's care plan and stated depression was not care planned for R44. DSS-A stated R44 had been on the Celexa since admission and she was not sure what R44's physician progress notes stated about the	F 279	Tag F279 – Comprehensive Care Plans Pine Haven Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services. The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. During the August 15, 2016, mandatory meeting, the staff will be 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents' care plans must be current at all times and 3)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 279	Continued From page 8 Celexa. On 7/14/16, at 10:11 a.m., the director of nursing stated that it was very important to care plan the use of an antidepressant medication. The facility policy Psychotropic Medication Usage, dated 1/23/06, indicated consistent monitoring of all target symptoms will be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy. A facility policy for the comprehensive care plan was requested but not provided.	F 279	instructed that care plans must address depression and related interventions for residents with a diagnosis of depression. The social worker has reviewed the plan of care for resident number 44 and has revised it to include the diagnoses of depression and related goals, treatments, and interventions. To monitor compliance, the social worker will audit the care plans of all residents with the diagnosis of depression to assure that mood symptoms, goals, and interventions are appropriately addressed. Care plans will be revised as necessary. As part of the quarterly care conference process, the interdisciplinary team will continue to review the care plans for completeness, accuracy, and relevancy. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the care plan for	F 282	Tag F282 Services by Qualified Personnel per Care Plan	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	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, the bath needed to be made up as soon as possible. The DON stated she would expect staff to follow the care plan for bathing.	F 282	Pine Haven Care Center provides care and services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicates the resident's care needs to the direct care givers by use of the "pocket care plan" (PCP). The PCPs are routinely updated to reflect revisions in the interdisciplinary plan of care. During the August 15, 2016, mandatory meetings, the nursing staff will be reminded/instructed 1) that the plans of care must be followed 2) that job performance expectations include being aware of and following the resident's plan of care with a focus on nail care, bathing frequency, assisting with transfers and respecting sleep/wake preferences and 3) of the need for monitoring/documenting target behaviors. The orientation for new employees will continue to address the importance of respecting the resident's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	Continued From page 10 R14's current care plan, indicated R14 required assistance for transferring form one position to another related to deconditioning related to low back pain with intervention of provide two persons contact guidance and physical assist using the EZ stand mechanical lift. On 7/13/16, at 7:02 a.m., R14 was observed to be transferred by nursing assistant (NA)-B from R14's bed into R14's wheelchair. NA-B used the EZ stand mechanical lift to transfer R14. NA-B failed to transfer R14 with two assist as per R14's care plan indicated. On 7/13/16, at 8:09 a.m., NA-B stated R14 was to be transferred by one or two assist using the EZ stand lift. NA-B stated it depended on R14's mood if one or two staff assist was used to transfer R14. On 7/13/14, at 8:25 a.m., the DON stated R14 was to be transferred using the EZ stand lift and two assist. R44's current care plan, indicated potential for adverse side effects due to use of antipsychotic medications after traumatic brain injury, long history of psychosis. Interventions included: Evaluate effectiveness and side effects of medications for possible decease/ elimination of psychotropic drugs periodically and observe resident mood and behaviors. The care plan identified the behavior of hallucinations, pulling at strings. On 7/11/16, at 3:40 p.m., observation revealed R44 was sitting in his wheelchair in his room. R44 was observed to be moving his hands back and	F 282	care preferences and following the resident's individualized plan of care. Resident number 43 – The resident's care plan for bathing was reviewed and found appropriate. The direct care staff was informed that the resident's assigned bath day is Saturday morning. If the bath is not given on Saturday, the charge nurse is to be notified. Resident number 14 – The resident's ability to transfer has been reassessed; the resident continues to require two staff to assist with the EZ stand lift. The direct care staff have been informed of the continuing need for two person assist with transfers. The care plan was reviewed and found to appropriately address transferring. Resident number 44 – The resident has a diagnosis of frontotemporal dementia with delusional thoughts. The resident exhibits nearly continual string pulling/hand rolling motions related to parasitosis. Even though the behavior is exhibited very frequently and seems normal for the resident, the direct care staff have been informed that the behavior must be documented on every shift that it is observed. Resident number 45 – As addressed in the care plan, the resident has a life long pattern of going to bed late at night and sleeping late in the morning. The nursing assistants have been instructed to allow the resident to awake naturally; the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	Continued From page 11 forth constantly and then made the motion with his hand of throwing something. At 5:42 p.m., R44 was observed wheeling his wheelchair with his feet in the hallway and moving his hands back and forth. On 7/12/16, at 8:30 a.m., R44 was observed to be sitting in his wheelchair in the dining room being served breakfast. R44's right hand was making a rolling motion. On 7/13/16, at 8:22 a.m., R44 was sitting in the dining room and his hands were moving in a rolling motion. On 7/13/16 at 1:56 p.m., nursing assistant (NA)-C and NA-J stated R44 had a hallucination behavior of pulling strings, but R44 had not had that 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. 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. The facility policy dated 1/23/06, Psychotropic Medication Monitoring, indicated Monitoring Guidelines: III. When anti-psychotic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and the presence of adverse reactions. Nurse reviews the NA behavior sheet and summarizes on weekly routine charting.	F 282	nursing assistant PCP has been updated accordingly. Resident number 53 – The resident's grooming plan of care was reviewed and found appropriate. The direct care staff are aware of the need to provide nail care as part of the resident's routine grooming/bathing procedures. Compliance will be monitored by weekly auditing/observations of the following for one month: 1) resident bathing and transfers–observations to be assigned by the Director of Nurses/designee 2) nail care–observations to be done by the Life Enrichment staff 3) documentation of target behaviors–audits to be conducted by the Social Worker. 4) The interdisciplinary team will review and monitor the resident's PCPs for accuracy related to the comprehensive care plan. If noncompliance is noted additional monitoring and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	Continued From page 12	F 282		

A policy for implementing the care plan was requested and not provided.
R45 has a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Resident was started on Heartland Hospice services on 2/17/16.
R45 care plan dated with last review date of 6/2/16, identified that R45 likes to sleep late, will get up near noon, and decline breakfast, this was her normal pattern at home, offer food drink when she gets up.
Reviewed progress notes from 5/27/16 to 7/12/16, which showed an increase in R45 behaviors including being combative, refusing breakfast, refusing to get out of bed in the morning, refusing morning medications, refusing morning baths, pinching and biting a staff member. These progress notes were written describing behaviors during the morning hours when R45 as well as F-A had identified to the facility that she is not a morning person. In review of progress notes there were three separate notes including from hospice as well as R45 care conference, which indicated that F-A had reported to facility staff that R45 doesn't do well in the morning and cares and visits should be provided in the afternoon hours.
During observations as follows:

7/12/16, 2:29 p.m. getting hair done in beauty shop.

7/12/16, 3:06 p.m. in beauty shop, smiling.

7/13/16, 7:06 a.m. asleep in bed.

7/13/16, at 7:20 a.m. nursing assistant (NA)-G entered R45 room and offered juice and coffee,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	Continued From page 13	F 282		

asked R45 if she could get her up for the day to which R45 replied I don't get up right away. NA-G told R45 what time it was and R45 responded, I don't care. NA-G stated, can I get you dressed and then you can rest and I'll come back to which R45 responded, I don't like to be bothered. NA-G told R45 that she would be back in 10 minutes. NA-G stated, I'll check back in 10 minutes otherwise she'll get in a bad mood.
7/13/16, at 7:34 a.m. NA-G re-approached R45 in her bedroom and again R45 declined to get up. NA-G stated why don't you let me get you changed and began lifting the bed. R45 became upset and stated, don't do that. NA-G offered juice or coffee and asked to open R45 curtains. After this, began raising the bed again and R45 again stated no I just want to lay here for a while.

7/13/16, 8:50 a.m. in bed asleep.

Interview with licensed social worker (LSW)-B on 7/12/16, at 3:10 p.m. identified that she had just become aware of an increase in R45 behaviors on 7/11/16. LSW stated that she hadn't been made aware of this prior to 7/11/16 due to floor staff not checking the 24 hour note text when they are documenting their progress notes.
Interview with nursing assistant (NA)-G on 7/13/16, at 7:13 a.m. stated that she starts to wake R45 up around 6 am and will go in every 15 minutes until she's ready to get up. Continued to state that she gets up anywhere between 6 and 8 in the morning. On 7/13/16, at 8:52 a.m. NA-G stated R45 had again refused to get up so we just fed her in her room and we will try again later.
Interview with NA-G on 7/13/16, at 9:09 a.m. stated she knows how to care for R45 from her pocket care plan (PCP). PCP identified care areas including dining needs, activities of daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	Continued From page 14	F 282		

living (ADL) which specifically identified R45 requiring the assist of 1 for dressing, bathing and pericare BID and PRN. Partial assist of 1 for grooming. PCP identified care for bowel and bladder, transfer, ambulation, devices, orientation sensory, skin care, dentures, activities and comments. Under comments it states, make bed daily, change bed linens weekly, Heartland Hospice, Female Caregivers only. There was nothing noted about R45 preference to stay in bed until noon. NA-G stated she has access to the care plan and showed a binder which had copies of the PCP in the 600 wing nurse's station. NA-G stated these were the only care plans she had access to. NA-G stated R45 usually has behaviors when we get her up in the morning but usually once she is up she is better.

Interview with R45 family (F)-A on 7/13/16, at 9:28 a.m. stated, R45 had never been a morning person and had always like to stay up late into the night watching television. F-A stated that she had spoken often with staff and was very comfortable with R45 not having breakfast but would like R45 up for lunch and supper.

Interview with registered nurse case manager (RN)-B on 7/13/16, at 12:00 p.m. stated she was unaware that the care plan identified R45 should stay in bed until noon and she had never heard R45 family say that. RN-B went on to state mornings are a "terrible idea" for R45 as she does better in the afternoon. RN-B also stated she doesn't do the care plans that another registered nurse (RN)-1 handles the care plans and then RN-1 gives the information to the administrative assistant (AA)-F to complete the PCP for direct care staff.

Interview with RN-1 on 7/13/16, at 12:36 p.m. stated care plans are triggered off of the MDS and she updates sections of the MDS when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	Continued From page 15	F 282		

gets new information. The new information comes to her first and then the AA-F is responsible for updating the PCP that direct care staff utilize when caring for residents. Stated R45 has "never been a morning person, it has always been on the PCP, maybe it was removed by Hospice when they started working with her".
Interview with AA-F on 7/13/16, at 1:43 p.m. stated she gets the information to update the PCP from RN-B. Also stated she gets direct information from the therapy department and from Hospice if changes need to be made. AA-F stated the information was on the PCP but information had been changed when occupational therapy was working with her at meal times.
Interview with director of nursing (DON) on 7/13/16, at 2:29 p.m. stated the PCP should be a reflection of the comprehensive care plan and the expectation is that what is in the care plan would be reflected on the PCP.
Interview with occupational therapy assistant (OTA) on 7/14/16, at 8:21 a.m. stated [R45] was discharged from physical therapy and occupational therapy on 1/29/16.
Policy: Requested a policy concerning care plans but policy was not received.
R53 was admitted to the facility with the diagnosis of diabetes mellitus, according to facility Admission Record.

The significant change Minimum Data Set (MDS) dated 4/7/16, revealed R53's cognition was intact and required extensive assist of 1 staff for personal hygiene which included nail care. R53's care plan dated 1/2/15, directed staff to provide 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 282	Continued From page 16 R53 with long and soiled finger nails. During interview on 7/13/16, at 9:48 a.m., registered nurse (RN)-A verified R53 required extensive assistance with personal hygiene. During interview on 7/14/16, at 8:25 a.m., R53 stated finger her nails were long. During interview on 7/14/16, at 8:40 a.m., director of nursing verified R53's finger nails were long and soiled. She stated she expected nursing staff to provide R53's nail care as needed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify a non-pressure related skin injury for 1 of 3 residents (R53) reviewed for non-pressure related skin. In addition, the facility failed to ensure that 1 of 1 resident (R45) receiving hospice services had a coordinated plan of care between facility and hospice agency which was communicated to direct care staff. Findings include:	F 309	Regulation 483.25 Tag F309 - Provide Care/Services for Highest Well-being Pine Haven Care Center provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 309	Continued From page 17 R53 was observed on 7/11/16, at 3:27 p.m., with a skin tear on the right wrist, approximately one by one centimeter, open to air and no drainage noted. R53 stated he bumped into something. The Admission Record identified R53 was admitted to the facility with diagnoses that included diabetes mellitus and atrial fibrillation. The significant change Minimum Data Set (MDS) dated 4/7/16, noted R53 to have intact cognition, required limited assistance of one staff for bed mobility and transfer, supervision with set up help for walking in room, walking in hall and locomotion on the unit, and required extensive assist of one staff for toilet and personal hygiene. R53's care plan dated 1/2/15, identified a risk for alteration in skin integrity related to nutritional deficit, cognitive impairment, presence of former jejunostomy tube, diabetes and received anticoagulant therapy. Interventions included staff to observe for changes in skin integrity daily with cares and notify the nurse as needed, and nurse to proceed as indicated. On 7/13/16, at 7:43 a.m., licensed practical nurse (LPN)-A stated R53 received wound treatment to the former jejunostomy tube sight. LPN-A further stated there were no other wound treatments for R53. On 7/12/16, at 11:40 a.m., nursing assistant (NA)-B stated she had assisted R53 with morning cares and identified R53 had no skin issues. On 7/13/16, at 12:13 p.m., R53 sat on the edge of bed, feeding himself lunch. The right outer wrist wound was approximately two centimeters with	F 309	each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. The residents' needs including end-of-life care and hospice services as well as cares to preserve skin integrity and treat skin problems are identified and a plan of care developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments. The policies and procedures for identifying, reporting, investigating, monitoring and communicating open areas and other skin lesions were reviewed and found appropriate. A licensed nurse evaluates the resident's skin condition on a weekly basis. Residents with open skin areas are reviewed weekly by the interdisciplinary care team; the nurse practitioner/physician is notified of concerns regarding nonhealing or worsening of skin lesions. On August 4, 2016, the Director of Nursing and the Heartland Hospice agency nurse coordinator addressed the current procedures for coordination of care between the facility and the hospice staff as well as implementation and documentation of the coordinated efforts. Options for notifying the facility staff about which hospice staff will visit the resident, when the visits will occur, and what cares/services will be provided as well as the process for notifying the facility of changes in the hospice staff visitation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 309	Continued From page 18 an open, dry wound bed. The skin tear was without a dressing and had no drainage. At 2:25 p.m., the right outer wrist wound remained uncovered. R53 stated he bumped himself and denied pain. On 7/14/16, at 8:25 a.m., R53's right outer wrist wound had two steri-strip tapes in place. The wound had a dark brown surface with no redness or drainage. 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. Document review of facility Skin Ulcer policy review dated 5/4/09, revealed "D. Monitor Skin Integrity. Skin will be observed daily during cares done by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. R45 was started on hospice services on 2/17/16. 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 multiple systems failure. R45's care plan with a revision date of 6/2/16, identified comfort care guidelines for resident's that no longer wish to be hospitalized for a significant change in condition. In collaboration with the hospice agency will provide hospice services to resident and family. Refer to hospice	F 309	schedule were discussed. During the August 15, 2016 mandatory nursing staff meeting, instruction will include the need to observe for skin lesions and the importance of appropriately identifying, reporting, documenting, monitoring and treating skin lesions. Procedures related to the above will be reviewed as well as developing care plans to monitor/treat/prevent pressure related and other skin lesions. Instruction will be provided to the nursing assistants on the need to be alert to skin injuries/lesions and to immediately report the findings to the licensed nurse. Observing and reporting the resident's skin condition will continue to be part of the nursing assistant's bathing protocol. During the August 15, 2016 meeting, the staff will also be informed of the process for coordinating care between the facility and hospice staff including the hospice procedures for notifying the facility of who (Nurse, CNA, Social Worker, etc.) will be visiting the resident, when the visits will be made, and what care/services the hospice staff will provide as well as how changes in the schedule will be communicated. Resident number 53 – A licensed nurse assessed the resident's skin July 12, 2016 at which time a 1.5 cm skin tear was identified on the resident's right wrist; steri strips were applied. A July 18, 2016 nurse's note stated that the skin tear was healed. The care plan was reviewed and revised to reflect history of and risk for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 309	Continued From page 19 interdisciplinary care plan and documentation notes in hard copy of chart for current updates 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 aide (HHA)-I indicated a hospice aid was present at the facility twice a week to provide showers for R45 and a nurse was present twice a week. HHA-I stated following her visits she filled out a form for the care provided and left a copy with the facility. HHA-I stated she communicated with either the licensed practical nurse (LPN) or registered nurse (RN) who was in charge on the day of her visit. On 7/12/16, at approximately 1:45 p.m. trained medication aid (TMA)-D stated she knew R45 was on hospice because it was on the pocket care plan (PCP). TMA-D stated she found out when hospice was coming when they arrived at the facility. On 7/12/16, at approximately 1:50 p.m. LPN-C stated there was a calendar in R45's room that identified when hospice was coming. LPN-C stated the hospice care plan and notes were accessible in PointClick care (facility documentation system). On 7/13/16, at 9:09 a.m. nursing assistant (NA)-G 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) which stated assist of 1 for dressing, bathing and pericare BID (twice daily) and PRN (as needed), partial assist of 1 for grooming. The PCP identified care for bowel and bladder, transfer, ambulation, devices, orientation sensory, skin care, dentures, activities and comments. Under comments the PCP stated make bed daily,	F 309	skin tears. Resident number 45 – The Director of Nursing and the resident's hospice nurse care coordinator have discussed the coordination services between the facility and hospice staff. The resident has a coordinated plan of care in his record describing the types of services that will be provided by the hospice agency staff, the schedule for the services, and what staff will be providing the service (aide, nurse, social worker, etc.). The hospice agency will notify the facility of any changes in the visitation schedule/plans which will then be communicated to the staff. The care plan was reviewed and found appropriate. To monitor compliance with hospice visit schedules, a random audit of records of hospice residents will be done for two weeks to determine if the visits followed the documented schedule and, if not, whether the facility staff was notified of the change. If noncompliance is noted, the hospice agency administrative staff will be notified and additional auditing will be done. To monitor compliance with the identification of new skin problems, a licensed nurse will observe the resident's skin condition weekly. The Director of Nurses/designee will review the skin audit reports for seven days to assure appropriate follow up to acute problems. If there is evidence that skin problems are not identified in a timely manner, or if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 309	Continued From page 20 change bed linens weekly, hospice, and female caregivers only. There was nothing noted about what cares were provided to R45 from the hospice agency. NA-G stated she had access to the care plan through a binder at the 600 wing nurse's station which had copies of the PCP. NA-G stated these were the only care plans she had access to. On 7/13/16, at 10:19 a.m. the hospice agency registered nurse patient care coordinator (RN)-J stated there was a care plan in the front of R45's hard chart that listed what activities of daily living (ADL) hospice was responsible for on their visits. The hospice care plan was integrated into the facilities care plan. RN-J stated the hospice schedule was located in the front of R45's hard chart. This was the schedule the facility should be following when instructing their staff of visiting times. If changes were made, hospice would notify the facility of these changes. On 7/13/16, at 12:00 p.m. RN-B stated she never really knew when the hospice nurse was going to be at the facility, but it was usually Thursday. RN-B verified the hospice schedule was in the front of R45's hard chart which identified the hospice aid was at the facility on Monday of each week and the RN came on Tuesday of each week. The schedule was dated 2/17/16, which was the day R45 started on hospice services. RN-B stated that whenever hospice was at the facility they communicated their visit with floor nurses as well as herself. They also left a copy of their visit notes in the hard chart. RN-B verified there was a nurse's note in R45's hard chart weekly for the past 30 days. On 7/13/16, at 2:29 p.m. the director of nursing (DON) stated hospice spoke directly to the direct care nurse and nurse manager when in the facility. Any changes hospice made should be	F 309	appropriate follow up is not documented, additional auditing and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 309	Continued From page 21 added to the pocket care plan (PCP). The DON further stated when information was relayed to a member of the direct care staff this should be passed on to the charge nurse. The charge nurse would pass information along in daily reports at shift change. The DON went on to state that each morning there was report at 9:00 a.m. for members of the interdisciplinary team. The nurse gave a verbal report of any new information from the last 24 hours as well as any notes entered into the PointClick care system for the last 24-72 hours. The undated facility policy for Coordination of a Resident Receiving Hospice Services stated, "If care is provided by the hospice in the facility, the hospice and the nursing home are jointly responsible for developing a coordinated plan of care guiding both providers based on assessed needs and goals. The coordinated care plan will identify which provider is responsible for the various aspects of care and updated according to State, local and Federal regulations". The policy did not address how the information would be communicated to direct care staff within the facility.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 312	Regulation 483.25(a)(3) Tag F312	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 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 extensive assistance with personal hygiene. During interview on 7/14/16, at 8:25 a.m., R53 stated the finger nails were long. During interview on 7/14/16, at 8:40 a.m., the director of nursing verified R53's finger nails were long and soiled. She stated she expected nursing staff to provide R53's nail care as needed.	F 312	Activities of Daily Living Care Pine Haven Care Center provides the necessary services to maintain good nutrition, grooming, personal care and oral 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 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. During the mandatory meeting August 15, 2016, the nursing staff will be 1) reinstructed on the facility's policies for providing personal hygiene to the residents 2) reminded that their job description requires knowledge of and responsibility for following the resident's plan of care and 3) instructed on the importance of providing nail care. The need to provide cares as necessary to improve/enhance the residents' appearance, comfort, and dignity will be emphasized. The grooming plan of care for resident number 53 was reviewed and found appropriate in addressing the resident's personal care needs. The direct care staff are aware of the need to provide nail care as part of the routine grooming/bathing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 312	Continued From page 23	F 312	procedures. The Life Enrichment Director/designee will be responsible for monitoring compliance 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 done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to treat identified pressure ulcers and prevent further pressure ulcers from developing for 1 of 1 resident (R62). Findings include: R62's admission record, dated 3/15/16, indicated	F 314	Tag F314 – Prevent/Heal Pressure Sores Based on the comprehensive assessment, Pine Haven Care Center staff ensure that residents who enter the facility without pressure sores do not develop pressure sores unless the	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 314	Continued From page 24 that the resident had diagnoses of repeated falls and a fracture of the upper end of the left humerus (long bone running from the shoulder to the elbow). R62's care plan, dated 3/15/16, indicated the resident was at risk for an alteration in skin integrity related to her immobility and incontinence. There were a number of interventions provided with the goal in mind that R62 would maintain her skin integrity. R62's care area assessment (CAA), dated 7/8/16, indicated that the resident currently had a 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	F 314	resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services 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 risks 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 residents' skin condition and risk factors were reviewed and found appropriate. An evaluation of the resident's skin condition, skin risk factors, and tissue tolerance will continue to be completed at the time of admission, readmission from the hospital, 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 monitored and measured on a routine basis and 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 314	Continued From page 25 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 on at all, she stated 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 consisted of pudding, a bowl of cream of wheat, toast, a cup of milk, a cup of juice, a cup of coffee. R62 also had a cup of water at her table. NA-D stated this was all that was served for R62's meal. When interviewed on 7/13/16 at 8:32 a.m., licensed practical nurse (LPN)-D was asked what interventions were in place to prevent the recurrence of pressure ulcers for R62. LPN-D stated R62 was given the air mattress on 6/21/16. She stated that the air mattress was initiated for R62's coccyx area and R62 complained of a lot of stiffness when she went to bed. LPN-D stated that it looked like the mattress was started then but R62 had a care conference meeting on 6/22/16 and the resident was very upset about the air mattress. R62 did not want to use it. LPN-D stated that maybe something else should be tried to alleviate pressure. When interviewed on 7/13/16 at 11:42 a.m., trained medication aide (TMA)-D stated supplements were served by the nursing assistants and nursing staff would document that it had been served. Both NA-D and TMA-D identified where the dietary staff would drop the supplements off in the fridge on the unit which were then to be delivered to the resident's. They explained that the dietary staff would put a printed label on each supplement which directed which	F 314	During the August 15, 2016 mandatory meeting, the nursing staff will be reinstructed on the facility's skin related policies and procedures. Discussion will include the need to 1) complete weekly monitoring and documentation describing the healing/nonhealing of open lesions 2) implement skin-related nursing practices and clinician ordered interventions and 3) monitor the effectiveness and resident acceptance of the interventions. The staff will be reminded to notify the clinical manager if the resident chooses not to follow the recommended plan of care. Resident number 62 – Recent skin assessments indicate intact skin with occasional blanchable redness on coccyx. The resident's air mattress has been discontinued at her request; use of a wheelchair ROHO pressure reduction cushion continues. The resident is receiving a dietary supplement due to risk of weight loss. The care plan has been reviewed and revised. Compliance will be monitored by the Administrator/designee by 1) auditing the orders for supplements to assure that the dietary department is aware of the order and is delivering the ordered supplement to the nursing care area and 2) reviewing the use of pressure reduction mattresses to assure proper use/function and resident acceptance. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 314	Continued From page 26 resident the supplement went to. Observation of the supplements in the refrigerator on the unit revealed that R62 did not have a supplement with her name on it. When interviewed on 7/13/16 at 11:50 a.m., TMA-D stated that she had just spoken with the dietary staff who stated they never received an order to provide a supplement to R62. Licensed Practical Nurse (LPN)-A verified there had been a break in communication between the nursing staff and dietary. The dietary department never received the order to provide the supplement. When interviewed on 7/13/16 at 1:49 p.m. LPN-D stated when a resident developed a pressure ulcer, a plan of care would be developed. The nurse manager would assess the pressure ulcer on a weekly basis and would determine if any new interventions needed to be implemented. LPN-D stated she was removing the air mattress from R62's bed as she did not know that the air mattress was not being inflated. When interviewed on 7/14/16 at 8:41 a.m., the dietary manager stated that she never received an order from the nursing department that R62 was to receive a supplement with meals. When interviewed on 7/14/16 at 9:49 a.m., registered nurse (RN)-B stated that there had been a breakdown in communication which resulted in R62 not receiving the ordered supplement with meals. RN-B further stated they tried an air mattress on R62's bed in June in order to try and prevent pressure ulcers. A day later they held a care conference and the resident stated she did not like the air mattress. RN-B explained to R62 that she wanted her to try it for a	F 314	and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 314	Continued From page 27 couple more days to see if she changed her mind. RN-B explained the nursing staff did not report back to her that the air mattress had not been turned on as R62 did not want to use it. When interviewed on 7/14/16 at 1:23 p.m. the director of nursing (DON) stated she would have expected the nursing staff to be notified that the resident had been declining the use of the air mattress on her bed. The DON further stated she expected the dietary department would have been notified in order to provide R62 with the supplement with meals. Review of the facility policy updated on 5/4/09, Skin Ulcers, advised to notify the dietary department when a pressure ulcer was identified.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 329	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 regimen included Celexa for R44's depressive symptoms. R44's medication administration record dated 7/16, identified R44 was receiving the medication as prescribed. R44's PHQ-9 (depression test) dated 4/6/16,	F 329	483.25(l) Tag F329 Unnecessary Drugs Pine Haven Care Center staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible. Pine Haven Care Center staff ensure that 1) residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record and 2) residents who use psychotropic drugs receive gradual dose	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 329	Continued From page 29 indicated score NA and PHQ-9 dated 6/30/16, identified a score of 7. R44's care plan did not address the diagnosis of major depression. R44's record failed to identify specific symptoms and interventions for the diagnosis of depression. On 7/14/16, at 9:35 a.m., the director of social services (DSS)-A stated she was responsible for monitoring the use pf psychotropic medications. DSS-A reviewed R44's care plan and stated there was no depression care plan for R44. DSS-A stated R44 had been on the Celexa since admission and she was not sure what R44's physician progress notes stated about the Celexa. DSS-A stated the increase in PHQ-9 scores was because R44 said he felt depressed a little bit, and indicated he slept too much. DSS-A stated she had not seen a mood change in R44. On 7/14/16, at 10:11 a.m., the director of nursing (DON) stated it was very important to care plan the use of an antidepressant medication. The DON stated she concerned, and believed there needed to be a more thorough review of medications. The facility policy dated 1/23/06, Psychotropic Medication Usage, indicated consistent monitoring of all target symptoms will be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy. R47's admission record, dated 2/24/14, indicated that the resident had a diagnosis of dementia with Lewy bodies. R47's medication review report, dated 2/15/16,	F 329	reductions with attempts to manage behaviors using nonpharmacological interventions. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during their routine 30/60 day visits and more often as indicated. Based on the resident's comprehensive assessment, Pine Haven Care Center staff routinely identify target behaviors and mood symptoms that justify the use of psychotropic medications. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use, that related target behavior/mood symptoms are identified and monitored, and that assessments are completed as indicated. On August 2, 2016, the Consultant Pharmacist, Director of Nursing, and Social Workers met to review the regulations related to the use of psychotropic medications. The policies and procedures related to the administration of psychotropic medications and medications used to treat insomnia were reviewed and revised.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 329	Continued From page 30 indicated the resident had been prescribed Trazodone (antidepressant) for insomnia. He was to receive 50 mg (milligrams) at bedtime. R47's care plan, dated 10/23/15, indicated that the resident had trouble sleeping, staying asleep, getting to sleep and getting back to sleep. The care plan directed to establish a calm, quiet and soothing environment prior to an established bedtime and interview the resident regarding what the resident did at home to establish a restful sleep. This was to be incorporated in to the care plan on admission. R47 was to take medications as ordered to promote sleep. The staff were to perform a monthly sleep log while on medication and as needed. The care plan also recommended a periodic sleep assessment by licensed staff. R47's undated sleep assessment, identified he had been told he snored. The bottom of the document indicated the resident had symptoms which could be related to sleep apnea. In handwritten documentation, it stated the resident woke at night occasionally, and he had days and nights mixed up according to R47's former facility. R47's 24 hour sleep log, dated 6/4/16 through 6/10/16, had three days that were not completed. Of the remaining days, two nights showed R47 did wake up over the night and went back to sleep. When interviewed on 7/14/16 at 10:17 a.m., registered nurse (RN)-B stated the facility did a 7 day sleep log to monitor sleep. She stated that the facility would only do a sleep assessment upon admission to the facility. She stated that information taken from the original sleep	F 329	The daily behavior log will continue to be used to track 1) target behaviors justifying the use of antipsychotic medications 2) interventions to modify behavior and 3) the effectiveness of the interventions. Mood symptoms related to the use of antidepressant medications will be addressed in the care plan and discussed at least quarterly at the resident's care conference. During the mandatory meetings on August 15, 2016, the licensed nursing staff will be instructed on 1) the documentation procedures for tracking target behaviors as well as related interventions and their effectiveness 2) addressing target behaviors/mood symptoms in the care plan and 3) the new procedures for tracking sleep/wake patterns, conducting sleep assessments and documenting nighttime sleep habits. The direct care staff will be reminded of the importance of being observant for behavior/mood symptoms and reporting symptoms to the charge nurse in a timely manner. Resident number 44 – The care plan has been updated to address the diagnosis and symptoms of depression. The Social Worker will complete a depression screen questionnaire every 90 days and with a significant change in condition. The physician will be contacted if there is an increase in symptoms of depressed mood. The care plan will be reviewed and revised as necessary. Resident number 47 – The resident's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 329	Continued From page 31 assessment was put into a monthly sleep log. R47's sleep log review notes, from 2/16 through 7/16, stated the resident was awake all day and slept all night. R47 slept a majority of the night. It stated he did have a period where he was awake for an hour or two at night but able to get back to sleep. It further stated he napped a few times during the day. 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. 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. Review of the facility document dated 4/22/09, Insomnia Assessment, advised staff to assess the cause of insomnia before initiating the use of hypnotic sleeping medications. It stated a sleep assessment and sleep log would be completed upon admission, sleep pattern change or complaints of insomnia, pre administration of ordered sleeping medications, and 7 days after discontinuing sleep medication. The 3 day sleep log would be documented according to acute charting.	F 329	sleep/wake patterns will be tracked for three days after which a registered nurse will review the data and complete a sleep assessment. A licensed nurse will continue to document on the resident's sleep quality/patterns weekly. The nurse practitioner/physician will be notified of any ongoing problems with insomnia. The resident's care plan has been reviewed and updated accordingly. To monitor compliance, the Director of Nurses/designee will review the records of residents receiving medications to treat insomnia to ensure appropriate sleep tracking/assessments have been completed. The Medical Record Coordinator will review the records of new admissions for next 90 days to assure admission sleep tracking logs and assessments are completed in a timely manner. To further monitor compliance the Social Workers will audit the care plans of all residents with the diagnosis of depression to ensure that depression and related mood indicators are addressed. During the consultant pharmacist's monthly medication audits and the quarterly care planning process, the residents' medication regimen will continue to be reviewed to assure that medications used to manage mood and insomnia are appropriate and are monitored. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 329	Continued From page 32	F 329	and Improvement Committee meeting.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were offered for 2 of 3 residents (R53, R47) reviewed for dental services and who had oral concerns. Findings include: R53 had diabetes mellitus, according to the facility Admission Record. Observations on 7/14/16, at 8:40 a.m., revealed R53 had missing teeth on the lower right and lower left of his mouth. R53 stated he had not seen a dentist for years. At that time, the director of nursing (DON) verified the missing teeth. Document review of significant change Minimum Data Set (MDS) dated 4/7/16, revealed R53's cognition was intact and he required extensive	F 412	Regulation 483.55(b) (Tag F412) Routine/Emergency Dental Care Pine Haven Care Center routinely assists the residents in obtaining routine and emergency dental services. The facility assists the resident in making appointments and arranging for transportation to and from the dentist's office. The family is notified of lost or damaged dentures and resident is referred to a dentist as appropriate. The policies and procedures related to dental assessments and referrals has been reviewed and revised. A new oral assessment form will be implemented. The need/desire for a dental referral will be routinely discussed during the annual care conferences and more frequently if	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 412	Continued From page 33 assist of one staff for personal hygiene which included brushing teeth. The MDS identified no tooth fragments, no abnormal tissue, no cavity or broken teeth, no bleeding gums, and no pain or difficulty chewing. Document review of R53's oral assessment dated 4/7/16, revealed the last dental exam was many years ago and he had some lost teeth. R53's care plan revised dated 4/12/16, directed R53 required assistance with oral care and interventions included set up supplies for oral care within reach, assist as needed. Interventions also included offer to set up dental appointments, refer to dentist as needed and staff provide oral hygiene at least two times a day and as needed. During interview on 7/12/16, at 11:40 a.m., nursing assistant (NA)-B stated R53 preferred morning cares after breakfast and oral care one time daily at bedtime. NA-B stated R53 brushed his own teeth at bedtime. During interview on 7/14/16, at 1:30 p.m., nursing assistant (NA)-D stated R53 required assist of one staff to set up supplies for oral care. NA-D stated R53 brushed his own teeth. During interview on 7/14/16, at 1:30 p.m., registered nurse (RN)-B verified the lack of evidence of offering R53 dental services for missing teeth. R47's admission record, dated 2/24/14, indicated the resident had a diagnosis of dementia with Lewy bodies. R47's annual Minimum Data Set (MDS), dated 5/5/16, indicated the resident was moderately impaired cognitively.	F 412	there are complaints of mouth pain or chewing problems. The option of contracting with Apple Tree Dental to provide on-site dental care is being explored. During the August 15, 2016 mandatory staff meeting, the following will be discussed: 1) any resident who has difficulty chewing or complains of mouth pain or other dental related problems should be assessed to determine the need for referral to the physician or dentist 2) the implementation of the revised oral assessment form and 3) the need to offer a dental referral at least annually. Resident number 53 – The resident is receiving hospice services; there have been no complaints of mouth pain or difficulty chewing. During the resident's July 20, 2016 care conference, the family declined an offer for a dental referral stating that they want a dentist appointment only if there is an issue. The care plan has been updated accordingly. Resident number 47 – An oral assessment was completed by a registered nurse August 5, 2016. The resident had no complaints of pain or problems chewing. The resident did/did not wish to see a dentist –"teeth aren't paining me." The resident's oral status will be discussed with his wife; a dental referral will be addressed. The care plan has been reviewed and revised. To monitor compliance, any resident who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 412	Continued From page 34 On 7/12/16 at 9:32 a.m., R47 stated his teeth were beginning to deteriorate and starting to decay. He stated it had been over a year since he had been to the dentist. Upon observation, R47 was noted to have multiple missing teeth on the upper right side of his mouth. R47 stated the staff had not offered him a dental appointment. R47's last oral assessment, dated 5/4/16, stated it was unknown when the last time he had a dental exam was. It recommended no immediate referral to a dental professional. R47's nutritional assessment, dated 6/14/2016, indicated that he had his own teeth. R47's medical record indicated that he had last been to a dentist on 2/24/14. At that time, R47 had dental concerns which required a tooth extraction. 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. On 7/14/16, at 9:38 a.m., registered nurse (RN)-A stated residents received an annual oral assessment. If they had problems they would be offered a dental appointment. She stated dental issues were not brought up at every care conference. If someone was noted to have a problem the physician would be notified. She stated they have to request an appointment unless an issue would come up.	F 412	indicates mouth pain on the MDS assessment will be reassessed for the need for a referral to the physician or dentist. The need for a dental referral for other residents will be addressed at the resident's next routine care conference. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 412	Continued From page 35 On 7/14/16, at 1:11 p.m., the director of nursing (DON) stated that she expected nursing staff to offer a dental appointment at least every six months to a year. Review of the document dated 1/13/06, Assessment, it stated that oral assessments would be done upon admission and quarterly.	F 412		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1 of 7 residents	F 425	Regulation 483.60(a)(b) Tag F425 – Pharmacy Services	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 425	Continued From page 36 (R14) received a lidocaine patch by licensed staff qualified staff, failed to ensure a prescribed medication was documented by the licensed personnel that had administered the medication and to ensure a prescribed medication was not left unattended by qualified medication staff. Findings include: R14 was observed on 7/13/16, at 7:02 a.m., when nursing assistant (NA)-B was observed to apply a medication patch to the middle lower back of R14. The medication patch had the initials of licensed practical nurse (LPN)-A and the date of 7/13/16. NA-B stated the medication patch was a lidocaine patch. NA-B confirmed the initials on the patch were LPN-A's initials. NA-B confirmed she was not a trained medication aide. NA-B stated LPN-A had left the medication patch in the room for her to apply. NA-B stated typically the medication patch was left in the room for the nursing assistant to apply. R14's physician orders, dated 7/14/16, identified an order for icy hot pad five percent, apply to low back topically one time a day for pain and two times a day as needed. R14's medication administration record (MAR), dated 7/16, identified the initials of NA-A as being the person who administered the icy hot medication patch. On 7/13/16, at 8:05 a.m., LPN-A confirmed she was the person who initialed the icy hot medication patch and left the patch in R14's room for the nursing assistant to apply. LPN-A stated we usually have the nursing assistants apply the patch, as R14 likes it when the nursing assistants	F 425	Pine Haven Care Center provides pharmaceutical services (including procedures that ensures the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services within the facility and to guide development and implementation of pharmaceutical services and procedures. Persons authorized to administer medications must meet related state and federal requirements. The medication administration policies and procedures have been reviewed and found appropriate. The Consultant Pharmacist routinely provides training to the nursing staff on medication administration procedures and techniques. The next training session by 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 medications, that the nurse/trained medication aide who administers the medication must document its administration, that the person initialing a skin patch must be the person who applies it, and that medications are not to be left unattended with the resident unless the appropriate assessments, clinician orders, and care planning for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 425	Continued From page 37 apply the patch. LPN-A stated the patch had been applied by the nursing assistants since she had worked at the facility for 1 and ½ years. LPN-A stated she would imagine it would be care planned that way because that was how it has always been done. On 7/13/16, at 8:18 a.m., NA-A, who was a trained medication aide, confirmed she had initialed for R14's icy hot medication patch. NA-A stated I did that because I got the medication patch out for LPN-A who put the patch on. On 7/13/16, at 8:25 a.m., the director of nursing (DON) stated the policy of the facility was staff had to be a trained medication aide or a nurse to administer medication. The DON stated medications were not to be applied by a nursing assistant. The DON stated the policy of the facility was the person initialing for the medication was to be the person administering the medication. On 7/13/16, a t 12:45 p.m., the DON stated she expected medications were never left unattended unless the resident had been assessed to be able to self-administer the medication. The DON stated R14 was not able to self-administer medications. The facility policy dated 2/15, Medication Administration General Guidelines, indicated medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly orientated to the facility's medication distribution system. Preparation 1) Medications are prepared only by licensed nursing, medical,	F 425	self-administration of medications have been completed. The Icy Hot patch ordered for resident number 14 will be applied by staff authorized to administer medications. To monitor compliance, the Clinical Manager will observe for correct application of the Icy Hot patch for resident number 14 and for any other resident with an order for an over-the-counter analgesic patch. If noncompliance is noted additional observations and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 425	Continued From page 38 pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications. B. Administration 7) The person who prepares the dose for administration is the person who administers the dose. 14) Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self -administration of medications. D. Documentation (including electronic) 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 431	Continued From page 39 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview facility failed to ensure that all medications were properly labeled and within proper outdates. Findings include: Observation: Observation of medication cart and medication room on the 600 wing was completed on 07/11/16, 5:00 p.m. with trained medication aid (TMA)-A. Upon observation of medication cart found a bottle of Senna syrup prescribed to (R50) with the directions to give 10 ml (milliliters) per g-tube daily as needed with an expiration date of 4/2016, Loperamide also prescribed for (R50) 20 ml per J (jejunostomy) tube for first loose stool and 10 ml after with expiration date of 6/2016. Senna tablets prescribed to (R45) give one tablet by mouth three times daily as needed with expiration date of 6/2016. Upon observation of medication room refrigerator found facility stock medication, Aplisol (a tuberculin derivative) injection 1 ml which was 1/4 of the way full with a lot #772984 that had an open date of 5/27/16 and outdated 30 after opening or June 26, 2016. Acetaminophen that was prescribed to (R22) 650	F 431	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 facility staff to coordinate pharmaceutical services and guide the development and implementation of related policies/procedures to ensure the accurate 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 with currently accepted professional principles and standards and that all drugs and biologicals are stored in a secure, locked location with access only by authorized personnel. Outdated and expired drugs and biologicals are routinely discarded	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 431	Continued From page 40 mg suppository, insert one suppository per rectum every six hours as needed with an expiration date of 4/2016 and Bisacodyl prescribed to (R50) suppository 10 mg (milligram), insert one suppository rectally daily as needed with an expiration date of 4/2016. Observation of medication cart and medication room on the 300 wing was completed on 7/11/16, at 5:29 p.m. with licensed practical nurse (LPN)-B. Upon observation found Quetiapine which was prescribed to (R47) 50 mg with an expiration date of 5/22/15, Tylenol prescribed to (R14) give two tablets by mouth three times daily as needed with an expiration date of 12/2015, Ultram prescribed to (R14) 1 tablet by mouth four times daily as needed with an expiration date of 8/2015. Observation of medication cart and medication room on the 500 wing was completed on 7/11/16, at 6:00 p.m. with trained medication aide (TMA)-C. Upon observation found a stock Nitrostat 0.4 mg with an expiration date of 7/2015. This medication was administered to (R60) on 6/27/16 according to facility documents. Robitussin prescribed to (R49) 5 ml by mouth every six hours as needed with an expiration date of 3/2016, Stock supply of Tums with expiration date of 5/2016. Milk of Magnesia prescribed to (R37) give 30 ml by mouth daily as needed with an expiration date of 4/2016, Nitrostat prescribed to (R29) place one tab under tongue every five minutes for three doses with an expiration date of 7/2015, Novolog prescribed to (R17) inject 10 units subcutaneous per sliding scale which had an open date of 6/11/2016 and artificial tears prescribed to (R32) one drop in left eye four times a day with an expiration date of 2/2015. Found medication bottles including Vitamin B12 and Bone builder for (R42) that had no resident	F 431	according to accepted practice standards. The medication related policies and procedures were reviewed and found appropriate. According to facility policy 1) if there is a change in medication administration instructions, an adhesive sticker stating “Directions Changed Refer To Chart” will be applied to the medication container to alert the staff to refer to the medication administration record for changes and 2) expiration dates are to be checked before administering medications/biologicals. During the mandatory meeting August 15, 2016, the nurses and trained medication assistants will be reinstructed on 1) the importance of medication label accuracy and the procedure for attaching notification labels to the containers when there is an order change 2) the need to check expiration dates before administering medications/biologicals 3) the policy for disposing of outdated medications/biologicals as well as those that have unreadable labels or are mislabeled/unlabeled. The labels of all medications/biologicals were checked for expiration dates, completeness and readability. Continued compliance with the disposition of outdated medications/biologicals and those that are mislabeled/unlabeled will be monitored monthly by Director of Nurses/designee - staff member authorized to administer medications and the consultant pharmacist. To monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 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 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 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 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 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 the needle. RN-C started to prime the pen with 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. Interviews:	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 medication administration record. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 431	Continued From page 42 Interview with TMA-A on 7/11/16, at 5:00 p.m. verified expiration dates of medications. TMA-A stated if an expired medication is found it would be removed from the medication cart/medication room, would be re-ordered and the director of nursing (DON) would be informed. Interview with LPN-B on 7/11/16, at 5:29 p.m. verified expiration dates of medication and stated that another LPN on the night shift is supposed to be going through all the carts and medication rooms looking for expired medications. LPN-B verified that if an expired medication is found that it should be removed from the medication cart/medication room so that it isn't given to any residents. Interview with TMA-C on 7/11/16, at 6:00 PM verified expiration dates of medications and verified missing resident identifying labels and stated that all medications should be labeled with resident name and that any medications without a label should not be given. TMA-C stated the expired medications should have been removed and placed in a bin in the medication room as well as the DON should have been notified. TMA-C verified that expired medications should not be administered. Interview with RN-C on 7/12/16, at 9:21 a.m. verified the labels on the insulin pens and vials were incorrect. RN-C stated when an order is changed by the doctor that a label change sticker should have been placed over the existing label as soon as the order was changed. Interview with DON on 7/13/16, at 2:24 p.m. stated that staff should be checking for expired	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 431	Continued From page 43	F 431		

medications every time they are administering medications and the expectation when finding expired medications is that they are pulled out of circulation, placed in medication room, sent back to pharmacy, reordered, notify family if needed. DON verified that label change stickers should be placed immediately once the order has changed. DON verified that nursing staff had received training on the proper use of insulin pens. DON reported that staff received training at least once a year related to insulin pen usage.

Record Review:

DON provided the staff training information that was presented to nursing staff on the proper use of insulin pen administration. Training documentation titled, "Insulin Pen Administration" identifies, "it is possible for small amounts of air to collect in the cartridge with normal use. To avoid injecting air, an "airshot" is performed before each injection. Turn the dose selector to 2 units. Hold the pen pointing the needle up, press the push-button all the way in until the dose selector shows 0. You should see a drop of insulin at the tip of the needle. DON provided a list of nursing staff who had received training on the proper use of insulin pen and RN-C is documented to have received training on 12/30/2015.

Manufacturer's guidelines for Long-Acting Lantus Insulin was provided by the DON. Manufacturer's guidelines identify to perform a safety test prior to injecting insulin. This test is performed by dialing a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 431	Continued From page 44 the injection button all the way in and check to see that insulin comes out of the needle. Policy: Specific Medication Administration Procedures policy dated February of 2015 states check expiration date on package/container before administering any medication. Medication Ordering and Receiving from Pharmacy policy dated February of 2015 identifies If the physicians's directions for use change or the label is inaccurate, the nurse may place a "directions changed-refer to chart" label on the container indicating there is a change in directions for use. Resident-specific nonprescription medications that are not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name. Medication storage in the facility policy dated February of 2015 identifies that outdated medications are immediately removed from inventory. The nurse will check the expiration date of each medication before administering it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 441	Continued From page 45 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to implement an infection control program which included analysis of collected data to determine interventions to prevent the spread of infection. This had the potential to affect all 51 residents who resided in the facility. Findings include:	F 441	Regulation 483.65 Tag F441 – Infection Control Pine Haven Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 441	Continued From page 46 Interview: 07/14/16, at 9:11 a.m. registered nurse (RN)-G was asked how the facility conducts data analysis to help detect unusual or unexpected outcomes and to determine the effectiveness of infection prevention and control practices. RN-G stated that this information is reviewed at the facility quality assurance (QA) meetings every month and that they go over resident and staff infections to try and correlate any possible staff infections to resident infections. RN-G also stated they have monthly reports of resident and staff infections and are tracking antibiotic use for different infections and are asking for cultures even on tests that have come back negative. RN-G stated that the only place this information was documented was in the facility QA meeting minutes. When asked how the facility is monitoring for trends in infections RN-G reported that it is all in QA and that they don't have anything formal in place. RN-G stated there is a consultant that comes into the facility who is helping and that she has been trying to work on it when she has the time. When asked how the facility monitors for the resolution of an infections RN-G reported, "I don't really know, we don't have that in place right now but there should be some sort of form that is filled out when the antibiotic is done." RN-G stated in the infection control log that she documents which resident has an infection, what symptoms associated with the infection and with the doctor order start and end date of the antibiotic. RN-G stated that she doesn't know if the resident actually finishes the antibiotic on that date since she isn't notified, she just goes by the date the doctor's order indicates for end date.	F 441	infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility's monthly infection control log tracks the resident, room, infection type, causative organism (if cultured), and antibiotic treatment dates. To further analyze collected data, charts will be used to compare the number of infections for the current quarter with the previous quarter and the previous year. The infection control nurse has reviewed the infection control regulations with a focus on the requirements for infection surveillance and analysis. A comprehensive infection control resource manual is available for reference. Infection control practices and infection control data are discussed during the monthly infection control meetings. Data from the 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 requirements and facility policies for an infection control analysis will be monitored by the Director of Nursing/designee for the next three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 441	Continued From page 47 Reviewed infection control logs. Included in the infection control logs were map layouts of the facility which had color coded infection tools. These were marked on the map indicating where a specific infection was located. Also present in the infection control log was a list of residents, what infection, symptoms, start and end dates of antibiotics. No cultures were identified. Requested to view any facility documentation related to conducting data analysis of infections but none was provided. Policy: Requested policy related to infection control practices but none was provided.	F 441	months through a review of the infection control tracking data. If noncompliance is noted, additional training and auditing will be done. Compliance will be reviewed during the October 2016 quarterly Quality Assurance and Improvement Committee meeting and ongoing.	
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean and sanitary environment for the facility kitchen where all meals were prepared. This had the potential to affect residents who resided in the older wings of the facility and not the newly renovated wing of the facility. In addition, the facility failed to maintain the cleanliness of the bathroom ceiling vents for 3 of 6 shared bathrooms on the 200 wing of the facility. This had the potential to affect all residents residing on the 200 wing unit.	F 465	Regulation 483.70(h) Tag F465 – Safe, Sanitary, Comfortable Environment It is the policy of Pine Haven Care Center to provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public. As part of an ongoing process to provide a pleasant, homelike environment, Pine Haven Care Center has a schedule for routine cleaning, repairs, and	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 465	Continued From page 48 Findings include: 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 Seven of ten sprinkler heads in the kitchen were covered with dust During the kitchen tour on 7/13/16, at 9:30 a.m., the dietary manager (DM) verified the soiled areas. The DM stated the daily cleaning schedule for the Monday AM cook included checking hood vents and dish room vents, and if soiled, dietary was to write out a maintenance slip for them to clean it. The DM verified the cleaning schedules lacked ceilings, light fixtures, ceiling exhaust vents, and sprinklers. The DM further stated the stove hood screens were last cleaned 2/17/15. The DM verified the invoices provided were for	F 465	maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/supervisory staff. During the mandatory meetings August 15, 2016, the staff will be reminded to observe for equipment/furnishings/structures that need to be repaired, cleaned, or replaced. The procedures for reporting work items to the Maintenance Director will be reviewed. The soiled kitchen ceiling light fixtures, stove hood vent screens, ceiling exhaust vents, ceiling tiles, ceiling vent screen, and sprinkler heads were cleaned. The maintenance staff will be responsible for ongoing cleaning of ceiling exhaust vents, ventilation screens, sprinkler heads, light fixtures and tiles. These tasks have been added to the maintenance cleaning task list and will be checked quarterly and cleaned as needed. During the August 4, 2016 meeting, the dietary staff were instructed to be observant for areas that need cleaning and were informed of the cleaning schedule for the stove hood vent screens and water pipes. The dietary staff will inform the maintenance staff of any areas that need attention between the routine maintenance checks. Due to a major addition to the facility, during the week of the survey the residents in the 200 wing were in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 465	Continued From page 49 cleaning in the kitchen. The DM stated the gas stove hood was scheduled to be cleaned on 7/15/16. The DM verified the maintenance department had not been notified to clean the soiled areas prior to the initial tour. Document review of invoice dated 2/17/15, identified hood cleaning completed. Document review of invoice dated 8/2/15, identified cleaning ceiling and floors completed. During interview on 7/14/16, at 7:00 a.m., director of nursing verified all 51 residents ate food prepared from the facility kitchen. 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 Foodservice 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.	F 465	process of being relocated. The rooms and bath rooms in the 200 wing are in the process of being deep cleaned including painting and rewaxing floors in preparation for residents being moved back to the 200 wing. The bathroom vents/ducts in all resident bathrooms were checked for dust build up. Compliance will be monitored by the Maintenance Director through observation of ceiling fixtures/tiles and review of maintenance cleaning logs and by the dietary supervisor through observation of the stove hood vent screens and audits of the kitchen cleaning task sheets. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 465	Continued From page 50 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 contained 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 to have collected balls of dust in the grating of the ceiling vent. The maintenance director stated that the facility did not regularly monitor the ceiling vents in the bathrooms to ensure that they were cleaned on a regular basis. The facility did not have a policy that addressed the regular cleaning of resident bathrooms.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2016**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 12, 2016. At the time of this survey, Pine Haven Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Pine Haven Care Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1970, addition was constructed to the North Wing that was determined to be of Type II(111) construction. In 1991, another addition was added to the West Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 45 at the time of the survey.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2016**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**07/13/2016**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Citation Text for Tag 0000, Regulation K302 Bld 02 KINGSLEY, ROY FIRE SAFETY A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Pine Haven Care Center) was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The Facility is a new addition 1 story building,was constructed in 2016 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. At the time of this survey the 34 bed addition was found NOT in substantial compliance.	K 000	EPOC	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with	K 018		7/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**07/13/2016**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 1 positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 On facility tour between 09:00 AM and 1:00 PM on July 12, 2016, observation and documentation reviewed revealed that both sets of the smoke barrier doors did not close when tested.	K 018	Tag K018 Life Safety Survey The contractor responsible for the installation of the fire doors in the recently occupied new addition was notified of the need to adjust the door to allow complete closure. The doors were adjusted July 14, 2016. The Maintenance Director is responsible for monitoring compliance. Completion date: July 14, 2016	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On July 11, 12, 13 & 14, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive care plan for the diagnosis of depression for 1 of 5 residents (R44) reviewed for unnecessary medications. Findings include:	2 560	Comprehensive Care Plans Pine Haven Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 2 R44's physician orders dated 7/14/16, identified an order for citalopram (Celexa) (anti-depressant) 40 milligrams once a day. R44's physician progress note dated 4/4/16, identified the diagnosis of major depression and indicated R44's medication regimen included Celexa for R44's depressive symptoms. R44's PHQ-9 (depression test) dated 4/6/16, indicated score NA and the one dated 6/30/16, indicated a score of 7. R44's care plan failed to address the diagnosis of major depression and specific symptoms and interventions. On 7/14/16, at 9:35 a.m., the director of social services (DSS)-A stated she was responsible for monitoring the use pf psychotropic medications. DSS-A reviewed R44's care plan and stated depression was not care planned for R44. DSS-A stated R44 had been on the Celexa since admission and she was not sure what R44's physician progress notes stated about the Celexa. On 7/14/16, at 10:11 a.m., the director of nursing stated that it was very important to care plan the use of an antidepressant medication. The facility policy Psychotropic Medication Usage, dated 1/23/06, indicated consistent monitoring of all target symptoms will be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy. A facility policy for the comprehensive care plan was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a system to ensure care plans	2 560	individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services. The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. During the August 15, 2016, mandatory meeting, the staff will be 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents' care plans must be current at all times and 3) instructed that care plans must address depression and related interventions for residents with a diagnosis of depression. The social worker has reviewed the plan of care for resident number 44 and has revised it to include the diagnoses of depression and related goals, treatments, and interventions. To monitor compliance, the social worker will audit the care plans of all residents with the diagnosis of depression to assure that mood symptoms, goals, and interventions are appropriately addressed. Care plans will be revised as necessary. As part of the quarterly care conference	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 3 comprehensively represent the individual resident. The DON or designee could in-service all appropriate employees on that system. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560	process, the interdisciplinary team will continue to review the care plans for completeness, accuracy, and relevancy. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the care plan for 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	2 565	Services by Qualified Personnel per Care Plan Pine Haven Care Center provides care and services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 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, the bath needed to be made up as soon as possible. The DON stated she would expect staff to follow the care plan for bathing. R14's current care plan, indicated R14 required assistance for transferring form one position to another related to deconditioning related to low back pain with intervention of provide two persons contact guidance and physical assist using the EZ stand mechanical lift. On 7/13/16, at 7:02 a.m., R14 was observed to be transferred by nursing assistant (NA)-B from R14's bed into R14's wheelchair. NA-B used the EZ stand mechanical lift to transfer R14. NA-B failed to transfer R14 with two assist as per R14's care plan indicated. On 7/13/16, at 8:09 a.m., NA-B stated R14 was to be transferred by one or two assist using the EZ	2 565	modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicates the resident's care needs to the direct care givers by use of the "pocket care plan" (PCP). The PCPs are routinely updated to reflect revisions in the interdisciplinary plan of care. During the August 15, 2016, mandatory meetings, the nursing staff will be reminded/instructed 1) that the plans of care must be followed 2) that job performance expectations include being aware of and following the resident's plan of care with a focus on nail care, bathing frequency, assisting with transfers and respecting sleep/wake preferences and 3) of the need for monitoring/documenting target behaviors. The orientation for new employees will continue to address the importance of respecting the resident's care preferences and following the resident's individualized plan of care. Resident number 43 – The resident's care plan for bathing was reviewed and found appropriate. The direct care staff was informed that the resident's assigned bath day is Saturday morning. If the bath is not given on Saturday, the charge nurse is to be notified. Resident number 14 – The resident's ability to transfer has been reassessed; the resident continues to require two staff to assist with the EZ stand lift. The direct care staff have been informed of the continuing need for two person assist with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5 stand lift. NA-B stated it depended on R14's mood if one or two staff assist was used to transfer R14. On 7/13/14, at 8:25 a.m., the DON stated R14 was to be transferred using the EZ stand lift and two assist. R44's current care plan, indicated potential for adverse side effects due to use of antipsychotic medications after traumatic brain injury, long history of psychosis. Interventions included: Evaluate effectiveness and side effects of medications for possible decease/ elimination of psychotropic drugs periodically and observe resident mood and behaviors. The care plan identified the behavior of hallucinations, pulling at strings. On 7/11/16, at 3:40 p.m., observation revealed R44 was sitting in his wheelchair in his room. R44 was observed to be moving his hands back and forth constantly and then made the motion with his hand of throwing something. At 5:42 p.m., R44 was observed wheeling his wheelchair with his feet in the hallway and moving his hands back and forth. On 7/12/16, at 8:30 a.m., R44 was observed to be sitting in his wheelchair in the dining room being served breakfast. R44's right hand was making a rolling motion. On 7/13/16, at 8:22 a.m., R44 was sitting in the dining room and his hands were moving in a rolling motion. On 7/13/16 at 1:56 p.m., nursing assistant (NA)-C and NA-J stated R44 had a hallucination behavior of pulling strings, but R44 had not had that	2 565	transfers. The care plan was reviewed and found to appropriately address transferring. Resident number 44 – The resident has a diagnosis of frontotemporal dementia with delusional thoughts. The resident exhibits nearly continual string pulling/hand rolling motions related to parasitosis. Even though the behavior is exhibited very frequently and seems normal for the resident, the direct care staff have been informed that the behavior must be documented on every shift that it is observed. Resident number 45 – As addressed in the care plan, the resident has a life long pattern of going to bed late at night and sleeping late in the morning. The nursing assistants have been instructed to allow the resident to awake naturally; the nursing assistant PCP has been updated accordingly. Resident number 53 – The resident's grooming plan of care was reviewed and found appropriate. The direct care staff are aware of the need to provide nail care as part of the resident's routine grooming/bathing procedures. Compliance will be monitored by weekly auditing/observations of the following for one month: 1) resident bathing and transfers–observations to be assigned by the Director of Nurses/designee 2) nail care–observations to be done by the Life Enrichment staff 3) documentation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6 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. 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. The facility policy dated 1/23/06, Psychotropic Medication Monitoring, indicated Monitoring Guidelines: III. When anti-psychotic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and the presence of adverse reactions. Nurse reviews the NA behavior sheet and summarizes on weekly routine charting. A policy for implementing the care plan was requested and not provided. R45 has a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Resident was started on Heartland Hospice services on 2/17/16. R45 care plan dated with last review date of 6/2/16, identified that R45 likes to sleep late, will get up near noon, and decline breakfast, this was her normal pattern at home, offer food drink when she gets up. Reviewed progress notes from 5/27/16 to 7/12/16, which showed an increase in R45 behaviors including being combative, refusing breakfast, refusing to get out of bed in the morning, refusing morning medications, refusing morning baths, pinching and biting a staff member. These progress notes were written	2 565	target behaviors–audits to be conducted by the Social Worker. 4) The interdisciplinary team will review and monitor the resident's PCPs for accuracy related to the comprehensive care plan. If noncompliance is noted additional monitoring and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 7 describing behaviors during the morning hours when R45 as well as F-A had identified to the facility that she is not a morning person. In review of progress notes there were three separate notes including from hospice as well as R45 care conference, which indicated that F-A had reported to facility staff that R45 doesn't do well in the morning and cares and visits should be provided in the afternoon hours. During observations as follows: 7/12/16, 2:29 p.m. getting hair done in beauty shop. 7/12/16, 3:06 p.m. in beauty shop, smiling. 7/13/16, 7:06 a.m. asleep in bed. 7/13/16, at 7:20 a.m. nursing assistant (NA)-G entered R45 room and offered juice and coffee, asked R45 if she could get her up for the day to which R45 replied I don't get up right away. NA-G told R45 what time it was and R45 responded, I don't care. NA-G stated, can I get you dressed and then you can rest and I'll come back to which R45 responded, I don't like to be bothered. NA-G told R45 that she would be back in 10 minutes. NA-G stated, I'll check back in 10 minutes otherwise she'll get in a bad mood. 7/13/16, at 7:34 a.m. NA-G re-approached R45 in her bedroom and again R45 declined to get up. NA-G stated why don't you let me get you changed and began lifting the bed. R45 became upset and stated, don't do that. NA-G offered juice or coffee and asked to open R45 curtains. After this, began raising the bed again and R45 again stated no I just want to lay here for a while. 7/13/16, 8:50 a.m. in bed asleep.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 8 Interview with licensed social worker (LSW)-B on 7/12/16, at 3:10 p.m. identified that she had just become aware of an increase in R45 behaviors on 7/11/16. LSW stated that she hadn't been made aware of this prior to 7/11/16 due to floor staff not checking the 24 hour note text when they are documenting their progress notes. Interview with nursing assistant (NA)-G on 7/13/16, at 7:13 a.m. stated that she starts to wake R45 up around 6 am and will go in every 15 minutes until she's ready to get up. Continued to state that she gets up anywhere between 6 and 8 in the morning. On 7/13/16, at 8:52 a.m. NA-G stated R45 had again refused to get up so we just fed her in her room and we will try again later. Interview with NA-G on 7/13/16, at 9:09 a.m. stated she knows how to care for R45 from her pocket care plan (PCP). PCP identified care areas including dining needs, activities of daily living (ADL) which specifically identified R45 requiring the assist of 1 for dressing, bathing and pericare BID and PRN. Partial assist of 1 for grooming. PCP identified care for bowel and bladder, transfer, ambulation, devices, orientation sensory, skin care, dentures, activities and comments. Under comments it states, make bed daily, change bed linens weekly, Heartland Hospice, Female Caregivers only. There was nothing noted about R45 preference to stay in bed until noon. NA-G stated she has access to the care plan and showed a binder which had copies of the PCP in the 600 wing nurse's station. NA-G stated these were the only care plans she had access to. NA-G stated R45 usually has behaviors when we get her up in the morning but usually once she is up she is better. Interview with R45 family (F)-A on 7/13/16, at 9:28 a.m. stated, R45 had never been a morning person and had always like to stay up late into the night watching television. F-A stated that she had	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 9	2 565		

spoken often with staff and was very comfortable with R45 not having breakfast but would like R45 up for lunch and supper.
Interview with registered nurse case manager (RN)-B on 7/13/16, at 12:00 p.m. stated she was unaware that the care plan identified R45 should stay in bed until noon and she had never heard R45 family say that. RN-B went on to state mornings are a "terrible idea" for R45 as she does better in the afternoon. RN-B also stated she doesn't do the care plans that another registered nurse (RN)-1 handles the care plans and then RN-1 gives the information to the administrative assistant (AA)-F to complete the PCP for direct care staff.
Interview with RN-1 on 7/13/16, at 12:36 p.m. stated care plans are triggered off of the MDS and she updates sections of the MDS when she gets new information. The new information comes to her first and then the AA-F is responsible for updating the PCP that direct care staff utilize when caring for residents. Stated R45 has "never been a morning person, it has always been on the PCP, maybe it was removed by Hospice when they started working with her".
Interview with AA-F on 7/13/16, at 1:43 p.m. stated she gets the information to update the PCP from RN-B. Also stated she gets direct information from the therapy department and from Hospice if changes need to be made. AA-F stated the information was on the PCP but information had been changed when occupational therapy was working with her at meal times.
Interview with director of nursing (DON) on 7/13/16, at 2:29 p.m. stated the PCP should be a reflection of the comprehensive care plan and the expectation is that what is in the care plan would be reflected on the PCP.
Interview with occupational therapy assistant (OTA) on 7/14/16, at 8:21 a.m. stated [R45] was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 10	2 565		

discharged from physical therapy and occupational therapy on 1/29/16.
Policy: Requested a policy concerning care plans but policy was not received.
Based on observation, interview and record review, the facility failed to follow the care plan for 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 11 On 7/13/16, at 12:41 p.m., the director of nursing (DON) stated if R43 had not received her bath, the bath needed to be made up as soon as possible. The DON stated she would expect staff to follow the care plan for bathing. R14's current care plan, indicated R14 required assistance for transferring form one position to another related to deconditioning related to low back pain with intervention of provide two persons contact guidance and physical assist using the EZ stand mechanical lift. On 7/13/16, at 7:02 a.m., R14 was observed to be transferred by nursing assistant (NA)-B from R14's bed into R14's wheelchair. NA-B used the EZ stand mechanical lift to transfer R14. NA-B failed to transfer R14 with two assist as per R14's care plan indicated. On 7/13/16, at 8:09 a.m., NA-B stated R14 was to be transferred by one or two assist using the EZ stand lift. NA-B stated it depended on R14's mood if one or two staff assist was used to transfer R14. On 7/13/14, at 8:25 a.m., the DON stated R14 was to be transferred using the EZ stand lift and two assist. R44's current care plan, indicated potential for adverse side effects due to use of antipsychotic medications after traumatic brain injury, long history of psychosis. Interventions included: Evaluate effectiveness and side effects of medications for possible decease/ elimination of psychotropic drugs periodically and observe resident mood and behaviors. The care plan identified the behavior of hallucinations, pulling at strings.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 12 On 7/11/16, at 3:40 p.m., observation revealed R44 was sitting in his wheelchair in his room. R44 was observed to be moving his hands back and forth constantly and then made the motion with his hand of throwing something. At 5:42 p.m., R44 was observed wheeling his wheelchair with his feet in the hallway and moving his hands back and forth. On 7/12/16, at 8:30 a.m., R44 was observed to be sitting in his wheelchair in the dining room being served breakfast. R44's right hand was making a rolling motion. On 7/13/16, at 8:22 a.m., R44 was sitting in the dining room and his hands were moving in a rolling motion. On 7/13/16 at 1:56 p.m., nursing assistant (NA)-C and NA-J stated R44 had a hallucination behavior of pulling strings, but R44 had not had that 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. 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. The facility policy dated 1/23/06, Psychotropic Medication Monitoring, indicated Monitoring Guidelines: III. When anti-psychotic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 13 presence of adverse reactions. Nurse reviews the NA behavior sheet and summarizes on weekly routine charting. A policy for implementing the care plan was requested and not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are followed for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify a non-pressure related skin injury for 1 of 3 residents (R53) reviewed for non-pressure related skin. In addition, the facility failed to ensure that 1 of 1 resident (R45) receiving hospice services had a coordinated plan of care between facility and hospice agency which was communicated to direct care staff. Findings include: R53 was observed on 7/11/16, at 3:27 p.m., with a skin tear on the right wrist, approximately one by one centimeter, open to air and no drainage noted. R53 stated he bumped into something. The Admission Record identified R53 was admitted to the facility with diagnoses that included diabetes mellitus and atrial fibrillation. The significant change Minimum Data Set (MDS) dated 4/7/16, noted R53 to have intact cognition, required limited assistance of one staff for bed mobility and transfer, supervision with set up help for walking in room, walking in hall and locomotion on the unit, and required extensive assist of one staff for toilet and personal hygiene. R53's care plan dated 1/2/15, identified a risk for alteration in skin integrity related to nutritional deficit, cognitive impairment, presence of former jejunostomy tube, diabetes and received anticoagulant therapy. Interventions included staff to observe for changes in skin integrity daily with cares and notify the nurse as needed, and nurse to proceed as indicated. On 7/13/16, at 7:43 a.m., licensed practical nurse	2 830	- Provide Care/Services for Highest Well-being Pine Haven Care Center provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. The residents' needs including end-of-life care and hospice services as well as cares to preserve skin integrity and treat skin problems are identified and a plan of care developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments. The policies and procedures for identifying, reporting, investigating, monitoring and communicating open areas and other skin lesions were reviewed and found appropriate. A licensed nurse evaluates the resident's skin condition on a weekly basis. Residents with open skin areas are reviewed weekly by the interdisciplinary care team; the nurse practitioner/physician is notified of concerns regarding nonhealing or worsening of skin lesions. On August 4, 2016, the Director of Nursing and the Heartland Hospice agency nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15 (LPN)-A stated R53 received wound treatment to the former jejunostomy tube sight. LPN-A further stated there were no other wound treatments for R53. On 7/12/16, at 11:40 a.m., nursing assistant (NA)-B stated she had assisted R53 with morning cares and identified R53 had no skin issues. On 7/13/16, at 12:13 p.m., R53 sat on the edge of bed, feeding himself lunch. The right outer wrist wound was approximately two centimeters with an open, dry wound bed. The skin tear was without a dressing and had no drainage. At 2:25 p.m., the right outer wrist wound remained uncovered. R53 stated he bumped himself and denied pain. On 7/14/16, at 8:25 a.m., R53's right outer wrist wound had two steri-strip tapes in place. The wound had a dark brown surface with no redness or drainage. 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. Document review of facility Skin Ulcer policy review dated 5/4/09, revealed "D. Monitor Skin Integrity. Skin will be observed daily during cares done by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. R45 was started on hospice services on 2/17/16.	2 830	coordinator addressed the current procedures for coordination of care between the facility and the hospice staff as well as implementation and documentation of the coordinated efforts. Options for notifying the facility staff about which hospice staff will visit the resident, when the visits will occur, and what cares/services will be provided as well as the process for notifying the facility of changes in the hospice staff visitation schedule were discussed. During the August 15, 2016 mandatory nursing staff meeting, instruction will include the need to observe for skin lesions and the importance of appropriately identifying, reporting, documenting, monitoring and treating skin lesions. Procedures related to the above will be reviewed as well as developing care plans to monitor/treat/prevent pressure related and other skin lesions. Instruction will be provided to the nursing assistants on the need to be alert to skin injuries/lesions and to immediately report the findings to the licensed nurse. Observing and reporting the resident's skin condition will continue to be part of the nursing assistant's bathing protocol. During the August 15, 2016 meeting, the staff will also be informed of the process for coordinating care between the facility and hospice staff including the hospice procedures for notifying the facility of who (Nurse, CNA, Social Worker, etc.) will be visiting the resident, when the visits will be made, and what care/services the hospice staff will provide as well as how changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16 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 multiple systems failure. R45's care plan with a revision date of 6/2/16, identified comfort care guidelines for resident's that no longer wish to be hospitalized for a significant change in condition. In collaboration with the hospice agency will provide hospice services to resident and family. Refer to hospice interdisciplinary care plan and documentation notes in hard copy of chart for current updates 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 aide (HHA)-I indicated a hospice aid was present at the facility twice a week to provide showers for R45 and a nurse was present twice a week. HHA-I stated following her visits she filled out a form for the care provided and left a copy with the facility. HHA-I stated she communicated with either the licensed practical nurse (LPN) or registered nurse (RN) who was in charge on the day of her visit. On 7/12/16, at approximately 1:45 p.m. trained medication aid (TMA)-D stated she knew R45 was on hospice because it was on the pocket care plan (PCP). TMA-D stated she found out when hospice was coming when they arrived at the facility. On 7/12/16, at approximately 1:50 p.m. LPN-C stated there was a calendar in R45's room that identified when hospice was coming. LPN-C stated the hospice care plan and notes were accessible in PointClick care (facility documentation system). On 7/13/16, at 9:09 a.m. nursing assistant (NA)-G	2 830	in the schedule will be communicated. Resident number 53 – A licensed nurse assessed the resident's skin July 12, 2016 at which time a 1.5 cm skin tear was identified on the resident's right wrist; steri strips were applied. A July 18, 2016 nurse's note stated that the skin tear was healed. The care plan was reviewed and revised to reflect history of and risk for skin tears. Resident number 45 – The Director of Nursing and the resident's hospice nurse care coordinator have discussed the coordination services between the facility and hospice staff. The resident has a coordinated plan of care in his record describing the types of services that will be provided by the hospice agency staff, the schedule for the services, and what staff will be providing the service (aide, nurse, social worker, etc.). The hospice agency will notify the facility of any changes in the visitation schedule/plans which will then be communicated to the staff. The care plan was reviewed and found appropriate. To monitor compliance with hospice visit schedules, a random audit of records of hospice residents will be done for two weeks to determine if the visits followed the documented schedule and, if not, whether the facility staff was notified of the change. If noncompliance is noted, the hospice agency administrative staff will be notified and additional auditing will be done.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 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) which stated assist of 1 for dressing, bathing and pericare BID (twice daily) and PRN (as needed), partial assist of 1 for grooming. The PCP identified care for bowel and bladder, transfer, ambulation, devices, orientation sensory, skin care, dentures, activities and comments. Under comments the PCP stated make bed daily, change bed linens weekly, hospice, and female caregivers only. There was nothing noted about what cares were provided to R45 from the hospice agency. NA-G stated she had access to the care plan through a binder at the 600 wing nurse's station which had copies of the PCP. NA-G stated these were the only care plans she had access to. On 7/13/16, at 10:19 a.m. the hospice agency registered nurse patient care coordinator (RN)-J stated there was a care plan in the front of R45's hard chart that listed what activities of daily living (ADL) hospice was responsible for on their visits. The hospice care plan was integrated into the facilities care plan. RN-J stated the hospice schedule was located in the front of R45's hard chart. This was the schedule the facility should be following when instructing their staff of visiting times. If changes were made, hospice would notify the facility of these changes. On 7/13/16, at 12:00 p.m. RN-B stated she never really knew when the hospice nurse was going to be at the facility, but it was usually Thursday. RN-B verified the hospice schedule was in the front of R45's hard chart which identified the hospice aid was at the facility on Monday of each week and the RN came on Tuesday of each week. The schedule was dated 2/17/16, which was the day R45 started on hospice services. RN-B stated that whenever hospice was at the	2 830	To monitor compliance with the identification of new skin problems, a licensed nurse will observe the resident's skin condition weekly. The Director of Nurses/designee will review the skin audit reports for seven days to assure appropriate follow up to acute problems. If there is evidence that skin problems are not identified in a timely manner, or if appropriate follow up is not documented, additional auditing and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 facility they communicated their visit with floor nurses as well as herself. They also left a copy of their visit notes in the hard chart. RN-B verified there was a nurse's note in R45's hard chart weekly for the past 30 days. On 7/13/16, at 2:29 p.m. the director of nursing (DON) stated hospice spoke directly to the direct care nurse and nurse manager when in the facility. Any changes hospice made should be added to the pocket care plan (PCP). The DON further stated when information was relayed to a member of the direct care staff this should be passed on to the charge nurse. The charge nurse would pass information along in daily reports at shift change. The DON went on to state that each morning there was report at 9:00 a.m. for members of the interdisciplinary team. The nurse gave a verbal report of any new information from the last 24 hours as well as any notes entered into the PointClick care system for the last 24-72 hours. The undated facility policy for Coordination of a Resident Receiving Hospice Services stated, "If care is provided by the hospice in the facility, the hospice and the nursing home are jointly responsible for developing a coordinated plan of care guiding both providers based on assessed needs and goals. The coordinated care plan will identify which provider is responsible for the various aspects of care and updated according to State, local and Federal regulations". The policy did not address how the information would be communicated to direct care staff within the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for resident cares on the need to monitor non pressure related skin concerns and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 provide palliative cares as care planned. Then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 2 residents (R53) reviewed received 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	2 860	Activities of Daily Living Care Pine Haven Care Center provides the necessary services to maintain good nutrition, grooming, personal care and oral 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 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. During the mandatory meeting August 15,	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 20 R53 with long, soiled finger nails. During interview on 7/13/16, at 9:48 a.m., registered nurse (RN)-A verified R53 required extensive assistance with personal hygiene. During interview on 7/14/16, at 8:25 a.m., R53 stated the finger nails were long. During interview on 7/14/16, at 8:40 a.m., the director of nursing verified R53's finger nails were long and soiled. She stated she expected nursing staff to provide R53's nail care as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop systems to ensure dependent residents receive the assistance needed for their cares. The DON or her designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 860	2016, the nursing staff will be 1) reinstructed on the facility's policies for providing personal hygiene to the residents 2) reminded that their job description requires knowledge of and responsibility for following the resident's plan of care and 3) instructed on the importance of providing nail care. The need to provide cares as necessary to improve/enhance the residents' appearance, comfort, and dignity will be emphasized. The grooming plan of care for resident number 53 was reviewed and found appropriate in addressing the resident's personal care needs. The direct care staff are aware of the need to provide nail care as part of the routine grooming/bathing procedures. The Life Enrichment Director/designee will be responsible for monitoring compliance 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 done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director	2 900		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21 of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to treat identified pressure ulcers and prevent further pressure ulcers from developing for 1 of 1 resident (R62). Findings include: R62's admission record, dated 3/15/16, indicated that the resident had diagnoses of repeated falls and a fracture of the upper end of the left humerus (long bone running from the shoulder to the elbow). R62's care plan, dated 3/15/16, indicated the resident was at risk for an alteration in skin integrity related to her immobility and incontinence. There were a number of interventions provided with the goal in mind that R62 would maintain her skin integrity. R62's care area assessment (CAA), dated 7/8/16, indicated that the resident currently had a	2 900	Prevent/Heal Pressure Sores Based on the comprehensive assessment, Pine Haven Care Center staff ensure that residents who enter the facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services 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 risks 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	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 on at all, she stated 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 consisted of pudding, a bowl of cream of wheat, toast, a cup of milk, a cup of juice, a cup of coffee. R62 also had a cup of water at her table. NA-D stated this was all that was served for R62's meal. When interviewed on 7/13/16 at 8:32 a.m.,	2 900	comprehensively assessing the residents' skin condition and risk factors were reviewed and found appropriate. An evaluation of the resident's skin condition, skin risk factors, and tissue tolerance will continue to be completed at the time of admission, readmission from the hospital, 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 monitored and measured on a routine basis and 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. During the August 15, 2016 mandatory meeting, the nursing staff will be reinstructed on the facility's skin related policies and procedures. Discussion will include the need to 1) complete weekly monitoring and documentation describing the healing/nonhealing of open lesions 2) implement skin-related nursing practices and clinician ordered interventions and 3) monitor the effectiveness and resident acceptance of the interventions. The staff will be reminded to notify the clinical manager if the resident chooses not to follow the recommended plan of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 23 licensed practical nurse (LPN)-D was asked what interventions were in place to prevent the recurrence of pressure ulcers for R62. LPN-D stated R62 was given the air mattress on 6/21/16. She stated that the air mattress was initiated for R62's coccyx area and R62 complained of a lot of stiffness when she went to bed. LPN-D stated that it looked like the mattress was started then but R62 had a care conference meeting on 6/22/16 and the resident was very upset about the air mattress. R62 did not want to use it. LPN-D stated that maybe something else should be tried to alleviate pressure. When interviewed on 7/13/16 at 11:42 a.m., trained medication aide (TMA)-D stated supplements were served by the nursing assistants and nursing staff would document that it had been served. Both NA-D and TMA-D identified where the dietary staff would drop the supplements off in the fridge on the unit which were then to be delivered to the resident's. They explained that the dietary staff would put a printed label on each supplement which directed which resident the supplement went to. Observation of the supplements in the refrigerator on the unit revealed that R62 did not have a supplement with her name on it. When interviewed on 7/13/16 at 11:50 a.m., TMA-D stated that she had just spoken with the dietary staff who stated they never received an order to provide a supplement to R62. Licensed Practical Nurse (LPN)-A verified there had been a break in communication between the nursing staff and dietary. The dietary department never received the order to provide the supplement. When interviewed on 7/13/16 at 1:49 p.m. LPN-D stated when a resident developed a pressure	2 900	Resident number 62 – Recent skin assessments indicate intact skin with occasional blanchable redness on coccyx. The resident's air mattress has been discontinued at her request; use of a wheelchair ROHO pressure reduction cushion continues. The resident is receiving a dietary supplement due to risk of weight loss. The care plan has been reviewed and revised. Compliance will be monitored by the Administrator/designee by 1) auditing the orders for supplements to assure that the dietary department is aware of the order and is delivering the ordered supplement to the nursing care area and 2) reviewing the use of pressure reduction mattresses to assure proper use/function and resident acceptance. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 24 ulcer, a plan of care would be developed. The nurse manager would assess the pressure ulcer on a weekly basis and would determine if any new interventions needed to be implemented. LPN-D stated she was removing the air mattress from R62's bed as she did not know that the air mattress was not being inflated. When interviewed on 7/14/16 at 8:41 a.m., the dietary manager stated that she never received an order from the nursing department that R62 was to receive a supplement with meals. When interviewed on 7/14/16 at 9:49 a.m., registered nurse (RN)-B stated that there had been a breakdown in communication which resulted in R62 not receiving the ordered supplement with meals. RN-B further stated they tried an air mattress on R62's bed in June in order to try and prevent pressure ulcers. A day later they held a care conference and the resident stated she did not like the air mattress. RN-B explained to R62 that she wanted her to try it for a couple more days to see if she changed her mind. RN-B explained the nursing staff did not report back to her that the air mattress had not been turned on as R62 did not want to use it. When interviewed on 7/14/16 at 1:23 p.m. the director of nursing (DON) stated she would have expected the nursing staff to be notified that the resident had been declining the use of the air mattress on her bed. The DON further stated she expected the dietary department would have been notified in order to provide R62 with the supplement with meals. Review of the facility policy updated on 5/4/09, Skin Ulcers, advised to notify the dietary department when a pressure ulcer was identified.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 25 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents receive appropriate pressure ulcer treatment and prevention. The Director of Nursing or designee could educate all appropriate staff. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21330	Routine/Emergency Dental Care	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21330	Continued From page 26 review the facility failed to ensure dental services were offered for 2 of 3 residents (R53, R47) reviewed for dental services and who had oral concerns. Findings include: R53 had diabetes mellitus, according to the facility Admission Record. Observations on 7/14/16, at 8:40 a.m., revealed R53 had missing teeth on the lower right and lower left of his mouth. R53 stated he had not seen a dentist for years. At that time, the director of nursing (DON) verified the missing teeth. Document review of significant change Minimum Data Set (MDS) dated 4/7/16, revealed R53's cognition was intact and he required extensive assist of one staff for personal hygiene which included brushing teeth. The MDS identified no tooth fragments, no abnormal tissue, no cavity or broken teeth, no bleeding gums, and no pain or difficulty chewing. Document review of R53's oral assessment dated 4/7/16, revealed the last dental exam was many years ago and he had some lost teeth. R53's care plan revised dated 4/12/16, directed R53 required assistance with oral care and interventions included set up supplies for oral care within reach, assist as needed. Interventions also included offer to set up dental appointments, refer to dentist as needed and staff provide oral hygiene at least two times a day and as needed. During interview on 7/12/16, at 11:40 a.m., nursing assistant (NA)-B stated R53 preferred morning cares after breakfast and oral care one time daily at bedtime. NA-B stated R53 brushed	21330	Pine Haven Care Center routinely assists the residents in obtaining routine and emergency dental services. The facility assists the resident in making appointments and arranging for transportation to and from the dentist's office. The family is notified of lost or damaged dentures and resident is referred to a dentist as appropriate. The policies and procedures related to dental assessments and referrals has been reviewed and revised. A new oral assessment form will be implemented. The need/desire for a dental referral will be routinely discussed during the annual care conferences and more frequently if there are complaints of mouth pain or chewing problems. The option of contracting with Apple Tree Dental to provide on-site dental care is being explored. During the August 15, 2016 mandatory staff meeting, the following will be discussed: 1) any resident who has difficulty chewing or complains of mouth pain or other dental related problems should be assessed to determine the need for referral to the physician or dentist 2) the implementation of the revised oral assessment form and 3) the need to offer a dental referral at least annually. Resident number 53 – The resident is receiving hospice services; there have been no complaints of mouth pain or difficulty chewing. During the resident's July 20, 2016 care conference, the family	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21330	Continued From page 27 his own teeth at bedtime. During interview on 7/14/16, at 1:30 p.m., nursing assistant (NA)-D stated R53 required assist of one staff to set up supplies for oral care. NA-D stated R53 brushed his own teeth. During interview on 7/14/16, at 1:30 p.m., registered nurse (RN)-B verified the lack of evidence of offering R53 dental services for missing teeth. R47's admission record, dated 2/24/14, indicated the resident had a diagnosis of dementia with Lewy bodies. R47's annual minimum data set (MDS), dated 5/5/16, indicated the resident was moderately impaired cognitively. On 7/12/16 at 9:32 a.m., R47 stated his teeth were beginning to deteriorate and starting to decay. He stated it had been over a year since he had been to the dentist. Upon observation, R47 was noted to have multiple missing teeth on the upper right side of his mouth. R47 stated the staff had not offered him a dental appointment. R47's last oral assessment, dated 5/4/16, stated it was unknown when the last time he had a dental exam was. It recommended no immediate referral to a dental professional. R47's nutritional assessment, dated 6/14/2016, indicated that he had his own teeth. R47's medical record indicated that he had last been to a dentist on 2/24/14. At that time, R47 had dental concerns which required a tooth extraction.	21330	declined an offer for a dental referral stating that they want a dentist appointment only if there is an issue. The care plan has been updated accordingly. Resident number 47 – An oral assessment was completed by a registered nurse August 5, 2016. The resident had no complaints of pain or problems chewing. The resident did/did not wish to see a dentist –"teeth aren't paining me." The resident's oral status will be discussed with his wife; a dental referral will be addressed. The care plan has been reviewed and revised. To monitor compliance, any resident who indicates mouth pain on the MDS assessment will be reassessed for the need for a referral to the physician or dentist. The need for a dental referral for other residents will be addressed at the resident's next routine care conference. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21330	Continued From page 28 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. On 7/14/16, at 9:38 a.m., registered nurse (RN)-A stated residents received an annual oral assessment. If they had problems they would be offered a dental appointment. She stated dental issues were not brought up at every care conference. If someone was noted to have a problem the physician would be notified. She stated they have to request an appointment unless an issue would come up. On 7/14/16, at 1:11 p.m., the director of nursing (DON) stated that she expected nursing staff to offer a dental appointment at least every six months to a year. Review of the document dated 1/13/06, Assessment, it stated that oral assessments would be done upon admission and quarterly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop systems to ensure residents receive dental services per recommendations from individualized assessments. The DON or her designee could educate all appropriate staff members on this process. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days	21330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and record review, facility failed to implement an infection control program which included analysis of collected data to determine interventions to prevent the spread of infection. This had the potential to affect all 51 residents who resided in the facility. Findings include: Interview: 07/14/16, at 9:11 a.m. registered nurse (RN)-G was asked how the facility conducts data analysis to help detect unusual or unexpected outcomes and to determine the effectiveness of infection prevention and control practices. RN-G stated that this information is reviewed at the facility quality assurance (QA) meetings every month and that they go over resident and staff infections to try and correlate any possible staff infections to resident infections. RN-G also stated they have monthly reports of resident and staff infections and are tracking antibiotic use for different infections and are asking for cultures even on tests that have come back negative. RN-G stated that the only place this information was documented was in the facility QA meeting minutes. When asked how the facility is monitoring for trends in infections RN-G reported	21375	– Infection Control Pine Haven Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility's monthly infection control log tracks the resident, room, infection type, causative organism (if cultured), and antibiotic treatment dates. To further analyze collected data, charts will be used to compare the number of infections for the current quarter with the previous quarter and the previous year. The infection control nurse has reviewed the infection control regulations with a focus on the requirements for infection	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 30 that it is all in QA and that they don't have anything formal in place. RN-G stated there is a consultant that comes into the facility who is helping and that she has been trying to work on it when she has the time. When asked how the facility monitors for the resolution of an infections RN-G reported, "I don't really know, we don't have that in place right now but there should be some sort of form that is filled out when the antibiotic is done." RN-G stated in the infection control log that she documents which resident has an infection, what symptoms associated with the infection and with the doctor order start and end date of the antibiotic. RN-G stated that she doesn't know if the resident actually finishes the antibiotic on that date since she isn't notified, she just goes by the date the doctor's order indicates for end date. Reviewed infection control logs. Included in the infection control logs were map layouts of the facility which had color coded infection tools. These were marked on the map indicating where a specific infection was located. Also present in the infection control log was a list of residents, what infection, symptoms, start and end dates of antibiotics. No cultures were identified. Requested to view any facility documentation related to conducting data analysis of infections but none was provided. Policy: Requested policy related to infection control practices but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop appropriate infection control systems based on current standards and recommendations from the Centers for Disease	21375	surveillance and analysis. A comprehensive infection control resource manual is available for reference. Infection control practices and infection control data are discussed during the monthly infection control meetings. Data from the 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 requirements and facility policies for an infection control analysis will be monitored by the Director of Nursing/designee for the next three months through a review of the infection control tracking data. If noncompliance is noted, additional training and auditing will be done. Compliance will be reviewed during the October 2016 quarterly Quality Assurance and Improvement Committee meeting and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 31 Control. The DON or designee could educate all staff. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 5 of 5 residents (R26, R35, R54, R70, R60) and 5 of 5 employees (E-A,	21426	State Statute 144A.04 Tuberculosis Prevention and Control	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 32 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. Findings Include: 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 and "results of 2nd mantoux" on 6/23/16 was read at 3:37 p.m. with a 0 mm reading; both lacking interpretation. R35 was admitted to the facility on 6/7/16 according to the Admission Record. R35's Medication Administration Record (MAR) for June 2016 indicated "results of 1st mantoux [TST]" on 6/9/16 was read at 5:41 p.m. with a 0 mm reading and "results of 2nd mantoux" on 6/30/16 was read at 12:43 p.m. with a 0 mm reading; both lacking interpretation. R54 was admitted to the facility on 5/20/16 according to the Admission Record. R54's Medication Administration Record (MAR) for May 2016 indicated "results of 1st mantoux [TST] " on 5/22/16 was read at 5:19 p.m. with a 0 mm reading and R26 ' s MAR for June 2016 indicated "results of 2nd mantoux" on 6/12/16 was read at 12:19 p.m. with a 0 mm reading; both lacking interpretation. R70 was admitted to the facility on 5/24/16 according to the Admission Record. R70's	21426	Pine Haven Care Center has a comprehensive tuberculosis infection control program in accordance with the most current federal and state guidelines. The program includes a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. During the mandatory meeting August 15, 2016, the licensed nurses were instructed to document whether the results of the Mantoux tests are interpreted as “negative” or “positive” as well as the amount of induration. The TB reporting forms have been updated to include the positive/negative interpretation. Resident number 60 has been administered a second Mantoux test August 5, 2016. The results of the test will be read within 48 and 72 hours after administration. The results of the test will be documented in the resident’s record. Compliance will be monitored by the Infection Control nurse through audits of the reports of TB test results for the next 30 days. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 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.

R60 was admitted to the facility on 2/1/16 according to the Admission Record. R60's Medication Administration Record (MAR) for February 2016 indicated "results of 1st mantoux [TST]" on 2/3/16 was read at 9:05 p.m. with a 0 mm reading. R60's second TST was administered on 2/23/16 at 12:49 a.m. and read on 2/24/16 at 3:13 p.m. [38 hours and 25 minutes after administration] with a 0 mm reading; both lacking interpretation.

E-A received a TST administered on 6/28/16 with the results read on 7/1/16 at 9:35 p.m. with a 0 mm reading; lacking interpretation.

E-B received a TST administered on 5/31/16 with the results read on 6/2/16 at 1:30 p.m. with a 0 mm reading; lacking interpretation.

E-C received a TST administered on 6/2/16 with the results read on 6/5/16 at 10:55 a.m. with a 0 mm reading; lacking interpretation.

E-D received a TST administered on 5/9/16 with the results read on 5/11/16 at 4:15 p.m. with a 0.1 mm reading; lacking interpretation.

E-E received a step-one TST administered on 2/9/16 with the results read on 2/12/16 at 9:00 a.m. with a 0 mm reading; lacking interpretation. E-E received a step-two TST administered on 3/16/16 with the results read on 3/18/16 at 11:40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 34 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. Pine Haven Care Center Policies and Procedures, TB Control Plan-Residents, review date 7/14, reads; "7. Five U.S. units of TB [tuberculosis] skin testing is administered by a trained nurse via sub dermal injection and read within 48-72 hours...13. Documentation includes: a. TB skin tests are documented by date, site, nurse's initials, and the manufacturer and lot number recorded. TB skin test results are read in millimeters of induration." Pine Haven Care Center Policies and Procedures, TB Control Plan-Employees, review date 1/13, reads; "12. A. Mantoux tests should be documented in millimeters of induration and the manufacturer and lot number recorded." Minnesota Department of Health, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis infection control regulation in your facility, dated July 2013. Page 10, Screening Health Care Workers, General principles, "TST documentation should include the date of the test (i.e. month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). Baseline TB screening, "An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. Page 23, Screening Residents, General	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 35 principles, "Screening should be initiated within 72 hours of admission or 90 days prior to admission...TST documentation for residents should include the date (i.e., month, date, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative). Page 28, Baseline TB Screening Tool for Residents Template, Tuberculin Skin Testing (TST), reads; " Results (read between 48-72 hours)... " SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review tuberculosis screening standards meet the MDH and CDC recommendations. The DON or designee could educate all licensed nursing staff to the tuberculosis screening systems. The director of nursing could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply	21535		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 36 with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN 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 regimen included Celexa for R44's depressive symptoms. R44's medication administration record dated 7/16,	21535	Unnecessary Drugs Pine Haven Care Center staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible. Pine Haven Care Center staff ensure that 1) residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 37 identified R44 was receiving the medication as prescribed. R44's PHQ-9 (depression test) dated 4/6/16, indicated score NA and PHQ-9 dated 6/30/16, identified a score of 7. R44's care plan did not address the diagnosis of major depression. R44's record failed to identify specific symptoms and interventions for the diagnosis of depression. On 7/14/16, at 9:35 a.m., the director of social services (DSS)-A stated she was responsible for monitoring the use pf psychotropic medications. DSS-A reviewed R44's care plan and stated there was no depression care plan for R44. DSS-A stated R44 had been on the Celexa since admission and she was not sure what R44's physician progress notes stated about the Celexa. DSS-A stated the increase in PHQ-9 scores was because R44 said he felt depressed a little bit, and indicated he slept too much. DSS-A stated she had not seen a mood change in R44. On 7/14/16, at 10:11 a.m., the director of nursing (DON) stated it was very important to care plan the use of an antidepressant medication. The DON stated she concerned, and believed there needed to be a more thorough review of medications. The facility policy dated 1/23/06, Psychotropic Medication Usage, indicated consistent monitoring of all target symptoms will be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy. R47's admission record, dated 2/24/14, indicated	21535	diagnosed and documented in the clinical record and 2) residents who use psychotropic drugs receive gradual dose reductions with attempts to manage behaviors using nonpharmacological interventions. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during their routine 30/60 day visits and more often as indicated. Based on the resident's comprehensive assessment, Pine Haven Care Center staff routinely identify target behaviors and mood symptoms that justify the use of psychotropic medications. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use, that related target behavior/mood symptoms are identified and monitored, and that assessments are completed as indicated. On August 2, 2016, the Consultant Pharmacist, Director of Nursing, and Social Workers met to review the regulations related to the use of psychotropic medications. The policies and procedures related to the administration of psychotropic medications and medications used to treat insomnia	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 38 that the resident had a diagnosis of dementia with Lewy bodies. R47's medication review report, dated 2/15/16, indicated the resident had been prescribed Trazodone (antidepressant) for insomnia. He was to receive 50 mg (milligrams) at bedtime. R47's care plan, dated 10/23/15, indicated that the resident had trouble sleeping, staying asleep, getting to sleep and getting back to sleep. The care plan directed to establish a calm, quiet and soothing environment prior to an established bedtime and interview the resident regarding what the resident did at home to establish a restful sleep. This was to be incorporated in to the care plan on admission. R47 was to take medications as ordered to promote sleep. The staff were to perform a monthly sleep log while on medication and as needed. The care plan also recommended a periodic sleep assessment by licensed staff. R47's undated sleep assessment, identified he had been told he snored. The bottom of the document indicated the resident had symptoms which could be related to sleep apnea. In handwritten documentation, it stated the resident woke at night occasionally, and he had days and nights mixed up according to R47's former facility. R47's 24 hour sleep log, dated 6/4/16 through 6/10/16, had three days that were not completed. Of the remaining days, two nights showed R47 did wake up over the night and went back to sleep. When interviewed on 7/14/16 at 10:17 a.m., registered nurse (RN)-B stated the facility did a 7 day sleep log to monitor sleep. She stated that	21535	were reviewed and revised. The daily behavior log will continue to be used to track 1) target behaviors justifying the use of antipsychotic medications 2) interventions to modify behavior and 3) the effectiveness of the interventions. Mood symptoms related to the use of antidepressant medications will be addressed in the care plan and discussed at least quarterly at the resident's care conference. During the mandatory meetings on August 15, 2016, the licensed nursing staff will be instructed on 1) the documentation procedures for tracking target behaviors as well as related interventions and their effectiveness 2) addressing target behaviors/mood symptoms in the care plan and 3) the new procedures for tracking sleep/wake patterns, conducting sleep assessments and documenting nighttime sleep habits. The direct care staff will be reminded of the importance of being observant for behavior/mood symptoms and reporting symptoms to the charge nurse in a timely manner. Resident number 44 – The care plan has been updated to address the diagnosis and symptoms of depression. The Social Worker will complete a depression screen questionnaire every 90 days and with a significant change in condition. The physician will be contacted if there is an increase in symptoms of depressed mood. The care plan will be reviewed and revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 39 the facility would only do a sleep assessment upon admission to the facility. She stated that information taken from the original sleep assessment was put into a monthly sleep log. R47's sleep log review notes, from 2/16 through 7/16, stated the resident was awake all day and slept all night. R47 slept a majority of the night. It stated he did have a period where he was awake for an hour or two at night but able to get back to sleep. It further stated he napped a few times during the day. 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. 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. Review of the facility document dated 4/22/09, Insomnia Assessment, advised staff to assess the cause of insomnia before initiating the use of hypnotic sleeping medications. It stated a sleep assessment and sleep log would be completed upon admission, sleep pattern change or complaints of insomnia, pre administration of ordered sleeping medications, and 7 days after discontinuing sleep medication. The 3 day sleep log would be documented according to acute charting. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure resident medication regimens are thoroughly reviewed for	21535	Resident number 47 – The resident's sleep/wake patterns will be tracked for three days after which a registered nurse will review the data and complete a sleep assessment. A licensed nurse will continue to document on the resident's sleep quality/patterns weekly. The nurse practitioner/physician will be notified of any ongoing problems with insomnia. The resident's care plan has been reviewed and updated accordingly. To monitor compliance, the Director of Nurses/designee will review the records of residents receiving medications to treat insomnia to ensure appropriate sleep tracking/assessments have been completed. The Medical Record Coordinator will review the records of new admissions for next 90 days to assure admission sleep tracking logs and assessments are completed in a timely manner. To further monitor compliance the Social Workers will audit the care plans of all residents with the diagnosis of depression to ensure that depression and related mood indicators are addressed. During the consultant pharmacist's monthly medication audits and the quarterly care planning process, the residents' medication regimen will continue to be reviewed to assure that medications used to manage mood and insomnia are appropriate and are monitored. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 40 unnecessary medications. The DON or designee could educate all appropriate staff on unnecessary medications. The DON or designee could develop a monitoring system to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21535	and Improvement Committee meeting.	
21555	MN Rule 4658.1325 Subp. 2 Administrationof Medications Staff designated Subp. 2. Staff designated to administer medications. A nurse or unlicensed nursing personnel, as described in part 4658.1360, must be designated as responsible for the administration of medications during each work period. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a prescribed medication was administered by licensed personnel; failed to ensure a prescribed medication was documented by the licensed personnel that had administered the medication and failed to ensure a prescribed medication was not left unattended by the licensed personnel for 1 of 7 residents (R14) observed for medication administration. Findings include: On 7/13/16, at 7:02 a.m., nursing assistant (NA)-B was observed to apply a medication patch to the middle lower back of R14. The medication	21555	Pharmacy Services Pine Haven Care Center provides pharmaceutical services (including procedures that ensures the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services within the facility and to guide development and implementation of pharmaceutical services and procedures. Persons authorized to administer medications must meet related state and federal requirements.	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21555	Continued From page 41 patch had the initials of licensed practical nurse (LPN)-A and the date of 7/13/16. NA-B stated the medication patch was a lidocaine patch. NA-B confirmed the initials on the patch were LPN-A's initials. NA-B confirmed she was not a trained medication aide. NA-B stated LPN-A had left the medication patch in the room for her to apply. NA-B stated typically the medication patch was left in the room for the nursing assistant to apply. R14's physician orders, dated 7/14/16, identified an order for icy hot pad five percent, apply to low back topically one time a day for pain and two times a day as needed. R14's medication administration record (MAR), dated 7/16, identified the initials of NA-A as being the person who administered the icy hot medication patch. On 7/13/16, at 8:05 a.m., LPN-A confirmed she was the person who initialed the icy hot medication patch and left the patch in R14's room for the nursing assistant to apply. LPN-A stated we usually have the nursing assistants apply the patch, as R14 likes it when the nursing assistants apply the patch. LPN-A stated the patch had been applied by the nursing assistants since she had worked at the facility for 1 and ½ years. LPN-A stated she would imagine it would be care planned that way because that was how it has always been done. On 7/13/16, at 8:18 a.m., NA-A, who was a trained medication aide, confirmed she had initialed for R14's icy hot medication patch. NA-A stated I did that because I got the medication patch out for LPN-A and put the patch on. On 7/13/16, at 8:25 a.m., the director of nursing	21555	The medication administration policies and procedures have been reviewed and found appropriate. The Consultant Pharmacist routinely provides training to the nursing staff on medication administration procedures and techniques. The next training session by 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 medications, that the nurse/trained medication aide who administers the medication must document its administration, that the person initialing a skin patch must be the person who applies it, and that medications are not to be left unattended with the resident unless the appropriate assessments, clinician orders, and care planning for self-administration of medications have been completed. The Icy Hot patch ordered for resident number 14 will be applied by staff authorized to administer medications. To monitor compliance, the Clinical Manager will observe for correct application of the Icy Hot patch for resident number 14 and for any other resident with an order for an over-the-counter analgesic patch. If noncompliance is noted additional observations and staff training will be done.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21555	Continued From page 42 (DON) stated the policy of the facility was staff had to be a trained medication aide or a nurse to administer medication. The DON stated medications were not to be applied by a nursing assistant. The DON stated the policy of the facility was the person initialing for the medication was to be the person administering the medication. On 7/13/16, a t 12:45 p.m., the DON stated she expected medications were never left unattended unless the resident had been assessed to be able to self-administer the medication. The DON stated R14 was not able to self-administer medications. The facility policy dated 2/15, Medication Administration General Guidelines, indicated medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly orientated to the facility's medication distribution system. Preparation 1) Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications. B. Administration 7) The person who prepares the dose for administration is the person who administers the dose. 14) Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self -administration of medications. D. Documentation (including electronic) 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. SUGGESTED METHOD OF CORRECTION: The	21555	Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21555	Continued From page 43 director of nursing (DON) or designee could develop systems to ensure, other than residents self administration as appropriate, only qualified staff is administering medications. The DON or designee could educate all appropriate staff on these systems. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21555		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, record review and interview facility failed to ensure that all medications were properly labeled and within proper outdates. Findings include: Observation: Observation of medication cart and medication room on the 600 wing was completed on 07/11/16, 5:00 p.m. with trained medication aid (TMA)-A. Upon observation of medication cart found a bottle of Senna syrup prescribed to (R50) with the directions to give 10 ml (milliliters) per g-tube daily as needed with an expiration date of 4/2016, Loperamide also prescribed for (R50) 20 ml per J (jejunostomy) tube for first loose stool and 10 ml after with expiration date of 6/2016. Senna tablets prescribed to (R45) give one tablet by mouth three times daily as needed with expiration date of 6/2016. Upon observation of	21620	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 accurate 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 with currently accepted professional principles	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 44 medication room refrigerator found facility stock medication, Aplisol (a tuberculin derivative) injection 1 ml which was 1/4 of the way full with a lot #772984 that had an open date of 5/27/16 and outdated 30 after opening or June 26, 2016. Acetaminophen that was prescribed to (R22) 650 mg suppository, insert one suppository per rectum every six hours as needed with an expiration date of 4/2016 and Bisacodyl prescribed to (R50) suppository 10 mg (milligram), insert one suppository rectally daily as needed with an expiration date of 4/2016. Observation of medication cart and medication room on the 300 wing was completed on 7/11/16, at 5:29 p.m. with licensed practical nurse (LPN)-B. Upon observation found Quetiapine which was prescribed to (R47) 50 mg with an expiration date of 5/22/15, Tylenol prescribed to (R14) give two tablets by mouth three times daily as needed with an expiration date of 12/2015, Ultram prescribed to (R14) 1 tablet by mouth four times daily as needed with an expiration date of 8/2015. Observation of medication cart and medication room on the 500 wing was completed on 7/11/16, at 6:00 p.m. with trained medication aide (TMA)-C. Upon observation found a stock Nitrostat 0.4 mg with an expiration date of 7/2015. This medication was administered to (R60) on 6/27/16 according to facility documents. Robitussin prescribed to (R49) 5 ml by mouth every six hours as needed with an expiration date of 3/2016, Stock supply of Tums with expiration date of 5/2016. Milk of Magnesia prescribed to (R37) give 30 ml by mouth daily as needed with an expiration date of 4/2016, Nitrostat prescribed to (R29) place one tab under tongue every five minutes for three doses with an expiration date of 7/2015, Novolog prescribed to (R17) inject 10 units subcutaneous per sliding scale which had	21620	and standards and that all drugs and biologicals are stored in a secure, locked location with access only by authorized personnel. Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standards. The medication related policies and procedures were reviewed and found appropriate. According to facility policy 1) if there is a change in medication administration instructions, an adhesive sticker stating “Directions Changed Refer To Chart” will be applied to the medication container to alert the staff to refer to the medication administration record for changes and 2) expiration dates are to be checked before administering medications/biologicals. During the mandatory meeting August 15, 2016, the nurses and trained medication assistants will be reinstructed on 1) the importance of medication label accuracy and the procedure for attaching notification labels to the containers when there is an order change 2) the need to check expiration dates before administering medications/biologicals 3) the policy for disposing of outdated medications/biologicals as well as those that have unreadable labels or are mislabeled/unlabeled. The labels of all medications/biologicals were checked for expiration dates, completeness and readability. Continued compliance with the disposition of outdated medications/biologicals and those that are mislabeled/unlabeled will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 45 an open date of 6/11/2016 and artificial tears prescribed to (R32) one drop in left eye four times a day with an expiration date of 2/2015. Found medication bottles including Vitamin B12 and Bone builder for (R42) that had no resident 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 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 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 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 the needle. RN-C started to prime the pen with the cap on. Stopped RN-C at that time and again asked about manufacturer's guidelines related to	21620	monitored monthly by Director of Nurses/designee - staff member authorized to administer medications and the consultant pharmacist. To monitor 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 medication administration record. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 46 priming the insulin pen. RN-C removed the cap and primed the pen with two units of lantus. Interviews: Interview with TMA-A on 7/11/16, at 5:00 p.m. verified expiration dates of medications. TMA-A stated if an expired medication is found it would be removed from the medication cart/medication room, would be re-ordered and the director of nursing (DON) would be informed. Interview with LPN-B on 7/11/16, at 5:29 p.m. verified expiration dates of medication and stated that another LPN on the night shift is supposed to be going through all the carts and medication rooms looking for expired medications. LPN-B verified that if an expired medication is found that it should be removed from the medication cart/medication room so that it isn't given to any residents. Interview with TMA-C on 7/11/16, at 6:00 PM verified expiration dates of medications and verified missing resident identifying labels and stated that all medications should be labeled with resident name and that any medications without a label should not be given. TMA-C stated the expired medications should have been removed and placed in a bin in the medication room as well as the DON should have been notified. TMA-C verified that expired medications should not be administered. Interview with RN-C on 7/12/16, at 9:21 a.m. verified the labels on the insulin pens and vials were incorrect. RN-C stated when an order is changed by the doctor that a label change sticker should have been placed over the existing label as soon as the order was changed.	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 47 Interview with DON on 7/13/16, at 2:24 p.m. stated that staff should be checking for expired medications every time they are administering medications and the expectation when finding expired medications is that they are pulled out of circulation, placed in medication room, sent back to pharmacy, reordered, notify family if needed. DON verified that label change stickers should be placed immediately once the order has changed. DON verified that nursing staff had received training on the proper use of insulin pens. DON reported that staff received training at least once a year related to insulin pen usage. Record Review: DON provided the staff training information that was presented to nursing staff on the proper use of insulin pen administration. Training documentation titled, "Insulin Pen Administration" identifies, "it is possible for small amounts of air to collect in the cartridge with normal use. To avoid injecting air, an "airshot" is performed before each injection. Turn the dose selector to 2 units. Hold the pen pointing the needle up, press the push-button all the way in until the dose selector shows 0. You should see a drop of insulin at the tip of the needle. DON provided a list of nursing staff who had received training on the proper use of insulin pen and RN-C is documented to have received training on 12/30/2015. Manufacturer's guidelines for Long-Acting Lantus Insulin was provided by the DON. Manufacturer's guidelines identify to perform a safety test prior to injecting insulin. This test is performed by dialing a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 48 the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. Policy: Specific Medication Administration Procedures policy dated February of 2015 states check expiration date on package/container before administering any medication. Medication Ordering and Receiving from Pharmacy policy dated February of 2015 identifies If the physicians's directions for use change or the label is inaccurate, the nurse may place a "directions changed-refer to chart" label on the container indicating there is a change in directions for use. Resident-specific nonprescription medications that are not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name. Medication storage in the facility policy dated February of 2015 identifies that outdated medications are immediately removed from inventory. The nurse will check the expiration date of each medication before administering it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee develop systems to ensure medication is regularly monitored for expiration dates. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 49	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean and sanitary environment for the facility kitchen where all meals were prepared. This had the potential to affect residents who resided in the older wings of the facility and not the newly renovated wing of the facility. In addition, the facility failed to maintain the cleanliness of the bathroom ceiling vents for 3 of 6 shared bathrooms on the 200 wing of the facility. This had the potential to affect all residents residing on the 200 wing unit. Findings include: 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	21685	Safe, Sanitary, Comfortable Environment It is the policy of Pine Haven Care Center to provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public. As part of an ongoing process to provide a pleasant, homelike environment, Pine Haven Care Center has a schedule for routine cleaning, repairs, and maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/supervisory staff. During the mandatory meetings August 15, 2016, the staff will be reminded to observe for equipment/furnishings/structures that need to be repaired, cleaned, or replaced. The procedures for reporting work items to the Maintenance Director will be reviewed.	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 50 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 Seven of ten sprinkler heads in the kitchen were covered with dust During the kitchen tour on 7/13/16, at 9:30 a.m., the dietary manager (DM) verified the soiled areas. The DM stated the daily cleaning schedule for the Monday AM cook included checking hood vents and dish room vents, and if soiled, dietary was to write out a maintenance slip for them to clean it. The DM verified the cleaning schedules lacked ceilings, light fixtures, ceiling exhaust vents, and sprinklers. The DM further stated the stove hood screens were last cleaned 2/17/15. The DM verified the invoices provided were for cleaning in the kitchen. The DM stated the gas stove hood was scheduled to be cleaned on 7/15/16. The DM verified the maintenance department had not been notified to clean the soiled areas prior to the initial tour. Document review of invoice dated 2/17/15, identified hood cleaning completed. Document review of invoice dated 8/2/15, identified cleaning ceiling and floors completed. During interview on 7/14/16, at 7:00 a.m., director of nursing verified all 51 residents ate food prepared from the facility kitchen.	21685	The soiled kitchen ceiling light fixtures, stove hood vent screens, ceiling exhaust vents, ceiling tiles, ceiling vent screen, and sprinkler heads were cleaned. The maintenance staff will be responsible for ongoing cleaning of ceiling exhaust vents, ventilation screens, sprinkler heads, light fixtures and tiles. These tasks have been added to the maintenance cleaning task list and will be checked quarterly and cleaned as needed. During the August 4, 2016 meeting, the dietary staff were instructed to be observant for areas that need cleaning and were informed of the cleaning schedule for the stove hood vent screens and water pipes. The dietary staff will inform the maintenance staff of any areas that need attention between the routine maintenance checks. Due to a major addition to the facility, during the week of the survey the residents in the 200 wing were in the process of being relocated. The rooms and bath rooms in the 200 wing are in the process of being deep cleaned including painting and rewaxing floors in preparation for residents being moved back to the 200 wing. The bathroom vents/ducts in all resident bathrooms were checked for dust build up. Compliance will be monitored by the Maintenance Director through observation of ceiling fixtures/tiles and review of maintenance cleaning logs and by the dietary supervisor through observation of the stove hood vent screens and audits of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	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 contained 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 to have collected balls of dust in the grating of the ceiling vent. The maintenance director stated that the facility did not regularly monitor the ceiling vents in the bathrooms to ensure that they were cleaned on a regular basis.	21685	the kitchen cleaning task sheets. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 52 The facility did not have a policy that addressed the regular cleaning of resident bathrooms. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure the facility is well maintained for comfort, safety, and cleanliness. The administrator or designee could educate all appropriate staff on what those systems are. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21685		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in	21830		8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 53 writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 54 (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to provide choices for frequency of bathing for 2 of 3 residents (R42, R43) reviewed for choices. Findings include: R42's annual Minimum Data Set (MDS) dated 4/14/16, indicated R42 was cognitively intact and required assist of one staff for bathing. R42's	21830	Self-Determination/Participation Pine Haven Care Center staff respect the 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 resident. The facility recognizes the right of the resident or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 55 current care plan, indicated R42 required assistance for bathing and preferred showers. The facility bath schedule sheet dated 7/7/16, identified R42 was scheduled for a tub bath on Fridays for the day shift. On 7/11/16, at 5:11 p.m., R42 stated facility staff chose the bath for her and she "went along with it." R42 stated she received a bath once a week on Friday. R43's quarterly MDS dated 6/8/16, indicated R43 was cognitively intact and required assist of one staff for bathing. R43's current care plan, indicated R43 required assistance for bathing and was to have a sponge bath. However, the facility bath schedule sheet dated 7/7/16, identified R43 was scheduled for a tub bath or shower on Tuesdays during the day shift. On 7/11/16, at 1:28 p.m., R43 stated she was not allowed to choose the frequency of her bathing. R43 further stated she received a bath once a week but would prefer a bath twice a week. On 7/12/16, at 1:38 p.m., nursing assistant (NA)-E stated staff reference the bath sheet to know when a resident is scheduled to receive a bath. NA-E stated somebody "higher up" 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	21830	resident representative to make informed choices about care and treatment including the right to determine his/her bathing schedule, frequency, and type of bath. The residents are encouraged to participate to the greatest extent possible in the care planning process and the staff assists them in exercising their rights by discussing with the resident (or the resident's representative) the resident's condition, treatment options, personal preferences, and any potential consequences of accepting or refusing the recommended treatment. A policy for determining the residents' bathing preferences has been drafted and the related procedures reviewed and revised. As part of the admission process, residents are asked about preferences and the importance of choosing what to wear, type of bath, snack availability, locking up personal belongings, choosing arise/bedtime, having reading material available, listening to favorite music, keeping up with the news, participating in religious services/practices, etc. Attempts are made to follow preferences for cares and services to the greatest extent possible. The resident's preferred bathing schedule, frequency of bathing, and type of bath (tub/shower/sponge/bed bath) will be addressed and his/her preferences included in the individualized plan of care. The resident/legal representative will be asked about satisfaction with cares/services during the quarterly care conferences, with significant change and more often if indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 56 they prefer. Short term residents have showers in their rooms which makes it easier to accommodate the preference. RN-B stated she did not ask residents upon admission how many baths a week the resident would like. RN-B stated social services asked about bathing preference upon admission. RN-B stated she did not ask long term residents how many baths a week they preferred. On 7/12/16, at 3:18 p.m., director of social services (DSS)-A stated social services did not ask about resident preference for bathing preference. On 7/12/16, at 3:25 p.m., RN-A stated when RN-B was unable to complete the admission process for residents she filled in. RN-A stated staff usually assigned one bath a week upon admission and administrative assistant (AA)-F assigned which day the resident would receive a bath. RN-A stated asking the resident frequency of bathing was not a formal question she had ever asked upon admission. RN-A stated during the resident's initial care conference, usually within five days of admission, staff asked the resident if they wanted any changes in their plan of care. RN-A stated we are not documenting the frequency of bathing unless there is a concern. On 7/12/16, at 3:35 p.m., AA-F stated she was responsible for the scheduling of baths. AA-F stated she scheduled new admissions a weekly bath unless they want more. AA-F stated staff let her know if a resident requested a change in bathing. On 7/13/16, at 8:36 a.m., the director of nursing (DON) stated residents were asked about bathing preferences. The residents are assigned a bath	21830	During the mandatory meeting August 15, 2016, the nursing staff will be informed of the residents' right to make choice regarding heath care services consistent with his/her interests, assessments, and plans of care including the right to have their bathing preferences respected. Resident number 42 - The RN clinical manager will interview the resident regarding her preferred bathing type and frequency. The resident's plan of care and the nursing assistants' care reference cards will be reviewed and updated as 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. Resident number 43 – The resident is currently in the hospital. Upon her return to the facility, the resident will be interviewed by RN clinical manager regarding her preferred bathing type and frequency. The resident's plan of care and the nursing assistants' care reference cards will be reviewed and updated as necessary to reflect 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 routine care conferences. Respect for the resident's right to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 57 once a week unless they specifically requested they wanted one more often. A policy regarding the choice for frequency of bathing was requested. On 7/14/6, at 7:20 a.m., the DON stated the facility did not have a policy for the choice of bathing. 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. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21830	self-determine and participate in health care decisions as well as their satisfaction with cares will be monitored by the Social Workers during one-on-one interviews, during the routine care conferences, and through feedback from Resident Council meetings. The Life Enrichment staff will continue to ask the resident about the importance of choosing the type of bath as part of the minimum data set completion process. Any care concerns will be communicated to the appropriate department manager/supervisor. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to resolve resident council grievances in regards to nursing, dietary and social service department concerns reported to the facility by the resident council. This had the potential to effect residents who needed assistance with activities of daily living.	21870	– Resident and Family Groups Pine Haven Care Center respects and promotes the existence of the Resident Council. The concerns and recommendations of the families and residents are reviewed and taken into	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 58 Findings include: On 7/11/16, at 6:45 p.m., R14 stated the facility did not consistently follow up on grievances raised during resident council. When the resident council made suggestions/raised concerns, facility staff did not consistently get back to the resident that made the complaint. Review of the Resident Council meeting minutes revealed the following grievances: 2/23/16 - Resident council meeting minutes indicated nursing department concerns included taking too long to get ready for bed, overbed table or call light not within reach, not obtaining a nurse upon request, waiting too long to use the bathroom, call light time too long in the morning, overall poor call light response times including staff stating the will be right back and do not come back. It was decided that the nurse manager would meet with staff today at shift change to get this matter addressed quickly and follow up would take place to see if it improved. 3/22/16 - Resident council meeting minutes indicated dietary concerns included a resident not being fed right when assisted, mostly cold food at lunch, wanted soup/none puree, request for pizza, Sundays were always beef and mashed potatoes and residents would like something different. 4/26/16 - Resident council meeting minutes indicated nursing concerns included nursing and resident communication about tests/prep, dietary concerns included requests for more variety on Sundays, one resident requested he receive a variety of sandwiches not just egg salad, and	21870	consideration during decision-making and the development of policies and procedures affecting resident services. The facility attempts to accommodate the Councils' recommendations to the greatest extent possible. The Resident Council meetings are routinely attended by interdisciplinary care team department managers and the administrator. The Life Enrichment Director/designee facilitates the meetings, writes the meeting minutes, ensures that the appropriate department managers are notified of resident concerns, and tracks resolution of the concerns. The polices and procedures for conducting the Resident Council meetings were reviewed and revised. The meeting agenda and minutes will be expanded to routinely include action plans and follow up to resident concerns. During the August 3, 2016 monthly Quality Assurance and Assessment meeting, the importance of responding to resident concerns and the procedures for addressing resident concerns were reviewed with the department managers. As discussed, the department managers will continue to address/investigate resident concerns; the resolution/findings will be reported during the next Resident Council meeting. The minutes of previous four Resident Council meetings were reviewed to ensure that the residents' concerns/comments were addressed and the findings/resolution communicated and documented. Dave Christianson,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 59 social services concerns included privacy concerns which would be addressed with staff. 5/24/16 - Resident council meeting minutes identified nursing concerns including questions about resident death notification. Residents stated they learned of a resident death in the newspaper. Residents further stated were a family here and would like to support each other and families too. There would be a team formed and a plan made for resident notification of death. 6/28/16 - resident council meeting minutes indicated nursing concerns related to obtaining the assistance of a nurse. The nurse manger would follow up on communication between nursing staff. Resident council meeting minutes failed to include documentation of follow up for the concerns identified from 2/23/16 through 6/28/16. On 7/13/16, at 11:11 a.m., activity director (AD)-C stated the managers assigned concerns were supposed to take care of it. Managers were to get back to AD-C with solutions which would be documented in the minutes. AD-C stated the resident council minutes are sent out every month to all managers by email with a reminder to get back to her. AD-C stated if no resolution was documented in the minutes in the last six months the resolution was "probably not there." On 7/13/16, at 2:15 p.m., the administrator stated when grievances were expressed at the resident council meeting, each department manager there at the time of the meeting took the information went back and worked on the concern. AD-C's email should be the second reminder of grievances or concerns to be addressed. Staff	21870	Long-term Care Ombudsman, was a guest speaker at the July 26, 2016 Resident Council meeting and reviewed the residents' rights including the right to care and services that meet professional practice standards. During the mandatory meeting August 15, 2016, the staff will be reminded of the resident's right to have concerns reported and addressed in a timely manner and of the expectation that the care will be provided in a timely manner as outlined in the plan of care. Resident rights and tips/suggestions to improve the residents' care and quality of life are included in the monthly staff newsletter. To monitor compliance, the Administrator/Designee will audit the Resident Council minutes for the next three months to assure that residents' concerns are being addressed in a timely manner and that resolutions/responses are being reported to the Resident Council and/or specific residents as appropriate. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the October 2016 quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 60 was to follow up at the next resident council meeting by each department what they did to resolve the concern. The administrator stated concerns were brought up in the meeting and any resolution would probably be verbal, not written. The administrator stated it was not facility practice to document resolution to the concerns to be reviewed later with residents. The facility policy Resident Council, dated 4/7/09, indicated minutes of the council would reflect all concerns and suggestions addressed and facility response to suggestions. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures related to grievances and resolution of grievances to ensure residents/families are informed of the resolution. The administrator or designee could educate all staff on the process. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		