S
(

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART L. TO BE COMPLETED BY THE STATE SURVEY ACENC

						TE SURVEY AGENCY	ID: 6EF5 Facility ID: 00148
 MEDICARE/MEDICA (L1) 245359 STATE VENDOR OR M (L2) 664240300 			3. NAME AND AI (L3) PINE HAVE (L4) 210 NORTH (L5) PINE ISLA	EN CARE CEN IWEST 3RD ST	TER INC	(L6) 55963	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE C (L9)	HANGE OF OWNE	RSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 DATE OF SURVEY ACCREDITATION S[®] 0 Unaccredited 2 AOA 	11/17/202 TATUS: 1 TJC 3 Other	1 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CE From (a) : To (b) :	RTIFICATION				S:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN	e Following Requirements: 6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 13.Total Certified Beds		70 (L18)70 (L17)	B. Not in Co	Acceptable POC ompliance with Pro and/or Applied W	-	4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A *) 8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BE 18 SNF	ED BREAKDOWN 18/19 SNF 70	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37)	(L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AG	GENCY REMARKS	(IF APPLICABL	LE SHOW LTC CANC	ELLATION DAT	E):		
17. SURVEYOR SIGNA	ATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Karen Aldinge	er, Unit Supe	rvisor		12/02/2021	(L19)	Melissa Poepping, Enfo	prcement Specialist 12/02/2021 (L20)
	PAR	T II - TO BI	E COMPLETED	BY HCFA R	()	L OFFICE OR SINGLE ST.	
-	OF ELIGIBILITY y is Eligible to Partici ty is not Eligible	pate (L21)		MPLIANCE WITH GHTS ACT:	I CIVIL		cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE	23	. LTC AGREEN	IENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATIO 11/01/1986	N	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	nt 06-Fail to Meet Agreement
25. LTC EXTENSION	DATE: 27		VE SANCTIONS n of Admissions:	(T.44)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
	(L27)	B. Rescind Su	spension Date:	(L44) (L45)			00-Active
28. TERMINATION DA	.TE:	29	9. INTERMEDIARY/			30. REMARKS	
			00131				
		(L28)			(L31)		
31. RO RECEIPT OF CM	MS-1539	32	2. DETERMINATION 11/19/2021	OF APPROVAL I	DATE		
		(L32)			(L33)	DETERMINATION APPR	OVAL



Electronically delivered December 2, 2021 CMS Certification Number (CCN): 245359

Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

Dear Administrator:

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 December 1, 2021 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mighing

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Electronically delivered December 2, 2021

Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

RE: CCN: 245359 Cycle Start Date: July 8, 2021

Dear Administrator:

On July 29, 2021, we notified you a remedy was imposed. On December 2, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 1, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 13, 2021 be discontinued as of December 1, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 29, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 8, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Fing

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Electronically delivered

December 2, 2021

Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

Re: Reinspection Results Event ID: 6EF522

Dear Administrator:

On November 29, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 14, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Mi This

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

CENTERS FOR MEDICARE & MEDICAID SERVICES

-								
MEDIC	ARE/N	AEDIC	AID CER	TIFICATI	ON AND	TRANS	MITTAL	
	TOD		INT DUDD	DUTTE			ACENCE	7

ID: 6EF5

PART I	- TO BE COMPLETED BY THE STA	TE SURVEY AGENCY	Facility ID: 00148
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245359 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: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On Gith With the complete the second second
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 On-Site Visit Other Full Survey After Complaint
6. DATE OF SURVEY 09/16/2021 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II 04 SNF 08 OPT/SP 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 70 (L18)	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	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
	Requirements and/or Applied Waivers:	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 70	ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	ABLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Ruth Furan, HFE NE II	11/08/2021 (L19)	Melissa Poepping, Enforce	ement Specialist 11/12/2021 (L20)
PART II - TO BE	COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE ST	FATE AGENCY
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Finan Ownership/Contro Both of the Above 	I Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE	EMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNIN 11/01/1986	IG DATE ENDING DATE	VOLUNTARY 00 01-Merger, Closure 0	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination	
	TVE SANCTIONS on of Admissions: (L44)	04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
(L27) B. Rescind	Suspension Date: (L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	00131 (L31)		
	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPR	OVAL



Electronically delivered October 11, 2021

Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

RE: CCN: 245359 Cycle Start Date: July 8, 2021

Dear Administrator:

On July 29, 2021, we informed you of imposed enforcement remedies.

On September 16, 2021, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 13, 2021, will remain in effect.
- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 13, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 13, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

An equal opportunity employer.

As we notified you in our letter of July 29, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 13, 2021. However, due to the extended survey the new NATCEP loss date is July 8, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division

> Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 8, 2022 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

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

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145 Cell: (507) 361-6204 Email: william.abderhalden@state.mn.us Fax: (651) 215-0525

Feel free to contact me if you have questions.

Mi Ping

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO.	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	PLETED
		245359	B. WING		OMB NO. 09 (X3) DATE S COMPLI C 09/16	
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
	compliance with Ap Preparedness Required conducted during a	pendix Z, Emergency uirements, §483.73(b)(6) was standard recertification				
F 000	signature is not req page of the CMS-2 correction is require acknowledge receip	uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents	F 000)		
	recertification surve facility. Complaint in conducted. Your fac compliance with the	ey was conducted at your nvestigations were also cility was found NOT in e requirements of 42 CFR 483,				
	SUBSTANTIATED: H5359065C (MN67 725 H5359071C (MN48 deficiencies cited d	309) with a deficiency cited at 800) with no current ue to actions implementd by				
	UNSUBSTANTIATE H5359064C, (MN73 (MN59840), H5359	ED:H5359066C (MN71083), 3478), H5359067C 068C (MN68715), H5359069C				
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
AND PLAN OF CORRECTION DEBNTIFICATION NUMBER: A. BUILDING COMPLETED 1 243359 STREET ADDRESS. CITY. STATE. 2IP CODE C 1 NAKE OF PROVIDER OR SUPPLICR STREET ADDRESS. CITY. STATE. 2IP CODE C 1 PINE HAVEN CARE CENTER INC STREET ADDRESS. CITY. STATE. 2IP CODE C 1 SUMMAYS TRAMENT OF DEFICIENCES D PREVIX RECOUNTORY OR LSC IDENTIFYING INFORMATION 1 TAG SUMMAYS TRAMENT OF DEFICIENCES D PREVIX RECOUNTORY OR LSC IDENTIFYING INFORMATION 1 CO. 09/13/2021 thru 09/16/2021, a survey for compliance with Appendix Z. Emergency Preparedness Requirements, \$483.73(b)(6) was conducted during a standard recertification survey. The facility is enviled in ePOC and therefore a signature is not requirements, \$483.73(b)(6) was conducted at buo during a standard recertification survey. The facility as rounded at the bottom of the first page of the CMS-2657 form. Although no plan of correction is required. Its required that the facility acknowledge receipt of the electronic documents F 000 1 On 09/13/2021 through 09/16/2021, a standard recertification survey was conducted at your facility. Complaint were found to be SUBSTANTIATED: F 000 1 Do 19/13/2021 through 09/16/2021, a standard recertification survey was conducted at your facility. Complaints were found to be SUBSTANTIATED: F 000 1 Dr 100/13/2021 through 09/16/2021, a standard recertification survey was conducted at your facility. Complaints were found to be SUBSTAN			10/21/2021			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 11/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER 245359 B. WING C PINE HAVEN CARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 STREET ADDRESS, CITY, STATE, ZIP CODE 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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLE CROSS-REFERENCE TO THE APPROPRIATE COMPLE COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE COMPLE COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE COMPLE CROSS-REFERENCE TO T			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE PINE HAVEN CARE CENTER INC STREET ADDRESS, CITY, STATE, 2IP CODE (M) ID PREFIX ISTREET ADDRESS, CITY, STATE, 2IP (M) ISTREET ISTREET ADDRESS, CITY, STATE, 2IP (M) ISTREET ISTREET (M) ISTREET ISTREET (M) ISTREET </td <td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td></td> <td></td> <td>LE CONSTRUCTION</td> <td>(X3) DATE COM</td> <td>E SURVEY PLETED</td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PINE HAVEN CARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE PINE ISLAND, INN 5963 SUMMARY STATEMENT OF DEFICIENCIES ID PREVIDER OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION INST BE PRECIDED BY FULL (EACH DEPICIENCY MUST BE PRECIDED BY FULL TAG PREVIDE ACTIONS PLAN OF CORRECTION INST BE PRECIDED BY FULL (EACH DEPICIENCY MUST BE PRECIDED BY FULL TAG F 000 Continued From page 1 F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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. F 000 F 550 Resident Rights/Exercise of Rights SS=D F 550 SS=D CFR(s): 483.10(a)(1)(2)(b)(1)(2) §443.10(a)(1) A facility must treat each resident with respect and dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. F 550 §443.10(a)(1) A facility must treat each resident with respect and dignify and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and			245359	B. WING	i			
PINE HAVEN CARE CENTER INC PINE ISLAND, MN 55963 (m) ID PREERX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST ERRECODE DO FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEX TAG PREEX (EACH CORRECTIVE ACTION BHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DO COMPLE DEFICIENCY F 000 Continued From page 1 The facility plan of correction (POC) will serve as your allegation of compliance upon the Departments 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. F 000 F 550 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. F 550 F 550 10/29/ SS=D CFR(s): 483.10(a) (R)(1)(2)(b)(1)(2) \$483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. F 483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY F 000 Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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. F 000 F 550 10/29/ 10/29/ F 550 Resident Rights/Exercise of Rights SS=D F 550 10/29/ 5483.10(a) (1)(2)(b)(1)(2) F 550 10/29/ 5483.10(a) (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and F 550	PINE HA	VEN CARE CENTER I	NC					
The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. F 550 F 550 Resident Rights/Exercise of Rights SS=D F 550 CFR(s): 483.10(a)(1)(2)(b)(1)(2) F 550 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. F 483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each residents individuality. The facility must protect and	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550	The facility's plan of as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an onsite revisit of your validate that substar regulations has beet Resident Rights/Ex CFR(s): 483.10(a)(§483.10(a) Resider The resident has a self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A fac with respect and dig resident in a manner promotes maintena her quality of life, re- individuality. The fa promote the rights of §483.10(a)(2) The fa access to quality ca severity of condition must establish and provision of service	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance. acceptable electronic POC, an r facility may be conducted to ntial compliance with the en attained. ercise of Rights 1)(2)(b)(1)(2) at Rights. right to a dignified existence, and communication with and and services inside and including those specified in ility must treat each resident gnity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's cility must protect and of the resident. facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all					10/29/21

If continuation sheet Page 2 of 97

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI	י יסוד		<u>1B NO.</u>	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				· ·	PLETED
			The BOILD			(C
		245359	B. WING				16/2021
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			IO NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 550	Continued From pa	age 2	F 5	550			
	rights as a resident or resident of the U §483.10(b)(1) The resident can exerci- interference, coerc from the facility. §483.10(b)(2) The free of interference reprisal from the fa rights and to be su exercise of his or h subpart. This REQUIREME by: Based on observa review, the facility f assistance to prom residents (R49) wh assistance with sha	he right to exercise his or her t of the facility and as a citizen Inited States. facility must ensure that the ise his or her rights without ion, discrimination, or reprisal resident has the right to be e, coercion, discrimination, and cility in exercising his or her pported by the facility in the her rights as required under this NT is not met as evidenced tion, interview, and document failed to provide personal care note dignity for 1 of 2 female o depended on staff for			Preparation and execution of this response and plan of correction doe constitute an admission or agreeme the provider of the truth of the facts alleged or conclusions set forth in th statement of deficiencies. The plan of correction is prepared and/or execut	nt by ie of	
	cognition was seve dependent on phys all activities of daily personal hygiene a R49's face sheet p R49's diagnoses in and Alzheimer's. R49's care plan las indicated R49 requ	B/6/21, indicated R49's erely impaired. R49 was sical assistance from staff for / living (ADLs) including and grooming. rinted on 9/15/21, indicated acluded depression, dementia, st review date 6/25/21, ired total assistance with which included shaving facial			solely because it is required by the provisions of federal and state law. If the purposes of any allegation that the center is not in substantial compliant with federal requirements of participant this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual 1. It is policy of Pine Haven Commune ensure that all residents are treated dignity. Resident R49 was shaved of 10/12/2021.	he ce ation, ion al. nity to with	

Facility ID: 00148

If continuation sheet Page 3 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245359	B. WING	i			C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET VINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From particular Continued From particular Content of the search of the searc	age 3 25 p.m. R49 was observed Ichair in her room. R49 had arse, white hairs that were nch in length on her chin and a.m. R49 was seated in her ining room. R49 had greater ite hairs that were nch in length on her chin and a.m. nursing assistant (NA)-D se (RN)-H were observed morning cares. R49 was , into her wheelchair. RN-H and dried it. NA-D combed ught R49 to the dining room. RN-H offered to assist R49 with hair. a.m. NA-D stated R49 al assistance from staff for nd grooming which included NA-D stated he had never esident with facial hair but needed. NA-D confirmed he s face with morning cares and a shaver in her room. NA-D e dining room then confirmed se, white hairs on her chin and	ľ	550		s were ed and / I to be ded. ted with having sure d daily x thly x Quality	

If continuation sheet Page 4 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	• • • • • • • • • • • • • • • • • • •	ige 4 s, we aren't doing it and staff	F 5	550			
	are in a hurry." RN- embarrassed and u	J indicated she would feel Incomfortable if she was ents and had long facial hair.					
	able to speak for he	a.m. RN-H stated if R49 was erself, she would be bothered air when around other rs.					
	(DON) stated she e care of on bath day DON expected fem assistance with sha would anticipate if the the mirror, the whis to them." DON com	29 a.m. director of nursing expected facial hair was taken is and as needed in between. hale residents received aving facial hair for dignity, "I hey were to see themselves in kers would not be acceptable inpared it to herself walking out at her hair being combed.					
F 623 SS=D	indicated each resid manner that promo sense of well-being and feelings of self- Notice Requiremen	hity" revision date 2/2021, dent shall be cared for in a tes and enhances his or her l, level of satisfaction in life, -worth and self-esteem. Its Before Transfer/Discharge 3)-(6)(8)	F 6	623			10/29/21
	resident, the facility (i) Notify the resider representative(s) of the reasons for the language and mann facility must send a	nsfers or discharges a r must- nt and the resident's f the transfer or discharge and move in writing and in a ner they understand. The copy of the notice to a ne Office of the State					

Facility ID: 00148

If continuation sheet Page 5 of 97

TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245359	B. WING _		09	C / 16/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
PINE HA		INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 623	 (ii) Record the reas discharge in the reas accordance with paragraph (c)(5) of §483.15(c)(4) Timir (i) Except as specif (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be before transfer or d (A) The safety of in be endangered under this section; (B) The health of in be endangered, under paragraph (c) (D) An immediate to required by the resident's hallow a more imme under paragraph (c) (D) An immediate to required by the resident has redays. §483.15(c)(5) Control (ii) The reason for the facility for the facility for the resident has redays. 	ons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section. In this section. In this section. In the notice of transfer or under this section must be or at least 30 days before the red or discharged. In the notice of transfer or under this section must be or at least 30 days before the red or discharged. In the facility would der paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of the alth improves sufficiently to diate transfer or discharge, E(1)(i)(B) of this section; ransfer or discharge is ident's urgent medical needs, E(1)(i)(A) of this section; or not resided in the facility for 30 ents of the notice. The written paragraph (c)(3) of this section llowing: transfer or discharge; te of transfer or discharge; te of transfer or discharge; te of transfer or discharge; which the resident is	F 62			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	and telephone num receives such reque to obtain an appeal completing the form hearing request; (v) The name, addr telephone number of Long-Term Care Or (vi) For nursing faci and developmental disabilities, the mail telephone number of the protection and a developmental disa C of the Developme and Bill of Rights Ac codified at 42 U.S.C (vii) For nursing fac disorder or related of email address and agency responsible advocacy of individu established under th for Mentally III Indiv §483.15(c)(6) Chan If the information in effecting the transfer must update the red as practicable once becomes available. §483.15(c)(8) Notic In the case of facilit the administrator of written notification p	address (mailing and email), ber of the entity which ests; and information on how form and assistance in a and submitting the appeal ess (mailing and email) and of the Office of the State nbudsman; lity residents with intellectual disabilities or related ing and email address and of the agency responsible for advocacy of individuals with bilities established under Part ental Disabilities Assistance ct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and lity residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder ne Protection and Advocacy iduals Act. ges to the notice. the notice changes prior to er or discharge, the facility cipients of the notice as soon the updated information	F 6	223			

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245359	B. WING		(09/1	C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	State Long-Term Ca the facility, and the well as the plan for relocation of the res 483.70(I). This REQUIREMEN by: Based on interview facility failed to provinotices to the reside representative who 1 of 1 resident (R48 hospitalizations. Findings include: R48's progress note indicated R48 was at 10:30 a.m. due to breath. R48's medical reconotification and/or re During an interview social services desi worker (LSW), and indicated the facility residents and/or reshospital transfer no During an interview director of nursing (reason for transfer nursing should have information.	are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced and document review, the vide written hospital transfer ent and/or resident's had a facility-initiated transfer by reviewed for e dated 8/13/21, at 10:30 a.m. transferred to the emergency of an increase in shortness of rd lacked evidence of eason regarding transfer. on 9/16/21, at 10:15 a.m. gnee (SSD), licensed social registered nurse (RN)-A, a had not been providing sident's representatives written	F 623	 I.It is policy of Pine Haven Communesure that all residents and/or responsible party receive written hot transfer notices. Resident R48 was discharged from the facility on 09/17/2021. This has the potential to affect all residents in the facility. Staff re-education will be complete nursing staff to ensure that the reas transfer is on the bed hold form on 10/21/2021 and 10/25/2021. Audits will be performed at to ensure that the reas transfer not be given to residents and/or respon party by Nursing Management or designee daily x 10 days, then week then monthly x 1. Results will be revel by our Quality committee for further recommendation. 	spital 69 ed with on for ure ices sible kly x 6, <i>v</i> iewed	10/29/21
F 656 SS=D			F 656			10/29/21

If continuation sheet Page 8 of 97

PRINTED: 11/01/2021

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245359	B. WING _			C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				21	10 NORTHWEST 3RD STREET		
	VEN CARE CENTER I	NC		Ρ	INE ISLAND, MN 55963		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETION DATE
TAG	REGULATORTOR	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)		
r e			1				
F 656	Continued From pa	ge 8	F 65	56			
	8/183 21(b) Compre	hensive Care Plans					
		facility must develop and					
		ehensive person-centered					
		esident, consistent with the					
		orth at §483.10(c)(2) and					
		includes measurable frames to meet a resident's					
		nd mental and psychosocial					
		tified in the comprehensive					
		omprehensive care plan must					
	describe the followi						
		t are to be furnished to attain dent's highest practicable					
		nd psychosocial well-being as					
	required under §48	3.24, §483.25 or §483.40; and					
	.,	at would otherwise be required					
		3.25 or §483.40 but are not resident's exercise of rights					
		uding the right to refuse					
	treatment under §4						
	(iii) Any specialized	services or specialized					
		es the nursing facility will					
	provide as a result o	of PASARR If a facility disagrees with the					
		ARR, it must indicate its					
		dent's medical record.					
		vith the resident and the					
	resident's represent						
	(A) The resident's g desired outcomes.	oals for admission and					
		preference and potential for					
		acilities must document					
	whether the resider	nt's desire to return to the					
		sessed and any referrals to					
		ies and/or other appropriate					
	entities, for this pur	pose. s in the comprehensive care					

Facility ID: 00148

If continuation sheet Page 9 of 97

PRINTED: 11/01/2021

TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	0938-039 SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:		NG	Сом	PLETED
		245359	B. WING			C
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		16/2021
				210 NORTHWEST 3RD STREET		
PINE HA	VEN CARE CENTER	INC		PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 656	Continued From pa	age 9	F 65	56		
	requirements set for section. This REQUIREME by: Based on observar review the facility for comprehensive ca- urinary indwelling of (R61) reviewed for Findings include: During an observar R61 laid in bed, R61 urine collection base his bed. R61 states hospitalized becau- infection from his of another facility. R61's face sheet do was admitted to the	re plan was developed for catheter for 1 of 1 resident		 It is policy of Pine Haven Co ensure that all residents have a comprehensive care plan for in catheters. Resident R61 was d from the facility on 10/04/2021. This has the potential to affect residents in the facility. All reside indwelling catheters were revise ensure there were comprehens including indwelling catheters of 10/22/2021. Staff re-education will be com licensed nurses to ensure com care plans including indwelling 10/21/2021 and 10/25/2021. Audits will be performed to en- compliance with care plans inc- indwelling catheters by Nursing Management or designee daily 	dwelling ischarged et all 69 lents with wed to sive n opleted with prehensive catheter on nsure uding	
	sepsis, acute rena R61's hospital disc the section Lines/E included "Indwellin Coude [curved type summary did not ic balloon (balloon to bladder). R61's admission M 8/18/21, indicated catheter.	I failure, and urinary retention. charge summary dated 8/11/21, Drains/Airways/Wounds g Urinary Catheter Latex; e] 16 Fr [French]". The dentify the size of the catheter hold catheter inside the Minimum Data Set (MDS) dated R61 had an indwelling urinary e plan dated 8/11/21, also did		then weekly x 6 and monthly x will be reviewed by our Quality for further recommendation.	1. Results	

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	11/01/2021 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	0	(X3) DATI COM	E SURVEY PLETED
		245359	B. WING	i				C 16/2021
NAME OF	PROVIDER OR SUPPLIER		•	ŝ	STREET ADDRESS, CITY, STATE	, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREI PINE ISLAND, MN 55963	ΞT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD O THE APPROPI	BE	(X5) COMPLETION DATE
F 656	not identify the size required. R61's current physi order for an indwell order dated 8/15/21 R61's catheter even R61's treatment ad R61's catheter was R61's record did no catheter was inserte During an interview RN-B was asked w did R61 have, RN-E size and type of cat physician orders an was not a physician urinary catheter, no R61's care plan. RN physician order for size and type of cat During an interview RN-B indicated he the size that was pr Fr (French), howev type. During an interview licensed practical n record and confirme size and type of cat stated she would ha an order. At 8:38 a. catheter and stated	and type of catheter R61 cian orders did not identify an ing catheter. The physician , directed staff to change	F	656				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		245359	B. WING				_ 16/2021
NAME OF	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656 F 657 SS=D	identify the type or I there was not a way catheter in place. During an interview director of nursing (required a physician size and type of cat there should have b changing the cather Facility policy Care Centered policy dat care plan interventi thorough analysis of part of a thorough of The comprehensive will describe the se to attain or maintain practicable physica well-being. Incorpor reflect treatment go in measurable outc person centered ca seven days of the of MDS. Assessment care plans are revis resident and the res Care Plan Timing a CFR(s): 483.21(b)(2) §483.21(b) Compre §483.21(b)(2) A cor be- (i) Developed within the comprehensive	on 9/16/21, at 11:44 a.m. (DON) stated a catheter n's order that identified the heter and balloon size and been an order obtained prior to ter. plans, Comprehensive Person ed 12/2016, included, The ons are derived from a of the information gathered as comprehensive assessment. e, person centered care plan rvices that are to be furnished on the resident's highest l, mental, and psychosocial rate identified problem areas, pals, timetables, and objectives oomes. The comprehensive, re plan is developed within completion of the required s of residents are ongoing and sed as information about the sident's conditions change. nd Revision 2)(i)-(iii) whensive Care Plans mprehensive care plan must a 7 days after completion of assessment. interdisciplinary team, that	F 6				10/29/21

Facility ID: 00148

If continuation sheet Page 12 of 97

		AND HUMAN SERVICES				FORM	11/01/202 APPROVED 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		245359	B. WING	÷			_ 16/2021
NAME OF F	ROVIDER OR SUPPLIER	I		;	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	/EN CARE CENTER	INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From pa	-	F	657	,		
	resident. (C) A nurse aide wiresident. (D) A member of for (E) To the extent pr the resident and the An explanation must medical record if th and their resident ro not practicable for the resident's care plan (F) Other appropriate disciplines as deter or as requested by (iii)Reviewed and ro team after each as comprehensive and assessments.	rse with responsibility for the th responsibility for the od and nutrition services staff. racticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the n. tte staff or professionals in mined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the					
	Based on observa- review the facility fa care plan for activit the completion of s Data Set (MDS) wa residents reviewed Findings include: R175's Restorative 7/14/21, indicated F bed mobility and re assistance for trans	r			 1.It is policy of Pine Haven Commensure that all residents care plans reviewed and revised after an MDS complete or significant change for relation to bowel and bladder. Residents for a plan will be updated by 10/22/2021. 2.This has the potential to affect al residents in the facility. All resident plans will be reviewed by 10/22/2021 ensure they reflect current ADL for and bladder. 3.Staff re-education will be complete licensed nursing staff on 10/21/2022 10/25/2021 on Pine Haven policy or plane will be reviewed by 10/21/2022 10/25/2021 on Pine Haven policy or plane will be reviewed by 10/21/2022 10/25/2021 on Pine Haven policy or plane will be reviewed by 10/25/2021 on Pine Haven policy or plane will be plane will be policy or plane will be plane	s are S is ADL in dent I 69 s care 21 to bowel ted for 21 and n	
		/locomotion dated 5/11/20, /ambulation with FWW [front			updating and revising care plans for significant changes are addressed		

Facility ID: 00148

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
					10 NORTHWEST 3RD STREET		
PINE HA	VEN CARE CENTER I	NC			INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 13	F 6	57			
F 657	wheeled walker] an longer distances ou plan for transfers da required assist of o dressing care plan of one. R175's significant of indicated R175 had The MDS identified assistance from two mobility, transfers, p personal hygiene. R175's care plan di assistance in accor During an observat R175 sat in her who station. Nursing ass practical nurse (LPI LPN-D stated an ur would call therapy; stated to NA-A, R17 gait belt and a walk her room, NA-D foll a gait belt around F attempted to assist however, R175 was not cooperative with LPN-D entered the with transferring R1 attempted to assist and again R175 was LPN-D stated he was therapist to assist. A a full body mechanic	Ige 13 Ind gait belt. Use wheelchair for Itside of room." R175's care ated 5/11/20, indicated R175 ine for use with FWW. R175's dated 4/2/21, indicated assist change MDS dated 8/23/21, I severe cognitive impairment. R175 required extensive o or more staff for bed dressing, toilet use, and id not identify the level of dance with the MDS. ion on 9/14/21, at 12:32 p.m. eelchair in front of the nursing sistant (NA)-A asked licensed N)-D how R175 transferred. hawareness and stated he LPN-D called therapy and 75 required two assist with a fer. NA-A wheeled R175 into lowed into the room. NA-A put R175, NA-A and NA-B R175 to a standing position, is not able to stand up and was in the NAs. At 12:38 p.m. room to try and assist NAs 175 to bed. NA-A and LPN-D R175 to a standing position as not able to stand up and as going to go get a physical At 12:49 p.m. NA-A pushed in ical lift into R175's room, PT-A PT attempted to stand R175 IA-B however, R175 was not	F 6	57	individual care plans are revised as necessary. 4.Audits will be completed to ensur significant changes are addressed care plan to ensure individual care are revised as necessary by Nursin Management or designee daily x 10 weekly x 6 and monthly x 1. Result be reviewed by our Quality committed further recommendation.	e any in the plans g D, then s will	

Facility ID: 00148

If continuation sheet Page 14 of 97

		AND HUMAN SERVICES			F	ORM /	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			3) DATE COMF	E SURVEY PLETED
		245359	B. WING			C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 657 F 677 SS=D	mechanical lift. PT- R175 into bed using During an interview director of nursing (record, DON indicat changed within the care plan was incor change MDS and s Facility policy Care Centered policy dat care plan intervention thorough analysis of part of a thorough of The comprehensive will describe the set to attain or maintain practicable physical well-being. Incorpor reflect treatment go in measurable outco person centered ca seven days of the c MDS. Assessments care plans are revis resident and the res ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of daily services to maintain personal and oral h This REQUIREMEN	then instructed to use the A and NAs then transferred g the full body mechanical lift. on 9/15/21, at 11:34 a.m. (DON) reviewed R175's ted R175's mobility had last month. DON verified the nsistent with the significant hould have been revised. plans, Comprehensive Person red 12/2016, included, The ons are derived from a of the information gathered as comprehensive assessment. e, person centered care plan rvices that are to be furnished in the resident's highest l, mental, and psychosocial rate identified problem areas bals, timetables and objectives omes. The comprehensive, ire plan is developed within completion of the required s of residents are ongoing and sed as information about the sident's conditions change. for Dependent Residents 2) ident who is unable to carry y living receives the necessary in good nutrition, grooming, and ygiene; NT is not met as evidenced		657			10/29/21
		tion, interview, and document			1.It is policy of Pine Haven Communit	ty to	

Facility ID: 00148

If continuation sheet Page 15 of 97

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		245359	B. WING			C 16/2021
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP COL		
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 677	review the facility fa 1 of 2 residents (R bladder. In addition grooming assistand residents (R64, R4 staff for shaving. R175 toileting R175's face sheet diagnosis of demen disturbance and m R175's significant of (MDS) dated 8/23/2 cognitive impairme required extensive staff for toilet use a MDS indicated R17 of urine and bowel. R175's toileting car staff to toilet R175 before and [after] a night rounds, and a During an observat R175 sat in her wh 7:50 a.m. licensed R175 had been in t	ailed to follow the care plan for 175) reviewed for bowel and a, the facility failed to ensure ce was provided to 2 of 2 9) who were dependent on dated 9/16/21, included ntia with behavioral uscle weakness. change Minimum Date Set 21, indicated R175 had severe ent. The MDS identified R175 assistance from two or more and personal hygiene. The 75 was occasionally incontinent re plan dated 9/1/20, directed upon rising, after breakfast, all other meals, at bedtime, on	F 67	 ensure that all residents ADI provided for Dependent resider bowel and bladder was review ensure it was meeting resider Resident R49 and R64 groom assistance were reviewed to evere meeting the resident s 10/22/2021. 2. This has the potential to affer residents. All residents were residents were residents were resure we were meeting reside in regard to bowel and bladde ensure grooming assistance were to a swell. 3. Staff re-education will be consursing staff to ensure toiletin being followed and grooming on 10/21/2021 and 10/25/202 4. Audits will be performed by Management or designee to extiliting plans are being follow grooming assistance daily x 1 weekly x 6 and monthly x 1. Fibe reviewed by our Quality confurther recommendation. 	ents. R175 red to t s needs. ing ensure we needs by ect all 69 eviewed to lents needs r and to vas being mpleted with g plans are assistance 1. Nursing insure red and 0 days, then Results will	

If continuation sheet Page 16 of 97

	-	AND HUMAN SERVICES					FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIP	PLE CONSTRUCTION			E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· /		S			PLETED
							(C
		245359	B. WING				09 / [.]	16/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE			
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREE PINE ISLAND, MN 55963	ΞT		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN C	F CORRECTION	1	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	O THE APPROPF		COMPLETION DATE
E 677	O times d Energy a	40			_			
F 677	• • • • • • • • • • • • • • • • • • •	•	F 6	()	! 			
	toileted or changed							
	During an observat	ion on 9/14/21, at 8:50 a.m.						
		r breakfast tray. At 9:27 a.m.						
		in her wheelchair by the her breakfast in front of her.						
	nuising station with	her breaklast in nont of her.						
		ion on 9/14/21, at 12:20 p.m.						
		the nursing station. At 12:32 how R175 transferred. LPN-D						
		ness and stated he would call						
		asked when R175 had last						
		stated the last time was						
		and 7:00 a.m. when she hift aide. At 12:49 p.m. R175						
		full body mechanical lift to her						
	bed by NA-A and N	A-B. When NA's exposed						
		garment it was observed to be						
		ith urine. NA-A stated R175 ed since 6-7:00 a.m. that						
	morning.							
	During on interview	a = 0/15/21 at 11.24 a m						
	0	on 9/15/21, at 11:34 a.m. (DON) stated the expectation						
		toileted in accordance with						
		N stated if residents refused,						
		s the nurse be notified, and						
	medical intervention	cian if necessary for further n.						
	R64 Shaving							
		DS dated 8/19/21, indicated						
		s intact. R64 required assistance from staff for all						
		ing (ADLs), including personal						
	hygiene.	5 (<i>),</i> 5 F						
	P61's face sheet pr	inted 0/16/21 indicated DE4's						
		inted 9/16/21, indicated R64's degenerative disease of the						
		pe 2 diabetes mellitus, and						

If continuation sheet Page 17 of 97

PRINTED: 11/01/2021

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	indicated R64 requi personal hygiene w hair. Record reviewed for R64's Point-of-Care for section labeled, Performance - How hygiene, including of shaving, applying m and hands", indicat assist of one staff. On 9/13/21, at 5:11 hallway as she was staff. R64 had black approximately 1/8 in covered her chin ar During observation 8:31 a.m. R64 was R64 acknowledged hairs that were app that thickly covered they were due to her that she had always and she wanted sta On 9/15/21, at 7:48 bed in her room and black and white hai	ase. as. as. as. as. as. as. as. as	F€	577			
		p.m. nursing assistant (NA)-B een too many whiskers on a					

Facility ID: 00148

If continuation sheet Page 18 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HAVEN CARE CENTER INC					10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 18	F6	677			
	NA-B further stated	have shaved the resident. I she had not assisted R64 not noticed any whiskers on					
	considered a part o further stated if a fe whiskers, assistance provided. R49 Shaving R49's significant ch indicated R49's cog R49 was dependen	p.m. NA-I stated shaving is of daily grooming care. NA-I emale resident had a lot of ce shaving should have been mange MDS completed 8/6/21, gnition was severely impaired. It on physical assistance from s of daily living (ADLs) hygiene.					
	indicated R49 requi	t review date 6/25/21, ired total assistance with /hich included shaving facial					
		rinted on 9/15/21, indicated cluded depression, dementia,					
	seated in her wheel greater than 30, coa	5 p.m. R49 was observed Ichair in her room. R49 had arse, white hairs that were nch in length on her chin and					
	wheelchair in the di than 30 coarse, whi	a.m. R49 was seated in her ining room. R49 had greater ile hairs that were nch in length on her chin and					
	On 9/15/21, at 7:31	a.m. nursing assistant (NA)-D					

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE SURVEY COMPLETED	
		245359	B. WING	i			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
PINE HAVEN CARE CENTER INC					210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	and registered nurs assisting R49 with r assisted out of bed, washed R49's face R49's hair then pus Neither NA-D nor R shaving her facial h On 9/15/21, at 7:43 required full physica personal hygiene at shaving facial hair. assisted a female r would do it if it was did not check R49's that R49 did have a observed R49 in the R49 had long, coars upper lip, "Yeah, the On 9/15/21, at 8:56 had several coarse and upper lip. RN-H who require physica hair, received the a stated she noticed assisted with morni shaver in her room, eyes." On 9/15/21, at 10:2 (DON) stated she e care of bath days a Facility policy, "Sha 2/2018 provided dir resident with shavir	 Se (RN)-H were observed morning cares. R49 was , into her wheelchair. RN-H and dried it. NA-D combed shed R49 to the dining room. RN-H offered to assist R49 with hair. S a.m. NA-D stated R49 al assistance from staff for nd grooming which included NA-D stated he had never resident with facial hair but needed. NA-D confirmed he s face with morning cares and a shaver in her room. NA-D e dining room then confirmed se, white hairs on her chin and ere's a lot there." S a.m. RN-H confirmed R49 , long, white hairs on her chin H expected female residents al assist with shaving facial ssistance as needed. RN-H R49's facial hair when she ing cares and R49 had a , "it was right in front of my 29 a.m. director of nursing expected facial hair was taken and as needed in between. 	F	677			
	resident with shavir frequency. According						

If continuation sheet Page 20 of 97

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		C PLE CONSTRUCTION	· · ·	E SURVEY PLETED	
		DENTIFICATION NOMBER.	A. BUILDIN	G	C		
		245359	B. WING			16/2021	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
PINE HAVEN CARE CENTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 677	Continued From pa	age 20	F 67	7			
	provide skin care.						
	Quality of Care CFR(s): 483.25		F 68	4		10/29/21	
	facility residents. Be assessment of a re that residents recei accordance with pr practice, the compr care plan, and the This REQUIREMEN by: Based on observar review, the facility f assessment, monit were completed for R44). This resulted required re-hospitar resulting in respirat chronic congestive Findings include: R48's facility face s admitted to the faci of heart failure, chr disease, and hyper R48's physician vis had leg swelling an (pounds). Plan was milligrams [mg], wil monitor weight, Chr	NT is not met as evidenced tion, interview, and document ailed to ensure appropriate oring and physician notification ³ of 3 residents (R48, R36, in actual harm when R48 lization with fluid overload ory failure and acute on		1.It is policy of Pine Haven Commensure that all residents ensure appropriate assessment, monitorin physician notification for fluid overl resulting in respiratory failure and a chronic congestive heart failure. R R36 was discharged on 9/24/2021 Resident R 48 was discharged on 9/17/2021 and Resident R44 was assessed to ensure policy was bei followed for respiratory failure and chronic congestive heart failure. 2. This has the potential to affect al residents and all residents with the diagnosis of CHF were reviewed to ensure compliance with our policy 3. Staff re-education will be comple licensed nursing staff to ensure the orders for residents with fluid imba and ensure they are clear and understandable and to ensure compliance of proper daily weights, edema monitoring, documentation of fluid	ng and oad acute or esident , ng for I 69 b ted with at lance npliance		

Facility ID: 00148

If continuation sheet Page 21 of 97

STATEMENT	ENTERS FOR MEDICARE & MEDICAID SERVICES TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED		
					с			
		245359	B. WING			09/16/2021		
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE			
PINE HAVEN CARE CENTER INC					10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	age 21	F 6	84				
	following -Daily weights, noti over 2 lbs. (pounds (start date 8/2/21) -Lasix 40 mg (millig congestive heart fa -Occupational there extremities Mondar 8/6/21) R48's Admission A indicated R48 had extremities; location not identified. R48's admission W 8/6/2021, identified impairment, required or more staff mem that involved mobil staff for personal h indicated R48 was medications. R48's care plan dat a diagnoses of con- corresponding inte	ders reviewed, included the ify physician for weight gain s) in a day OR 5 lbs. in a week grams) one time a day for ailure (start date 7/31/21) apy wrap bilateral lower y through Friday (start date sseessment dated 7/30/21, +3 pitting edema in both lower on in the lower extremities was linimum Data Set (MDS) dated d R48 did not have cognitive ed extensive assistance of two bers for activities of daily living ity and extensive assist of one hygiene and dressing. The MDS administered diuretic			and proper reporting on 10/21/2021 10/25/2021 to include fluid balance issues, edema monitoring and documentation. 4.All residents with the diagnosis of will have orders and care plan audit Nursing Management to ensure ord residents with fluid imbalance and et they are clear and understandable a ensure compliance of proper daily weights, edema monitoring, documentation of fluid intake and p reporting daily x 10, then weekly x 6 monthly x 1. Results will be reviewe our Quality committee for further recommendation.	CHF ed by lers for ensure and to roper and		
	periodically, medic observe for signs a edema, significant shortness of breath notify physician as weekly, or as order physician of signific	s medication program ations as ordered, staff to and symptoms of increased weight changes, increase h/new shortness of breath, and needed, and weight at least red by physician, notify cant weight gain. ated on 8/6/21, physician						

Facility ID: 00148

If continuation sheet Page 22 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE SURVEY COMPLETED	
	245359						C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HAVEN CARE CENTER INC					210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	ordered a chest X-ray r R48's chest X-ray r R48 had patching of replaced with other bacteria) in the righ effusion (water on t included " Patchy ri seen, follow up exa R48's weight record gain in a day withou notification per phys -On 8/3/21, weight v -On 8/3/21, weight v -On 8/5/21, weight v -On 8/7/21, weight v -On 8/7/21, weight v -On 8/9/21, weight v -On 8/9/2	ray to rule out tuberculosis. esults on 8/11/21, indicated pacification (air in lungs material such as fluid or t lower lobe, and small pleural he lungs). The report also ght lower lobe infiltrate is m recommended)." d identified over 2 lb. weight ut evidence of physician sician order. was 330.4 lbs. vas 334.2 lbs. was 334.2 lbs. was 343.0 lbs. was 343.0 lbs. d evidence of daily weights on 12/21, and 8/13/21. e dated 8/13/21, at 7:39 a.m. thad a sudden onset of around 4:00 a.m. Resident notic. Resident initially had ed, and oxygen increased to 3 PM). Lung sounds ital signs: blood pressure 0, respirations 28, and oxygen esident requested to be osition, fellow nurse assisted e on one supervision initiated. mbulance services. Symptoms ately 30 minutes after onset. I to be put back to bed with ed. Every one-hour checks taff notified of incident and	F	\$84			

If continuation sheet Page 23 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	indicated R48 was f ambulance related oxygen saturations. R48's discharge su indicated primary di hypercarbic (increa bloodstream)respira chronic congestive indicated between f and hospital admiss 8.8 lb. weight gain. liters of fluid was re discharge summary change diuretic fror 2-liter fluid restriction 848's physician ord 9/13/21 included: -Daily weights, notif over 2 lbs. in a day 8/25/21) -Fluid Restriction: 2 note with total 24-he Date 8/25/21) -Torsemide 60 mg of failure (start date 8/ -Compression Stoc getting out of bed. F bed (start date 8/25 R48's weight record to 9/13/21; record la	transferred to the hospital via to shortness of breath and low mmary dated 8/25/21, iagnosis for admission was se in carbon dioxide in the atory failure and acute on heart failure. The summary hospital discharge on 7/25/21 sion on 8/13/21, R48 had an The summary indicated 1.5 moved from R48's lungs. The y included new orders to m Lasix to Torsemide and add on. ders between 8/25/21 to fy physician for weight gain OR 5 lbs. in a week (start date 2 Liter-Document in progress our fluids consumed (Start one time a day related to heart (25/21) kings: Donn in a.m. prior to Remove in evening once in 5/21) d was reviewed from 8/25/21 acked physician notification in hysician orders until 9/7/21. t was 303.0 lbs. t was 307.2 lbs. was 310.0 lbs.	F6	584			

If continuation sheet Page 24 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	 -no weight was recorphysician's orders -On 9/5/21, weight -On 9/7/21, weight R48's physician notindicated R48 had a 8/31/21 with no othindicated R48 had a 8/31/21 with no othindicated R48 had a extremities. The no have some complation but is able rest. Lungs are clear posterior. R48's fluid intake renursing progress notintake evaluation. From sistently docum of documented intatit could not be calculated to the fluid restriction. R48's record identifi when R48's fluid was documented from 8 stated he was in the ago for fluid overload liters of fluid. R48 stated he haspital, he wei again to 315 lbs. R4the hospital, he had fluid was removed, progressing over time and the state of the sta	borded on 9/4/21 according to was 315.0 lbs. was 315.0 lbs. dification dated 9/7/21, a 13 lb. weight increase since er symptoms. The note +2 pitting edema to both lower te also included, He does ints of shortness of breath with to catch his breath when at ar bilaterally anterior and ecord was reviewed along with otes for the 24-hour fluid fluid intake was not ented every shift; with the lack ke on the 24-hour fluid intake ulated/reviewed in accordance on.	F	\$84			

If continuation sheet Page 25 of 97

	-	AND HUMAN SERVICES				FORM	APPROVED
		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 7	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
						(С
		245359	B. WING			09 /*	16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HAVEN CARE CENTER INC					210 NORTHWEST 3RD STREET		
				F	PINE ISLAND, MN 55963		
(X4) ID			ID	,	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
					DEFICIENCY)		
F 684	Continued From pa	ige 25	F 68	84	,		
	-	on 9/15/21, at 8:24 a.m.					
		ated there were clear					
		ng notify the physician when gain in accordance with					
	u	edical director indicated the					
		asurement for fluid volume					
	0 0	t gain. Medical director stated					
		be monitoring/evaluating					
	edema for the effect medications.	ctiveness of the treatments and					
	medications.						
	During an interview	on 9/15/21, director of					
	nursing (DON) state	ed she expected the physician					
		nt gain in accordance with					
		ON stated the expectation of					
		daily and findings documented					
		ated if there was a weight needed to be done to					
		ight gain was related to fluid,					
		Ild include a complete					
	respiratory assessn	ment, resident interview, and					
		na in extremities, hips, and					
		licated if there was a change					
		ed to be notified. DON stated					
		tness of breath should have in its entirety with a complete					
		assed along in shift report for					
	continual monitoring						
	R36	-					
		dicated R36 was admitted to					
		21, with diagnoses of ilure, chronic kidney disease					
	stage 4, and hyperk						
		harge summary dated 7/20/21, admitted in part related to fluid					

If continuation sheet Page 26 of 97

PRINTED: 11/01/2021

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245359	B. WING			(09/1	_ 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	overload with a prin hyperkalemia (high of hospitalization fo with the last visit in summary included, rehab to allow for cl weights/fluid status dosing of diuretic in summary indicated The discharge sum for daily weights wit R36's physician ord -Daily weights notify over 2 lbs. in a day date 7/23/21). -Lasix (diuretic meet the morning for fluid 7/23/21). R36's care plan dat diagnosis of conges interventions includ up in chair to help p monitor for signs ar hypovolemia/hypery when you have too body], monitor/docu the following signs/s gain of over 2 lbs. a difficulty breathing; blood pressure; skii breath sounds for c R36's physician visi R36's weight was s	nary diagnosis of potassium) and had a history r heart failure exacerbation May 2021. The discharge "would recommend short term loser monitoring of his to determine appropriate the outpatient setting." The R36's dry weight of 303.6 lbs. mary also included an order th close monitoring. ders included: y physician for weight gain of or over 5 lbs. in a week (start dication) 10 mg (milligrams) in d retention's (start date ted 7/25/21, identified R36's stive heart failure. Associated ed, elevate feet when sitting prevent dependent edema, nd symptoms of volemia [medical condition little/too much fluid in your ument/report to MD as needed symptoms: Edema; weight a day; neck vein distention; increased heart rate; elevated n temperatures; monitor	F	584			

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	R36's weight record and 9/13/21, identif 2 lbs. in a day or ov lacked evidence of R36's weights inclu -On 8/28/21, weight -On 8/30/21, weight -On 9/3/21, weight -On 9/4/21, weight -On 9/4/21, weight -On 9/6/21, weight -On 9/7/21, weight -On 9/12/21, weight -On 9/12/21, weight -On 9/13/21, weight -On 9/13/	d reviewed between 8/27/21 ied an increase in weight over ver 5 lbs in a week; record physician notification. ded: t was 302.2 lbs. t was 302.8 lbs. t was 304.2 lbs. was 306.6 lbs. was 308.0 lbs. was 308.4 lbs. was 310.0 lbs. was 313.4 lbs. t was 315.0 lbs. t was 315.4 lbs.	F	\$84			

If continuation sheet Page 28 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	/EN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	present. R36's doct were 90% on room average of 93-98% During an interview licensed practical n often do you measure facility, stated he we if the resident had a therapy had reporter During an observati at 12:11 p.m. LPN- was sitting in his wit the floor. LPN-D rec evaluate edema; R3 R36 had 2+ pitting of left ankles and 3+ to just below the knee R36's progress note entered by LPN-D, present" even thoug edema at 12:11 p.m surveyor. R44 According to R44's (EHR) admission rec diagnosis of chronic cardiomyopathy (da blood pressure, chr disease, shortness supplemental oxyge effusion (fluid in lun R44's quarterly Min assessment dated	d R36 did not have edema umented oxygen saturations air, which was below R36's on 9/14/21, at 12:05 p.m. urse (LPN)-D was asked, how ure edema, LPN-D stated he ed edema while working at this ould only measure the edema ace wraps or if physical ed concerns of edema. ion and interview on 9/14/21, D entered R36's room, R36 heelchair with his feet down on quested permission to 36 consented. LPN-D stated edema around both right and o 4+ edema from lower shin to o n both legs. Although, e dated 9/14/21, at 12:32 p.m. reflected R36 had "No edema gh LPN-D had evaluated the h. in the presence of the electronic health record ecord/face sheet included c congestive heart failure, amaged heart muscle), high ronic obstructive pulmonary of breath, a dependence on en and a history of pleural	Fθ	\$84			

If continuation sheet Page 29 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	monitor and evalua reduce the risk of fl orders included: 2 L (liters) fluid rest consumed each shi every day shift, Document progress consumed; Daily weights>not morning; Document progress pitting edema noted lung sounds, weigh practitioner] followe increased torsemid [bilateral lower extra until resolved, Wrap legs daily with off at HS [bedtime]. R44's orders also in heart, blood pressu Metoprolol succinat 25 mg, give 12.5 by Spironolactone tabl time a day, Torsemide tablet 20 two times a day. R4 increased on 8/13/2 increased again on day instead of once A review of R44's d on 9/3, 9/5, 9/10 or	ders instructed nursing staff to te R44 for fluid overload and uid overload. The following riction-document total ift. NOC (night shift) will total is note with total 24 hour fluids ify provider if >189 lbs in the s note on edema location, d, skin intact (fluid weeping) t, CNP [certified nurse id up on 8/13/21 and e [diuretic]. Edema to BLE emities]. Every evening shift h ACE bandages on in am and hcluded medications to control re and to relieve edema: te capsule ER 24 hour sprinkle / mouth in the morning, let, give 50 mg by mouth one 0 mg, give 40 mg by mouth 44's Torsemide dose had 21 from 20 mg to 40 mg and 8/16/21 to be taken twice a e per day aily weight was not recorded 9/11. On 9/12, 9/13 and 9/14	F	\$84			
		9/11. On 9/12, 9/13 and 9/14					

If continuation sheet Page 30 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	instructions for a pr on R44's edema loo skin intact (fluid wer weight. A review of identified missing p 9/9/21-9/11/21 no n or lung sounds 9/12/21-"weight was reweight [sic] tomor asymptomatic." No to edema or lung so 9/13/21-no note rela sounds 9/14/21 at 3:42 p.m resident is alert and 92-93% on 1 L, whe 4+ edema of R and today 190.2 lb. Nurs in weight, ACE wrap for scheduled appo On 9/14/21, at 8:19 in bed in his room, n and limbs was red a ice water was noted An oxygen concent was running, but R4 cannula in his nose On 9/14/21, at 8:43 sitting on the side o and swollen from th difficulty speaking, I through short phras and answering yes, had noticed his legs show they were get	ated 8/14/21 included ogress note to be written daily cation, pitting edema noted, eping), lung sounds and R44's record for September rogress notes for ote related to edema, weight, s taken after lunch. Will row and reassess. Resident is additional information related ounds. ated to edema, weight, or lung . "assessment conducted: l oriented x3, oxygen levels eezing auscultated bilaterally, L extremities. Weight for se manger notified of change o applied, resident left building intment." a.m. R44 was observed lying resting. His facial appearance and flushed. A one liter jug of I to be sitting at his bedside. rator was beside the bed and I4 did not have a nasal	F	584			

If continuation sheet Page 31 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	-	F€	684	L		
	wrapped. His hands held them up to be	s were slightly swollen and he seen.					
	lying in bed with his (RN)-C entered the compression wraps have his legs wrapp day. RN-C started toes and performed asked, "do you like After reaching R44" considerable amou RN-C proceeded to the ankle. Following the left leg in the sa wraps were too long	b.m. R44 was observed to be a legs bare. Registered nurse room with two elastic and informed R44 he should bed before going out for the wrapping R44's right leg at the d a figure eight wrap. He it tight? No, just a little loose?" s knee, there was a nt of wrap still on the roll, so wrap the leg back down to g the right leg, RN-C wrapped ame manner. RN-C stated the g, and that he should have nt wraps; however, RN-C did er wrap.					
	been weighed. RN- weighed every day. nursing assistant (N been weighed. Ano stated daily weights morning as soon as confirmed that R44 unknown reasons. I reported a weight o During an interview RN-C confirmed that edema. He stated t was to "squeeze the indent would occur" done this but would weight should be reasoned.	.m. R44 indicated he had not C stated R44 was to be RN-C called to a passing NA-F) who said R44 had not ther nursing assistant, NA-C s were to be done every s possible, before eating and had not yet been weighed for NA-C weighed R44 and f 195 lbs. on 9/14/21 at 12:17p.m. at R44 had an order to monitor he best way to assess edema e feet and watch how much ' and confirmed he had not I do it later. RN-C noted R44's e-checked because it was before. RN-C confirmed he					

If continuation sheet Page 32 of 97

		AND HUMAN SERVICES						FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245359	B. WING	;					C 16/2021
NAME OF	PROVIDER OR SUPPLIER				STF	REET ADDRESS, CITY, STATE, ZIP CODE		-	
PINE HA	VEN CARE CENTER I	NC) NORTHWEST 3RD STREET NE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 684	had been working t documented a weig the medical provide order to call the provide order to call the provide and the provide order to call the provide order to call the provide also lbs. RN-C state edema indicated a According to an inter nurse manager for weight was to be do edema monitoring a should also be done monitoring, RN-D c accomplished prior compression wraps find a shorter set of ones they had were should notify medic has a change in co- left for notifications for notification meth "SBAR" (situation, H result/request) form immediately, but an call a provider with of any guidelines sa manger to call. RN- order for a daily we review of his EHR s daily." RN-D stated document on R44's note as outlined in the edema, changes in information was not like there is no doct According to an inter the director of nursi	In the second se	F	684	4				

Facility ID: 00148

If continuation sheet Page 33 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	same time each da rising before breakt expectation for com before getting up for monitoring edema, like to have edema as in the afternoon, progresses when the general, edema mor morning prior to the compression wraps monitoring a reside excess it was exper- weights, monitor lut sometimes abdomi stated any orders s completed in the tree (TAR), but a progree well. During an interview facility medical dire watching R44's com "perplexing present not been fully succe trajectory continues unchecked fluid inta although he was cu concern for R44, ac exacerbation of his A request was mad fluid/edema manag was not provided. The Heart Failure-C November 2018 co	y, preferably right away upon ast. DON also stated an apression wraps to be applied or the day. In relation to DON stated some physicians checked later in the day, such to see if the condition he resident is up, but in onitoring should be done in the e application of the 5. DON said that when int for problems with fluid cted that nurses would do daily ng sounds, vital signs and nal girth if ordered. DON hould be initialed as being eatment administration record ss note should be written as 9/15/21, 8:46 a.m. with the ctor (MD-A), he stated he was idition closely as he had a ation," their interventions had essful and R44's "clinical to decline." MD-A stated ake would be problematic, rrently stable. The primary coording to MD-A was an	F	\$84			

If continuation sheet Page 34 of 97

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
						С
		245359	B. WING _		09/	16/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET		
PINE HA	VEN CARE CENTER I	NC		PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 685	Continued From pa	ae 34	F 68	35		
		to Maintain Hearing/Vision	F 68			10/29/21
	and assistive device	dents receive proper treatment es to maintain vision and e facility must, if necessary,				
	§483.25(a)(1) In ma	aking appointments, and				
	and from the office the treatment of vis the office of a profe provision of vision of	rranging for transportation to of a practitioner specializing in ion or hearing impairment or essional specializing in the or hearing assistive devices. NT is not met as evidenced				
	facility failed to ensu was offered regular specialist for her fai	vs and document review, ure that 1 of 1 resident (R24) vision appointments with a iling eyesight.		1.It is policy of Pine Haven Com ensure that all residents ensure a resident be offered regular vision appointment with a specialist. Re R24 was added to the list to be s	ill sident een by	
		ectronic health record (EHR)		the contracted facility optometrist 2.This has the potential to affect residents. All residents were revie	all 69	
	of macular degener	ration (loss of central vision).		and/or offered vision services 3.Staff re-education will be comp nursing staff on 10/21/2021 and		
		sician's note dated 4/25/2019, aucoma in both eyes and ion in both eyes.		 10/25/2021 to ensure all resident offered hearing and vision service needed. 4.Audits will be completed to ensure 	es as	
		n data set (MDS) assessment R24 was cognitively intact with ns.		compliance for hearing services l offered to all residents daily x 10 then weekly x 6 and monthly x 1	oeing days, Results	
	A facility "Long Terr	n Care Evaluation" dated orm the MDS did not include		will be reviewed by our Quality co for further recommendation.		

Facility ID: 00148

If continuation sheet Page 35 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER	·	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	VEN CARE CENTER I	NC		2	10 NORTHWEST 3RD STREET		
	VEN CARE CENTER I			Ρ	PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	Continued From para any information abore any information and any any any and any	ge 35 but R24's current visual status. care plan, a focus problem dicated R24 was at risk for mpaired vision related to on, glaucoma, generalized ws and shapes with current ated intervention (not dated) s made periodically and PRN am consultation for resident to meds and compensatory	1	\$85	DEFICIENCY)	RIATE	DATE
	a registered nurse (stated the facility ha	erview on 9/15/21, 10:37 a.m. (RN-D) managing the unit ad recently had in-house vices for the residents, but					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245359	B. WING	i			C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 685	RN-D was unable to been offered to R24 been seen. RN-D s offered at quarterly unable to find recor offered to or decline According to an intel licensed social work should offer any me needed. LSW also concerned about he provide assistance been the caregiver this, LSW said, R24 any help with appoi R24 had regular ap her vision problems offered at quarterly unable to find docu services had been to LSW stated that giv loss she should see On 9/16/21, 8:30 a. (DON) confirmed the recent documentatic current visual status to find any docume an appointment witt an expectation that visits be offered at a needed, and stated response should be the information was not assume that it he	o find record that services had 4 and confirmed she had not tated such services should be care conferences but was d that such services had been ed by R24. erview 9/15/21, 11:46 a.m. the ker (LSW) stated the facility edical follow-up visits as said R24 was known to be er family and their ability to to her, as she had always of their family. Because of 4 would not ask her family for ntments. LSW did not know if pointments set up to evaluate a but stated this should be care conferences. LSW was mentation indicating any such offered to or declined by R24. ven R24's significant vision e a vision specialist. m. the director of nursing nat the EHR did not contain on by nursing staff of R24's s. DON stated she was unable ntation that R24 was offered in the eye doctor. DON stated vision, hearing and dental every care conference and as this offer and the resident e documented. DON stated if a not documented, one could	F	585			

If continuation sheet Page 37 of 97

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245250	B. WING			С
	PROVIDER OR SUPPLIER	245359	B. WING	STREET ADDRESS, CITY, STATE, ZIP C		16/2021
	ROVIDER OR SUPPLIER			210 NORTHWEST 3RD STREET	ODE	
PINE HA	VEN CARE CENTER I	NC		PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 685	Continued From pa	ae 37	F 68	85		
	The facility provided	-				
		Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 68	36		10/29/21
	resident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the in demonstrates that to (ii) A resident with professional st promote healing, pro- new ulcers from de This REQUIREMENT by: Based on observator review the facility far assess risk for pressimplement intervent injuries for 1 of 2 re failures resulted in stage 2 pressure ul pressure ulcers and pressure ulcers and	es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives ant and services, consistent andards of practice, to revent infection and prevent		1.It is policy of Pine Haven ensure that all residents ens comprehensively assess ris ulcers and develop implement interventions and follow phy to prevent pressure ulcer in Resident R175 will be asses interventions implemented t and prevent pressure ulcers 10/22/2021. Resident R61 v discharged on 10/04/2021. 2.This has the potential to a residents. All residents were assessed to ensure any pre	sure to k for pressure ent vsician orders juries. ssed, to help treat s by was uffect all 69 e reviewed and	

Facility ID: 00148

If continuation sheet Page 38 of 97

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		245359	B. WING			_ 16/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 686	disturbance and co R175's significant of (MDS) assessment R175 had severe of identified R175 req from two or more sid dressing, toilet use, MDS indicated R17 of urine and bowel. at risk for pressure pressure ulcers or r damage at the time indicated pressure not used for chair h device was used for not have a turning a R175's record lacke assessment for risk became dependent R175's care plan di assistance in accor	Ige 38 Intia with behavioral Ingestive heart failure. Indicated 8/23/21, indicated ognitive impairment. The MDS uired extensive assistance taff for bed mobility, transfers, and personal hygiene. The 75 was occasionally incontinent The MDS identified R175 was ulcers and did not have moisture associated skin of the assessment. The MDS reducing device for chair was lowever a pressure reducing r bed and identified R175 did and repositioning program. Ed a comprehensive of skin breakdown after R175 to n staff for mobility. Id not identify the level of rdance with the MDS. R175's lated 9/1/20, directed staff to	F 68	6 3.Staff re-education will be com licensed nursing staff on 10/21/ 10/25/2021 to ensure completion accuracy of Braden assessmer audits, interventions and physic 4.Audits will be completed for or by Nursing management or des Skin only audits, care plan, and assessments will be monitored 10 days, then weekly x 6 and m Results will be reviewed by our committee for further recomme	2021 and on and its, skin ian orders. ompliance ignee on Braden daily for onthly x 1. Quality	
	and [after] all other rounds, and as nee dated 10/17/2019, i potential for pressu [related to] immobil prone to bruising, s petechiae (pinpoint the skin as a result interventions includ	sing, after breakfast, before meals, at bedtime, on night ded. R175's skin care plan indicated R175 "has the re ulcer development r/t ity. [R175] has thin, fragile skin kin tears, and age related , round spots that appear on of bleeding)." Associated ed follow facility or the prevention of skin				

If continuation sheet Page 39 of 97

		AND HUMAN SERVICES				FORM	: 11/01/2021 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245359	B. WING	;			C 16/2021
NAME OF	PROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HAVEN CARE CENTER INC					210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	R175's Skin Only E 11:44 p.m. indicated color, turgor norma upper abdomen. During an observat R175 laid on her bas smelled of urine. RI (NA)-H were at bed over to allow them to incontinent garmen was observed to als R175's behavior pro 10:41 p.m. included assistant got R175 was offered at the k did not understand. she yelled out in pa morphine was given about the process w attempts to motivat her side, washed al During an observat R175 had been in t because she had b unawareness of the toileted or changed During an observat R175 continued to a nursing station with During an observat	Evaluation dated 9/10/21, at d skin warm and dry, normal al, and had a skin tag on right dian on 9/13/21, at 7:40 p.m. ack in bed. R175's room N-H and nursing assistant diade encouraging R175 to roll to change her saturated at. R175's mattress protectors so be urine soaked. ogress note dated 9/13/21, at d tonight nurse and nursing out of bed. Pain medication beginning of the process, she . It was attempted to roll R175 ain and started hitting. The n and more communication was provided. After several te the patient we rolled her on nd laid new pads down. dion on 9/14/21, at 7:00 a.m. eelchair in a hospital gown. At practical nurse (LPN)-D stated the wheelchair all night peen restless, stated an e last time R175 had been	F	686			

If continuation sheet Page 40 of 97

		AND HUMAN SERVICES							FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONS	TRUCTION		0	(X3) DATI COM	E SURVEY PLETED
		245359	B. WING	;						C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			;	STREET A	ADDRESS, CITY	, STATE, ZIP	CODE		
PINE HA	VEN CARE CENTER I	NC				THWEST 3RD	-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		С	PROVIDER'S (EACH CORREC ROSS-REFEREI [CTIVE ACTIC	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 686	practical nurse (LPI sitting there since h stated he was not a incontinent brief or stated R175 had "n two" in her chair. During an observat R175 remained by NA-A asked LPN-D stated an unawaren therapy. NA-A was been toileted, NA-A between 6:00 a.m. assisted the night s was transferred via bed by NA-A and N R175's incontinent be heavily saturated onto her right side, small wound that w her lower left buttoo was observed on he exited the room to g RN-D entered the r impaired skin integr stage 1 pressure ul left buttock wound v to do further evaluat tissue injury. RN-D more redness than irritated. R175 was during the assessm new brief. During an interview RN-D stated the wo	ge 40 ursing station. Licensed N)-D stated R175 had been e got there this morning, and ware if NAs had checked her repositioned her. LPN-D odded off for an hour maybe ion on 9/14/21, at 12:20 p.m. the nursing station. At 12:32 how R175 transferred. LPN-D ness and stated he would call asked when R175 had last a stated the last time was and 7:00 a.m. when she hift aide. At 12:49 p.m. R175 full body mechanical lift to her A-B. When NAs removed garment, it was observed to d with urine. When R175 rolled a dark purple/blue area with a as bleeding was observed on ck and small reddened area er right lower buttock. NA-A get registered nurse (RN)-D. oom, RN-D observed the rity, and indicated R175 had a cer to the right buttock and the was a stage 2 and would have tion if the wound was a deep stated the left buttock had the right and appeared very cooperative with RN-D nent and with application of	F	686	5					

If continuation sheet Page 41 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245359	B. WING			C 09/16/2021	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	injury. RN-D stated member who thoug pressure ulcer to the within the last sever increased need to f independent with be herself. RN-D revie verified the care plat level of care R175 in assessment. RN-D not identify how ofted and repositioned and determine tissue re- had not been comp condition. RN-D stat questioned/prompter reposition R175 if the long R175 was sittle nursing desk. RN-E care then, it was ex- get someone else to on the floor, nurse as the charge nurse of indicated, if necess contacted for further interventions were refusals with interver of the interventions R175's progress not identified R175 had tissue injury 2 centi- purple/blue in color red blood around the diameter of fresh re- The evaluation indic consulted, and care repositioning sched	in the same area. RN-D stated ral weeks R175 had an istory of a be same area. RN-D stated ral weeks R175 had an for assistance; she used to be ed mobility and positioning tweed R175's care plan and an was not consistent with the required and the MDS confirmed the care plan did en R175 needed to be turned an assessment to response to pressure over time bleted after R175's change in ated the nurse should have ed or directed NAs to here was a question of how ing in her chair next to the D stated if R175 was refusing spected the NA's reattempt or o attempt, report to the nurse should then attempt and notify f continued refusals. RN-D rary, the physician should be er medical management if unsuccessful. RN-D stated the entions and the effectiveness needed to be documented.	F	586			

If continuation sheet Page 42 of 97

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
			(X2) MU	TID			U930-U391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	· /		G		PLETED
			_			(C
		245359	B. WING	_		09/ [,]	16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	VEN CARE CENTER I	NC		2	210 NORTHWEST 3RD STREET		
				F	PINE ISLAND, MN 55963		
(X4) ID			ID				(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
					DEFICIENCY)		
			1				
F 686	• · · · · · · · · · · · · · · · · · · ·	-	F 6	86	3		
	and hydrating lotion	n for dry skin for comfort.					
	During on interview	an 0/15/21 at 9:24 a m					
		on 9/15/21, at 8:24 a.m. ated a familiarity with R175 and					
		worsening heart failure and					
		a; goals of care were					
		cal director indicated an					
	awareness of R175 rejection/refusals of						
		gement for edema, however,					
	was not aware of re						
		ng. Medical director indicated					
		butine skin assessments and a					
		e in place for the prevention Medical director stated if a					
		ted self-neglecting behaviors					
		ospice) needed to be notified;					
		their own urine, it would need					
		When asked if the duration of					
		r wheelchair without ging incontinent brief					
		ressure ulcers, medical					
		, that would be the definition					
	of a pressure ulcer.						
	During on interview						
		on 9/15/21, at 11:34 a.m. (DON) indicated R175 should					
	have been assesse						
		am after her mobility declined.					
	DON stated the exp	pectation residents were					
		ice with their care plan. DON					
		efused, the expectation was d, and ultimately the physician					
		her medical intervention.					
	R61						
		narge summary dated 8/11/21, a left buttock stage 2 pressure					

If continuation sheet Page 43 of 97

PRINTED: 11/01/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245359	B. WING	i			C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	ulcer that had been treatment included cleanser, pat dry, a dressing, change d The discharge sum unstageable pressu for wound care. R61's Admission sk did not identify press note indicated resid information or interv R61's physician ord left buttock pressur hospital discharge s date of 9/2/21. R61's physician ord Pressure Injury Tre daily with normal sa thick layer of Santyl (soft black eschar), (sacral or large size R61's physician ord Daily skin monitorin skin alterations and Wound: pressure ir extremity-unstagea stage 2. R61's record identif pressure ulcer was assessed until 8/16 physician orders up record lacked evide pressure ulcer had	identified on 7/16/21; plan for cleanse skin with wound nd cover with foam boarder ressing daily and as needed. mary also identified an are ulcer on a leg with orders the assessment dated 8/11/21, sence of pressure ulcers. The lent refused with no further ventions for refusal. ler dated 8/11/21, identified the e ulcer as outlined by the summary, however had a stop ler dated 8/11/21 included: Leg atment: Cleanse affected area aline and gauze, apply nickel covering entire wound bed cover with mepilex border e). ler dated 8/14/21 included: g. If changes, document in wounds progress note.	F	586			

If continuation sheet Page 44 of 97

		AND HUMAN SERVICES				FORM	: 11/01/2021 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245359	B. WING				C 16/2021
NAME OF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	INC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	‹	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	there was a physici wound upon admissiboth pressure ulcer R61's skin evaluation R61 had an unstag left lower extremity identified) that mea 0.9 cm. The skin evaluation one stage 2 pressure pressure ulcer. R61's skin evaluation did not identify the stage R61's record did not ordered treatment to discontinued on 9/2 R61's skin evaluation did not identify the stage R61's physician or "Leg Buttocks Press Cleanse affected and and gauze, apply no cover with mepilex During an interview licensed practical no only had one wound unstageable ulcer of	an ordered treatment for the sion and an order that directed rs be monitored daily. on dated 8/16/21, indicated eable pressure ulcer on the (location on extremity was not usured 1.5 cm (centimeters) x valuation did not identify the e 2 pressure ulcer. inimum Data Set (MDS) 8/18/21, identified R61 had are ulcer and one unstageable on dated 8/23/21 and 8/31/21, stage 2 pressure ulcer. ot indicate why the physician to the left buttock was 2/21. ons dated 9/7/21 and 9/8/21, left buttock pressure ulcer. der dated 9/13/21, included, sure Injury Treatment": rea daily with normal saline ickel thick layer of Santyl and bed (black soft eschar), border (sacral or large size). on 9/14/21, at 9:15 a.m. purse (LPN)-D indicated R61 d treatment to complete; the	F 6	86			

If continuation sheet Page 45 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245359	B. WING	i		C 09/16/2021	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	PINE HAVEN CARE CENTER INC				210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	licensed practical n R61 he was going t change on his left of donned gloves, rem of the dressing, the then used a pen to dressing and donne performing hand hy dressing change per gloves, and washed During an interview LPN-D stated he sh between glove chan During an observat RN-B explained to the dressings on his gave consent. RN-F donned gloves, RN dressing from the left cap from the saline the wound in the cat depressor, and stirr RN-B then removed and cut the non-stift wound. RN-B then mixture of ointment the cover dressings on throughout the p had not disinfected the completion of th then picked up the floor, took off glove RN-B then informed change on his left b and undid R61's ind	urse (LPN)-D explained to to complete the dressing salf; R61 gave consent. LPN-D noved the dressing, disposed n removed gloves. LPN-D write the date on the new ed new gloves without rgiene. LPN-D completed the er physician orders, removed d hands.	F	586			

Facility ID: 00148

If continuation sheet Page 46 of 97

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/01/2021 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATI COM	E SURVEY IPLETED
		245359	B. WING	i			C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	care (a dressing was buttock where there wound that was red wipe to clean his gli and donned anothed disinfecting) over the and applied the left physician order. During an interview RN-B confirmed the buttock wound and RN-B stated if the w not anymore. RN-B changed his gloves after taking off the out not anymore. RN-B changed his gloves after taking off the out for the procedure. During an interview director of nursing of that pressure ulcers assessed upon adr as need, should be worsening daily with stated the expectat according to physic appropriate hand hy dressing changes, after dressing and r wound, hand hygien each glove changes need to go into a ga floor, and scissors a using on a clean dr Facility policy Press dated 3/2020, inclu	as not observed on R61's left e was a nickel sized superficial ddened), used an incontinent loves, walked to the bathroom er pair of gloves (without ne gloves he already had on buttock dressing per of 09/15/21, at 2:13 p.m. ere was not a dressing to the there should have been, wound had been resolved it's destated he should have and performed hand hygiene old dressing. RN-B stated an uble gloving was appropriate of 09/16/21, at 11:44 p.m. (DON) stated an expectation s were comprehensively mission, weekly thereafter and e monitored for improvement or h dressing changes. DON tion dressings were applied cian order. DON indicated ygiene was expected during gloves should be removed removal and cleansing the ne should be performed after . DON stated soiled dressings arbage can and not on the should be disinfected prior to	F	686			

If continuation sheet Page 47 of 97

		AND HUMAN SERVICES				FORM	: 11/01/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245359	B. WING	i			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	risk factors and the modified and which immediately address to modify. 2) Risk fa resident's susceptib PU's include b) imp decreased functions previously healed P fecal incontinence of altered skin status of cognitive impairmer conducted and risk characterized, a resi be created to addres pressure injuries. Facility policy Press Breakdown-Clinical not identify frequency comprehensive wor protocol indicated a completed upon ad Bowel/Bladder Inco CFR(s): 483.25(e)(1) §483.25(e)(1) The fi resident who is con admission receives maintain continence condition is or beco not possible to main §483.25(e)(2)For a incontinence, based comprehensive ass ensure that-	n determine which can be cannot, or which can be sed, and which will take time actors that increase a bility to develop or to not heal baired/decreased mobility and al ability, the presence of PU, exposure to urinary and or other source of moisture, over pressure points, and nt 6) once the assessment is factors are identified and sident centered care plan can ess the modifiable risks for sure Ulcers/Skin Protocol dated 4/2018, did cy of monitoring or completing und assessments. The a skin examine would be mission ontinence, Catheter, UTI 1)-(3) nence. facility must ensure that tinent of bladder and bowel on e unless his or her clinical omes such that continence is ntain. resident with urinary		586			10/29/21

Facility ID: 00148

If continuation sheet Page 48 of 97

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY
	IDENTIFICATION NOWDER.	A. BUILDIN	IG	COMF	PLETED
					2
	245359	B. WING _		09/1	6/2021
PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	LD BE	(X5) COMPLETIO DATE
indwelling catheter	is not catheterized unless the	F 69	0		
catheterization was (ii) A resident who e indwelling catheter is assessed for rem as possible unless demonstrates that e and (iii) A resident who receives appropriat prevent urinary trac continence to the e §483.25(e)(3) For a incontinence, base comprehensive ass	s necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder te treatment and services to ct infections and to restore extent possible. a resident with fecal d on the resident's sessment, the facility must				
receives appropriat restore as much no possible. This REQUIREMEN by: Based on observa review the facility fa management and s	te treatment and services to ormal bowel function as NT is not met as evidenced tion, interview, and document ailed to ensure appropriate services of an indwelling		ensure appropriate management services of an indwelling cathete	and r that	
order for size and to catheter, failed to eva output, failed to eva potential complication documentation of re resident (R61) who	ype of indwelling urinary consistently document urinary aluate urinary output for ions, and failed to ensure outine catheter care, for 1 of 1 had a recent hospitalization		and type of indwelling urinary cat consistently document urinary ou evaluate urinary output for poten complications, and to ensure documentation of routine cathete all residents with indwelling cathete Resident R61 discharged on 10/- 2.This has the potential to affect residents with indwelling cathete	heter, to itput, to tial er care for eters. 4/2021. all rs. All	
	(EACH DEFICIENC REGULATORY OR L Continued From parindwelling catheter resident's clinical c catheterization was (ii) A resident who indwelling catheter is assessed for ren as possible unless demonstrates that and (iii) A resident who receives appropriat prevent urinary trac continence to the e §483.25(e)(3) For a incontinence, base comprehensive ass ensure that a resid receives appropriat restore as much no possible. This REQUIREMED by: Based on observa review the facility fa management and s catheter that includ order for size and t catheter, failed to eva potential complicat documentation of r resident (R61) who related to catheter Findings include: During an observat	indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate management and services of an indwelling catheter that included; failed to obtain physician order for size and type of indwelling urinary output, failed to evaluate urinary output for potential complications, and failed to ensure document and services for a size and type of indwelling urinary eatheter, failed to evaluate urinary output for potential complications, and failed to ensure documentation of routine catheter care, for 1 of 1 resident (R61) who had a recent hospitalization related to catheter infection.	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAGContinued From page 48 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of blowel receives appropriate treatment and services to restore as much normal bowel function as possible.This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate management and services of an indwelling catheter that included; failed to obtain physician order for size and type of indwelling urinary catheter, failed to existently document urinary output, failed to evaluate urinary output for potential complications, and failed to ensure documentation of routine catheter care, for 1 of 1 resident (R61) who had a recent hospitalization related to catheter infection.Findings include: During an observation on 9/13/21, at 2:55 p.m.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD TAG Continued From page 48 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and F 690 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. 1.It is policy of Pine Haven Com ensure appropriate management and geme to advect or of an indwelling cathete including obtain physician order for size and type of indwelling urinary output, failed to evaluate urinary output for potential complications, and failed to ensure documentation of routine catheter care, for 1 of 1 resident (R61) who had a recent hospitalization related to catheter infection. 1.It is policy of Pine Haven Com ensure appropriate management ensure appropriate management nodwelling cathete including obtain physician order for and type of indwelling cathete all residents with indwelling cathete all residents with indwelling cathete residents with indwelling catheter residents with indwelling catheter residents with indwell	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-REFERENCE) THE APPROPRIATE DEFICIENCY Continued From page 48 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence, based on the resident's comprehensive assessment, the facility must ensure hat a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: catheter, failed to consistently document review the facility failed to ensure appropriate management and services of an indwelling catheter, failed to consistently document urinary output, failed to evaluate urinary output for potential complications, and failed to ensure documentation of routine catheter care, for 1 of 1 resident (R61) who had a recent hospitalization related to catheter infection. Findings include: During an observation on 9/13/21, at 2:55 p.m.

Facility ID: 00148

If continuation sheet Page 49 of 97

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
	245359	B. WING			C 16/2021
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
VEN CARE CENTER	INC				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	ILD BE	(X5) COMPLETIC DATE
urine collection bag his bed. R61 stated hospitalized becaus infection from his c another facility. R61's face sheet day was admitted to the diagnoses that incl sepsis, acute renal R61's hospital disc the section Lines/D included "Indwelling Coude [curved type summary did not id balloon (balloon to bladder) R61's admission M 8/18/21, indicated f catheter. R61's catheter care R61 had altered un indwelling catheter history of urinary tra- swelling. The care and type of catheter directed staff to com policy, empty urina	g secured to the right side of d he had been recently se of a bad urinary tract ratheter being mismanaged at ated 9/16/21, identified R61 e facility on 8/11/21, with uded urinary tract infection, failure, and urinary retention. harge summary dated 8/11/21, orains/Airways/Wounds g Urinary Catheter Latex; e] 16 Fr [French]". The lentify the size of the catheter hold catheter inside the linimum Data Set (MDS) dated R61 had an indwelling urinary e plan dated 8/11/21, indicated inary elimination related to due to prostate problems, act infection and scrotal plan did not identify the size er R61 required. The care plan mplete catheter care per facility ry drainage bag every shift and		 3.Staff re-education will be comp nursing staff on facility policy on appropriate management and se an indwelling catheter that include obtain physician order for size ar indwelling urinary catheter, to co document urinary output, to evalue urinary output for potential comp and to ensure documentation of catheter care on 10/21/2021 and 10/25/2021. 4.Audits will be completed on ap management and services of an indwelling catheter that including physician order for size and type indwelling urinary catheter, to co document urinary output, to evalue urinary output for potential comp and to ensure documentation of catheter care by Nursing Manage designee daily for 10 days, then 6 and monthly x 1. Results will be 	ervices of ing nd type of nsistently uate lications, routine propriate obtain of nsistently uate e lications, routine ement or weekly x	
	OF DEFICIENCIES DF CORRECTION PROVIDER OR SUPPLIER VEN CARE CENTER SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From pa urine collection bag his bed. R61 stated hospitalized becau: infection from his c another facility. R61's face sheet d was admitted to the diagnoses that incl sepsis, acute renal R61's hospital disc the section Lines/D included "Indwelling Coude [curved type summary did not ic balloon (balloon to bladder) R61's admission M 8/18/21, indicated I catheter. R61 had altered ur indwelling catheter history of urinary tr swelling. The care and type of cathete directed staff to col policy, empty urina	DEF CORRECTION IDENTIFICATION NUMBER: 245359 PROVIDER OR SUPPLIER VEN CARE CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 urine collection bag secured to the right side of his bed. R61 stated he had been recently hospitalized because of a bad urinary tract infection from his catheter being mismanaged at another facility. R61's face sheet dated 9/16/21, identified R61 was admitted to the facility on 8/11/21, with diagnoses that included urinary tract infection, sepsis, acute renal failure, and urinary retention. R61's hospital discharge summary dated 8/11/21, the section Lines/Drains/Airways/Wounds included "Indwelling Urinary Catheter Latex; Coude [curved type] 16 Fr [French]". The summary did not identify the size of the catheter balloon (balloon to hold catheter inside the bladder) R61's admission Minimum Data Set (MDS) dated 8/18/21, indicated R61 had an indwelling urinary catheter. R61's catheter care plan dated 8/11/21, indicated R61 had altered urinary elimination related to indwelling catheter due to prostate problems, history of urinary tract infection and scrotal swelling. The care plan did not identify the size and type of catheter R61 required. The care plan directed staff to complete catheter care per facility policy, empty urinary drainage bag every shift and as needed, record urine output every shift, and	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 245359 B. WING	OF DEFICIENCIES (X1) PROVIDERSUPPLIERULIA (X2) MULTIPLE CONSTRUCTION SPCOMDER OR SUPPLIER 245359 STREET ADDRESS, CITY, STATE, ZIP CODE VEN CARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES IP PROVIDERS TARD STREET VEN CARE CENTER INC IP PROVIDERS TATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES IP (EACH DEFICIENCY WILL BE PRECEDED BY FILL, REGULATORY OR LSC IDENTIFYING INFORMATION) IP Continued From page 49 IP urine collection bag secured to the right side of his bed. R61 stated he had been recently hospitalized because of a bad urinary tract infection from his catheter being mismanaged at another facility. F 690 R61's face sheet dated 9/16/21, identified R61 was admitted to the facility on 8/11/21, with diagnoses that included urinary tract infection, sepsis, acute renal failure, and urinary retention. F 690 R61's hospital discharge summary dated 8/11/21, the section lines/Drains/Airways/Wounds included "Indwelling Urinary Catheter Latex; Coude [curved type] 16 Fr [French]". The summary did not identify the size of the catheter balloon (balloon to hold catheter inside the bladder) A. Audits will be completed on ap management and services of an indwelling catheter, to co document urinary output, to evaluurinary output, to realter welling. The care plan dated 8/11/21, indicated R61 had altered urinary elimination related to indwelling catheter care plan did not identify the size and type of catheter R61 requir	OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION (X3) DATE OF CORRECTION 245359 (X2) MULTIPLE CONSTRUCTION (X3) DATE 24000E 245359 STREET ADDRESS.CITY. STATE, ZIP CODE (X3) DATE VEN CARE CENTER INC STREET ADDRESS.CITY. STATE, ZIP CODE STREET ADDRESS.CITY. STATE, ZIP CODE (X3) DATE VEN CARE CENTER INC STREET ADDRESS.CITY. STATE, ZIP CODE STREET PINE ISLAND, MN 55963 (20) ORTHWEST 3RD STREET VEN CARE CENTER INC ID PROVIDERS PLAN OF CORRECTION (20) CORRECTIVE ACTION SHOULD BE (20) CORRECTIVE ACTION SHOULD BE (ECH ORD THE CONSTRUCTION OR ISCHARTING INFORMATION) ID PREVISE CORRECTIVE ACTION SHOULD BE (20) CORRECTIVE ACTION SHOULD BE Continued From page 49 Urine collection bag secured to the right side of his bed. R61 stated he had been recently hospitalized because of a bad urinary tract infection, sepsis, acute renal failure, and urinary retention. F 690 3. Staff re-education will be completed with nursing staff on facility policy on appropriate management and services of an indwelling catheter that including urinary catheter Latex; Could document urinary output for potential complications, and to ensure documentation of routine catheter care on 10/21/2021 and 10/25/2021. 4. Audits will be completed on appropriate management and services of an indwelling catheter that including urinary catheter. R61's

If continuation sheet Page 50 of 97

		AND HUMAN SERVICES						FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			CONSTRUCTION	0	(X3) DATI COM	E SURVEY PLETED
		245359	B. WING	;					C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STRE	EET ADDRESS, CITY, STATE, ZIP CO	ODE		
PINE HA	VEN CARE CENTER I	NC				NORTHWEST 3RD STREET E ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 690	order dated 8/11/21 catheter for decreas obstruction as need R61's treatment ad R61's catheter was R61's progress note wrong type of cathet the hospital dischar on 8/30/21, at 2:15 monthly foley cathet inserted with 10cc [fluid for balloon. Re change with no c/o R61's recorded out reviewed between 8 conjunction with nu record identified uri every shift and/or re than R61's average for catheter associa obstruction or symp -R61's record ident where urine output 8/28/21, 8/29/21, 8/ 9/9/21, 9/11/21, and -R61'2 record ident output was 497 mill indicated decreased night shift 100 ml, c and on 9/14/21 output R61's record lacked provided in accorda facility policy.	, indicated Flush foley se urine output, suspected ded. ministration record indicated changed on 8/30/21. e dated 8/30/21, identified the eter was inserted according to 'ge summary. Progress note p.m. included "Resident had eter change. 16F catheter cubic centimeter] of sterile esident tolerated catheter [complaints] of pain" put documentation was 8/24/21 through 9/14/21 in rsing progress notes; the ne output was not recorded ecorded values were lower the record lacked evaluation ated complications such as broms of acute renal failure. ified 10 instances or shifts was not recorded: on 8/24/21, '31/21, 9/1/21, 9/2/21, 9/6/21, d 9/13/21. ified average overnight urinary illiters (ml), R61's record d urine output: on 9/5/21 for on 9/7/21 night shift 150 ml, out was 100 ml for night shift. d evidence catheter care was ance with the care plan and	F	690)	DEFICIENCY)			
		on 9/15/21, at 7:05 a.m.							

If continuation sheet Page 51 of 97

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PINE HAVEN CARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE ID PROVIDER'S SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH ODERTICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S PLAN OF CORRECTION (EACH ODERTICIENCY MUST BE PRECEDED BY FULL TAG F 690 Continued From page 51 F 690 F 690 Continued From page 51 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690 F 690			AND HUMAN SERVICES				FORM	APPROVED
245359 B. WING 09/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE HAVEN CARE CENTER INC ID PINE ISLAND, MN 55963 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE F 690 Continued From page 51 registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B F 690	STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
210 NORTHWEST 3RD STREET PINE HAVEN CARE CENTER INC 210 NORTHWEST 3RD STREET VX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX F 690 Continued From page 51 registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B F 690			245359	B. WING				
PINE HAVEN CARE CENTER INC 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 690 Continued From page 51 registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B F 690	NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
(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 690 Continued From page 51 registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B F 690	PINE HA	VEN CARE CENTER	INC					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 690 Continued From page 51 registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B F 690 F 690					'	-		
registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B	F 690	Continued From pa	age 51	F€	690			
type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B			-		.00			
reviewed R61's physician orders and care plan								
and stated there was not a physician order for the indwelling urinary catheter, nor was the								
information in the R61's care plan. RN-B stated								
there had to be a physician order for the catheter								
that included the size and type of catheter and								
balloon size. When asked about R61's urinary output, RN-B stated urinary output was not								
recorded and stated an unawareness that urinary								
output was recorded in the record. RN-B was								
informed by an unidentified nursing assistant		informed by an unio	dentified nursing assistant					
(NAs) recorded the output in the electronic								
medical record. RN-B then indicated that there								
was not enough time to go through and assess the amounts and there was a lot of other nursing								
tasks to complete.								
During an interview on 9/15/21, at 10:29 a.m.		During an interview	/ on 9/15/21. at 10:29 a.m.					
RN-B indicated he had checked R61's catheter,								
the size that was printed on the catheter was 16								
Fr (French), however, the print did not identify the		,	er, the print did not identify the					
type.		туре.						
During an interview on 9/16/21, at 7:52 a.m.		During an interview	/ on 9/16/21. at 7:52 a.m.					
licensed practical nurse (LPN)-A reviewed R61's								
record and confirmed there was not an order for								
size and type of catheter R61 required. LPN-A								
stated she would have to call the physician to get								
an order. At 8:38 a.m. LPN-A observed R61's catheter and stated the print on the catheter								
indicated the size as 16 Fr, however, did not								
identify the type or balloon size. LPN-A indicated								
there was not a way to tell if R61 had the correct		there was not a way	y to tell if R61 had the correct					
catheter in place. LPN-A stated she would not								
have changed the catheter without a physician order, stated she would also document in a								

If continuation sheet Page 52 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	progress note the c and if there were ar resident tolerated th that if there was a c would go check the draining appropriate intake, would look f infection or acute re would document sh the decrease and w interventions. LPN- should be doing cat morning, and eveni R61's record and si documentation cath completed. During an interview director of nursing (required a physician size and type of cath there should have b changing the cather catheter should not of physician order. needed to be docur amounts evaluated the catheter, and th documented. DON be completed at leas incontinent episode should be monitore and draining. DON order for catheter, e provided, lack of eve evaluation when the Facility policy Foley	ge 52 atheter had been changed by complications, and how the he procedure. LPN-A stated decrease in urine output, she catheter to make sure it was ely, if resident had decreased or signs and symptoms of enal failure. LPN-A stated she be completed an evaluation on <i>v</i> hat she had done for A stated nursing assistants theter care twice a day, ng cares. LPN-A reviewed tated the record does not have heter cares have been for 9/16/21, at 11:44 a.m. (DON) stated a catheter h's order that identified the heter and balloon size and been an order obtained prior to ter. DON indicated the have been changed without DON stated urinary output mented every shift and for possible issues related to be evaluation should be stated catheter care should ast twice per day and is. DON stated the catheter d to make sure urine is patent verified the lack of physician evidence of catheter care was very shift recorded output and are was a decreased output.	F	590			

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION (X3) DATE SU	IRVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLE	TED
		245359	B. WING		С	
	PROVIDER OR SUPPLIER	240009		STREET ADDRESS, CITY, STATE, ZIP CODE	09/16/2	2021
	VEN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) DMPLETIO DATE
F 690	Continued From pa order for this proce	-	F 69(D		
	indwelling catheter was not provided.	ocol was requested for care and management and				
	Respiratory/Trache CFR(s): 483.25(i)	ostomy Care and Suctioning	F 69	5	10/	/29/21
	The facility must en needs respiratory c care and tracheal s care, consistent wit practice, the compr care plan, the resid and 483.65 of this s	and tracheal suctioning. Isure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced				
	Based on observat review, facility failed equipment was ma for 3 of 4 residents for aerosolized med failed to ensure clea	tions, interview and document d to ensure that respiratory intained in a sanitary manner (R6, R54 and R64) reviewed dications and oxygen use and ar and accurate orders for ion for 1 of 3 residents (R44) xygen use.		1.It is policy of Pine Haven Communes ensure that respiratory equipment was maintained in a sanitary manner and oxygen orders are clear and accurat Resident R6, R54 and R64 respirato equipment were cleaned by 10/22/20 Resident R44 oxygen orders were clarified by 10/22/2021 2.This has the potential to affect all 6	as I that e. vry D21.	
	Admission Record/ of shortness of brea (congestive) heart f systolic (congestive acute and chronic r	ectronic health record (EHR) face sheet, R6 had diagnoses ath, acute on chronic diastolic failure, chronic combined and diastolic heart failure, espiratory failure with hypoxia ia, as well as a diagnosis of		 residents. All residents with respirate equipment were cleaned according t manufacture instructions. All residen with oxygen orders were reviewed at clarified. 3.Staff re-education will be complete nursing staff on the facility s policy or respiratory equipment is maintained sanitary manner on 10/21/2021 and 	ory to tts nd ed with on	

Facility ID: 00148

If continuation sheet Page 54 of 97

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
	245359					C 16/2021	
PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
VEN CARE CENTER	INC		21	10 NORTHWEST 3RD STREET			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETIO DATE	
asthma. According to a phys R6 was able to self medications and in Physician orders al Budesonide Suspe reduce respiratory the evening and in had a physician ord solution (to open pt (3)mg/3mL, inhale R6's care plan in th area (not dated) that self-administer medication a plan failed to indicat keeping the equipm On 9/13/21, 6:53 pt up the medication a medication aerosol the bedside stand a nebulization machin appear to be clean moisture inside the and poured in a sol stated the nurse hat self-administer, and self-administer any nurse was not in th had not cleaned the staff had cleaned the	sician's order dated 6/3/2021, -administer nebulized halers after set-up by a nurse. so included an order for nsion 1mg/2mL (a steroid to inflammation), inhale orally in the morning. Additionally, R6 der for lpratropium-albuterol ulmonary airways) 0.5-2.5 four times a day. The EHR had a focus problem at indicated R6 could dications; however, the care the who was responsible for nent clean. The R6 was observed to pick cup and mouthpiece for ization that had been lying on and attached to her the by tubing. The cup did not as it had some signs of container. R6 opened the cup lution from a plastic vial. She ad given her the medication to d she had been okayed to aerosolized medication. The e room. R6 confirmed that she e cup and did not know if any the equipment since she had ent. No nurse was present in poured the solution into the e machine.	F 69	95	oxygen orders on 10/21/2021 and 10/25/2021. 4.Audits will be completed on resp equipment were cleaned according manufacture instructions and oxyg orders are clear and followed by N Management or designee for com daily x 10 days, then weekly x 6 ar	iratory g to en ursing pliance nd		
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER VEN CARE CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa asthma. According to a phys R6 was able to self medications and in Physician orders al Budesonide Suspe reduce respiratory the evening and in had a physician orders al Budesonide Suspe reduce respiratory the evening and in had a physician orders al Budesonide Suspe reduce respiratory the evening and in had a physician orders al Budesonide Suspe reduce respiratory the evening and in had a physician order solution (to open pr (3)mg/3mL, inhale R6's care plan in th area (not dated) that self-administer med plan failed to indicat keeping the equipm On 9/13/21, 6:53 p. up the medication of medication aerosol the bedside stand at nebulization machina appear to be clean moisture inside the and poured in a sol stated the nurse hat self-administer, and self-administer any nurse was not in th had not cleaned the staff had cleaned the staff ha	RS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES OF DEFICIENCIES VEN CARE CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 asthma. According to a physician's order dated 6/3/2021, R6 was able to self-administer nebulized medications and inhalers after set-up by a nurse. Physician orders also included an order for Budesonide Suspension 1mg/2mL (a steroid to reduce respiratory inflammation), inhale orally in the evening and in the morning. Additionally, R6 had a physician order for Ipratropium-albuterol solution (to open pulmonary airways) 0.5-2.5 (3)mg/3mL, inhale four times a day. R6's care plan in the EHR had a focus problem area (not dated) that indicated R6 could self-administer medications; however, the care plan failed to indicate who was responsible for keeping the equipment clean. On 9/13/21, 6:53 p.m. R6 was observed to pick up the medication cup and mouthpiece for medication aerosolization that had been lying on the bedside stand and attached to her nebulization machine by tubing. The cup did not appear to be clean as it had some signs of moisture inside the container. R6 opened the cup and poured in a solution from a plastic vial. She stated the nurse had given her the medication to self-administer, and she had been okayed to self-administer medication from a plastic vial. She stated the nurse had given her the medication to self-administer any aerosolized medication. The nurse was not in t	RS FOR MEDICARE & MEDICAID SERVICES FOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245359 PROVIDER OR SUPPLIER 245359 B. WING_ VEN CARE CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 54 asthma. F 63 According to a physician's order dated 6/3/2021, R6 was able to self-administer nebulized medications and inhalers after set-up by a nurse. Physician orders also included an order for Budesonide Suspension 1mg/2mL (a steroid to reduce respiratory inflammation), inhale orally in the evening and in the morning. Additionally, R6 had a physician order for Ipratropium-albuterol solution (to open pulmonary airways) 0.5-2.5 (3)mg/3mL, inhale four times a day. R6's care plan in the EHR had a focus problem area (not dated) that indicated R6 could self-administer medications; however, the care plan failed to indicate who was responsible for keeping the equipment clean. On 9/13/21, 6:53 p.m. R6 was observed to pick up the medication cup and mouthpiece for medication aerosolization that had been lying on the bedside stand and attached to her nebulization machine by tubing. The cup did not appear to be clean as it had some signs of moisture inside the container. R6 opened the cup and poured in a solution from a plastic vial. She stated the nurse had given her the medication to self-administer, and she had been okayed to self-administer any aerosolized medication. The nurse was not in the room. R6 confirmed that she had not cleaned the cup an	RS FOR MEDICARE & MEDICAID SERVICES ICOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ICLA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING 245359 B. WING	RS FOR MEDICARE & MEDICAID SERVICES C COP DEFICIENCIES (X) PROVIDERSUPPLERICLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 245359 B. WING PROVIDER OR SUPPLIER 245359 VEN CARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 SWMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 54 asthma. ID According to a physician's order dated 6/3/2021, R6 was able to self-administer nebulized medications and inhalers after set-up by a nurse. Physician orders also included an order for Budesonide Suspension 1mg/2mL (a steroid to reduce respiratory inflammation), inhale orally in the evening and in the morning. Additionally, R6 had a physician order for forpatropium-albuterol solution (to open pulmonary airways) 0.5-2.5 (3)mg/3mL, inhale four times a day. F 695 R6's care plan in the EHR had a focus problem area (not dated) that indicated R6 could self-administer medications; however, the care plan failed to indicate who was responsible for keeping the equipment clean. Nanagement or designee for further recommendation. On 9/13/21, 6:53 p.m. R6 was observed to pick up the medication a solution from a plastic vial. She stated the nurse had given her the medication to self-administer any aerosolized medication. The nurse was not in the room. R6 confirmed that she had not cleaned the cup and did not know if any staff had cleaned the equipment since she had last had her treatannet. No nurse was present in the room when R6 poured	COF DEFICIENCIES (X1) PROVIDERSUPPLIER(LINCLA) (V2) MULTIFLE CONSTRUCTION (V3) MULTIFLE CONSTRUCTION (V3) MULTIFLE CONSTRUCTION PROVIDER OR SUPPLIER 245359 B. WING 09/ VEN CARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET 09/ VEN CARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET 09/ SUMMARY STATEMENT OF DEFICIENCIES IDE PROVIDERS PLAN OF CORRECTION 100/ (EACH CORRECTIVE ACTION SHOULD BE FRECEDED BY FULL FEECH CORRECTIVE ACTION SHOULD BE CONSERVENT ON USE DEFICIENCY ECAC CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CONSERVENT ON USE DEFICIENCY Continued From page 54 F 695 re-educated on the facility policy on oxygen orders and Inhalers after set-up by a nurse. F 695 Physician order for Ingratropium-albuterol solution (to open pulmonamiton), inhale orally in the evening and in the morning. Additionally, R6 had a physician order for Ipratropium-albuterol solution (to open pulmonary airways) 0.5-2.5 F 695 (3)mg/3mL, inhale four times a day. R6's care plan in the EHR had a focus problem area (not dated) that indicated R6 could self-administer medications; however, the care plan failed to indicate M6 could self-administer medications; however, the care plan failed to indicate M6 could self administer any ancsolized medication to a plastic vial. She stated the nurse had given her the medication to belf-administer,	

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	. <u> </u>	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	be laying inside R6' of various personal lotion bottles, etc. T that extended up ou attached to the nebus she had not used the evening before and anyone coming into equipment. She corr the cup inside her d not fall on the floor. R54 According to R54's sheet, R54 had diag and chronic respirat According to a 5/11/ could self-administer meter dose inhalers R54's care plan in the area (not dated) that self-administer meter dose inhalers On 9/13/21, 4:51 p.1 aerosolization of meter administration and of machine by tubing. laying on the counter was not sure if staff could not confirm it The mask looked view.	 ¹s bedside stand drawer on top items such as old letters, The cup was attached to tubing ut of the drawer and was pulization machine. R6 said he equipment since the stated she had not observed o her room to clean the infirmed that she had placed drawer after using it so it would EHR Admission Record/face gnoses of emphysema, acute tory failure and heart failure. /2020 physician order, R54 er nebulized medications and s once set up by the nurse. the EHR had a focus problem at indicated R54 could dications; however, the care the who was responsible for nent clean. m. R54's medication cup for edication was observed to to the face mask for connected to the nebulization The cup and mask were er beside the machine. R54 f cleaned the equipment and had been cleaned that day. isually soiled with many es on the inner portion of the 	F	695			

Facility ID: 00148

If continuation sheet Page 56 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY IPLETED
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	On 9/14/21, 2:20 p. aerosolization of me remain connected t soiled, and to tubing nebulization machin was sitting next to a cup and mask were counter. R54 stated self-administer med used the machine a the medication cup cleaned. An unoper medication for aero counter as well, and so she could take it breath, and she wo R54 confirmed she at that time. According to an inter registered nurse (R resident was done we the nurse should re cub and the mouth confirmed he had no clean the equipmer medication adminis RN-C had provided aerosolized solution During an interview practical nurse (LPH responsible to keep clean even if a reside medication. LPN-C or facemask should and then washed. L	m. R54's medication cup for edication was observed to to a face mask that appeared g connected to R54's ne. An empty medication vial and behind the nebulizer. The e laying on their side on the d she was able to dications and she had last around noon. R54 confirmed and mask had not been ned container of respiratory osolization was laying on the d R54 stated the nurse left it t whenever she got short of ould not have to call the nurse. did not need the medication erview 9/14/21, 2:27 p.m. a RN-C) stated that when a with a nebulization treatment eturn and clean the medication piece or facemask. RN-C not returned to R54's room to nt. A review of R54's stration record (MAR) indicated I R54 her last dose of n at noon.	F	595			

If continuation sheet Page 57 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 57	F6	695			
	remained on the co tubing connected to mask which were la white crusty area of directly under the m A review of R54's M nebulization treatme morning. This was documented dose of be given using the 10:00 p.m. on 9/14/ According to an inte RN-D, unit manage mask and medicate from the nebulizer a then set out to dry. as nebulization was resident could turn nurse know they ha	m. R54's nebulizing machine punter at her side with the p a medication cup and face aying on their side. A small f dried solution was observed nedication cup, on the counter. MAR at that time indicated no ent had yet been given that confirmed by R54. The last of any medication that would nebulizing equipment was at 21. erview 9/15/21, 10:28 a.m. r said the mouthpiece or face on cup should be detached after treatment, rinsed off and This was to be done as soon a complete. RN-D said a on the call-light to let the ad finished their treatment, or turn to the room as soon as eatment was likely to be					
	record/face sheet, I facility with a primar combined systolic ((congestive) heart f longer able to suffic the bodies need, ar overload. R44 also dysfunction with a c obstructive pulmona breath, a dependen	IR R44's admission R44 had been admitted to the ry diagnosis of chronic congestive) and diastolic ailure in which the heart is no ciently circulate blood to meet and with a component of fluid had significant pulmonary diagnosis of chronic ary disease, shortness of ace on supplemental oxygen ural effusion (fluid in lungs)					

Facility ID: 00148

If continuation sheet Page 58 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATI COM	E SURVEY PLETED
		245359	B. WING					C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP (CODE	-	
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 695	Continued From pa	•	Fe	695				
	among many other	co-morbidities.						
	assessment dated	erly Minimum Data Set (MDS) 7/30/2021, R44's primary vas considered to be a condition."						
	indicating "supplem oxygen saturations	n's order dated 7/29/21 ental oxygen to maintain >90%; document in progress r minute) and O2 saturations ery shift."						
	(TAR) for 9/01/21 th had signed each sh but not further docu saturations or rate of TAR. A review of R4 9/01/21 through 9/1 nurse documentation and in fact, contained 12:56 p.m. and on S							
	in his bed and had nasal cannula. R44 his oxygen, but the thought his O2 orde	m. R44 was observed resting oxygen running at 1.5 lpm via shrugged when asked about n wrote a note indicating he er was for 1.1 LPM (the or did not have increments to						
	LPN-C stated R44 of time. LPN-C stated having an oxygen s when she was work him using his oxyge	erview 9/14/21, 3:50 p.m. does not use his oxygen all the she did not remember R44 aturation lower than 90% ting but stated she had seen en. LPN-C said they should en saturation and the amount						

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COMI	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	confirmed the order of oxygen per minu was "pretty normal, order." LPN-C thou order to start reside oxygen but was una stated that if R44 ha less than 90% she and then titrate it do maintained his satu LPN-C also indicate equipment clean bu order to change R4 know when R44's of had been changed. According to an inter RN-D stated it was resident's oxygen s they required oxyge physician's order sa saturations above a should use between nasal cannula. RN- recommendation "it me check on that for she thought an LPN what level of oxyge they should alert an well. RN-D said if a not clear, a nurse s new order. According to an inter director of nursing (for nurses to clean equipment after a d	sing each shift. LPN-C did not say how many liters te to apply, but thought 2 LPM but it doesn't stay that in the ght the facility had a standing ents on 2 LPM if they needed able to find this order. LPN-C ad an oxygen saturation level would start oxygen at 2 LPM own until he was stable and rations greater than 90%. ed they should keep the at confirmed there was no 4's tubing. LPN-C did not xygen tubing or nasal canula erview 9/15/21, 10:33 a.m. the expectation to check a aturation levels each shift if en use. RN-D said if a aid to keep a resident's a certain percent, the nurse in 1 LPM and 5 LPM using a	Fδ	\$95			

If continuation sheet Page 60 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	medication and/or of promptly cleaned. If and the face mask/ and then inverted of DON also stated the responsibility, and a choose to clean the done by a nurse. If make the decision a resident should be an LPN scope of pr order for oxygen sh of oxygen to be pro- emergency, DON s facility policy to initial should seek out an administration. Oxy include instructions equipment such as The Administering If Volume (handheld) October 2010 provi- related to cleaning f "Rinse and disinfec- according to facility with warm soapy wa (c) place all pieces isopropyl (rubbing) minutes;(d) rinse all (NOT tap, bottled of dry on a paper towe equipment is compl- "	Condensation and this must be DON said the cup chambers mouthpiece should be cleaned into a clean dry paper towel. is was not a resident's although a resident may e equipment, it really should be DON also said an LPN cannot as to what level of oxygen a started on, and it is not within ractice to titrate. DON said an nould clearly state the amount vided in LPM. In an aid nurses could follow the ate oxygen, but then they order for on-going gen orders should also for cleaning and changing tubing. Medications through a Small nebulizer policy revised ded the following directions the equipment: t the nebulizer equipment protocol, or (a) wash pieced ater; (b) rinse with hot water; in a bowl and cover with alcohol. Soak for 5 I pieces with sterile water r distilled); and (e) allow to air el." The policy revised cated a nurse should first verify	F	595			

If continuation sheet Page 61 of 97

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY
ANDIENS	CONNECTION	DENTRIONION NONDER.	A. BUILDI	ING	3	COMPLET	
		245359	B. WING				16/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	_	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	following directions, otherwise ordered, rate of 2 to 3 liter per documentation lister oxygen flow, route a duration of the treat also to include reas assessment data of after the procedure. information about ca for those who require equipment. R64 Oxygen Use R64's admission MI R64's cognition was extensive physical a activities of daily livit oxygen therapy. R64's face sheet pr diagnoses included degenerative diseas 2 diabetes mellitus, R64's physician ord 8/12/21, for Oxygen night shift. On HS (I sleep apnea. R64's care plan, pri interventions related R64's care plan did related to sleep apn R64's September 2 Administration Reco	, "turn on the oxygen. Unless start the flow of oxygen at the er minute." Required ed: date and time, rate of and rationale, frequency, and tment. Documentation was son for the administration, any btained before, during and . The policy did not provide are of the oxygen equipment re the on-going use of such DS dated 8/19/21, indicated s intact. R64 required assistance from staff for all ing (ADLs) and received rinted 9/16/21, indicated R64's l obstructive sleep apnea, se of the nervous system, type , and chronic kidney disease. ders indicated an order dated in 1 liter every evening and bedtime) and off in AM for inted 9/16/21, did not indicate d to oxygen. Additionally, not indicate interventions nea.	F 6	;95			
	Administration Reco						

PRINTED: 11/01/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	COM	E SURVEY PLETED C
		245359	B. WING				_ 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	HS (bedtime) and o through 9/15/21. Ar indicated a start dat date oxygen tubing record lacked docur oxygen tubing had l On 9/14/21, at 8:31 with nasal cannular under a chair in R6- On 9/15/21, at 7:48 with nasal cannular the same location, o On 9/15/21, at 12:5 with nasal cannular the same location, o On 9/15/21, at 3:25 with nasal cannular the same location, o On 9/15/21, at 3:25 with nasal cannular the same location, o During an interview licensed practical n oxygen tubing with floor, under a chair "That's not good, th LPN-F picked up th oxygen concentrato replace it with a new tubing. When LPN- cannula should not "because of infectio asked what should tubing when not in o	off every AM from 9/1/21 dditionally, R64's ETAR te of 9/20/21, to change and every Monday evening. The mentation indicating the been changed prior to 9/16/21. a.m. R64's oxygen tubing was observed on the floor,	F	\$95			

Facility ID: 00148

If continuation sheet Page 63 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE COM	E SURVEY PLETED
		245359	B. WING	i			C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695 F 725 SS=F	During an interview Infection Prevention oxygen was not in u been wrapped up a concentrator, not or LPN-E stated that if used after it had be infection, staph, MF things". Facility policy, Oxyg 10/10, did not addres tubing when not in u did not address any Sufficient Nursing S CFR(s): 483.35(a)(1) §483.35(a) Sufficient The facility must had the appropriate com provide nursing and resident safety and practicable physical well-being of each m resident assessment and considering the diagnoses of the fac accordance with the at §483.70(e). §483.35(a)(1) The f by sufficient number types of personnel of nursing care to all m resident care plans (i) Except when wait this section, license	on 9/16/21, at 2:07 p.m. the hist (LPN)-E stated when use, the tubing should have nd placed on the oxygen in the floor or bed. Additionally, f the nasal cannula had been en on the floor, "it could cause RSA, E-coli, a lot of bad gen Administration revised ess placement of the oxygen use. Additionally, the policy or changing of oxygen tubing. Staff 1)(2) Int Staff. Ive sufficient nursing staff with hepetencies and skills sets to d related services to assure attain or maintain the highest l, mental, and psychosocial resident, as determined by hts and individual plans of care e number, acuity and cility's resident population in e facility must provide services rs of each of the following on a 24-hour basis to provide esidents in accordance with to wed under paragraph (e) of		725			10/29/21

If continuation sheet Page 64 of 97

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	()(0) 1411		O	FORM. MB NO.	11/01/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			COM	E SURVEY PLETED C
		245359	B. WING				16/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	limited to nurse aide	es.	F 7	25			
	paragraph (e) of thi designate a license nurse on each tour This REQUIREMEN by:	NT is not met as evidenced					
	facility failed to impl lights in a timely ma physical needs and security which had the residents residing	and document review the lement staff to answer call anner to meet resident a psychosocial sense of the potential to affect any of ng in the facility who use a ntly or with assist from visitor.			 1.It is policy of Pine Haven Communessing that all call lights are answered timely. 2.This has the potential to affect all residents 3.Staff re-education on answering on lights will be completed with nursing the potential to affect all residents. 	red 69 :all	
	Findings include:				on 10/21/2021 and 10/25/2021. 4.Audits will be completed for comp on answering call lights timely daily		
	(EHR) Admission R diagnoses of muscl	electronic health record Record (face sheet), R19 had e weakness, difficulty walking, history of a broken hip.			weekly x 6 and monthly x 1. Results be reviewed by our Quality committ further recommendation	s will	
	area (not dated) tha falls and a correspo staff should ensure	an included a focus problem at indicated she was at risk for onding intervention indicated the call-light was within reach o use it to call for assistance.					
		EHR Admission Record, R51 right side, his dominant side.					
	area (not dated) tha falls related to gait a corresponding inter encourage R51 to u assistance. Another	an included a focus problem at indicated he was at risk for and balance problems. A vention indicated staff should use his call-light to request r focus problem area (not in had the potential for bladder					

If continuation sheet Page 65 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245359	B. WING	i			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	offered upon rising, bedtime and during According to R51's required extensive a toileting. According to an inter R19 stated she had the night a few days arrive for over an ho generally been able had pain in her flam well. She said she e and was "wet from over everything." W R19 said she talked wait, and he apolog it took so long. R19 staff person. She s light wait time tende shift. According to an inter R51 said he require bathroom, but on th prior, he had turned assistance, but after no response, he ma get into his wheelch the toilet, and then a about an hour and a turn off his call-light had been so long th sleep. R51 told the already taken himse	ssistance to toileting should be before and after meals, at the night. MDS, 8/11/21, indicated R51 assistance of one person with erview on 9/13/21, 12:51 p.m. d turned her call light on during s before, and staff did not our. R19 said she has e to transfer herself, but she k, and she was not feeling ended up voiding in her bed head to toe" and "I peed all /hen a staff person arrived, d to him about the extended gized to her but did not say why was unable to identify the said that problems with call ed to occur during the night erview on 9/13/21, 2:48 p.m. ed assistance to get to the ne past weekend, a few days d on his call-light for er waiting for a long time with anaged to get up on his own, hair, go to the bathroom, use go back to bed. R51 said a half later a man came in to t and asked what he needed. It hat R51 had fallen back to staff person that he had elf to the bathroom and no	F	725	,		
	excuse was offered	elf to the bathroom and no I for the wait time. R51 n and anger about this					

Facility ID: 00148

If continuation sheet Page 66 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	Continued From pa instance.	ge 66	F7	25			
	for R19 and R51's u 9/14/21. This report took staff one hour respond to R19's ca	call-light times was requested unit dated 9/4/21 through t confirmed that on 9/12/21 it and sixteen minutes to all light at 3:25 a.m. and one es to R51's call light at 3:20					
	registered nurse (R during the night on on the same unit as unaware of any rep building that night w	erview 9/16/21, 10:03 a.m. a N-H) stated she had worked the past weekend but was not s R19 and R51. RN-H was orted significant events in the which would have interfered g a call light for an extended					
	facility administrato concerns about len past and said he ha complain about call days but was not av concerns. Administ expectation for staf a call-light comes of immediately attend are to let them know assist. The Admini- rule of thumb, if a li longer, we need to behind that?" The A knowledge of any e last week that might	erview 9/16/21, 11:06 a.m. the r stated there had been gthy call-light response in the ad had one other resident l light times in the past few ware of R19 or R51's rator stated it was the facility f to check on a resident when on, and if they are not able to to the resident concerns, they w when they would be back to strator said "typically, it is our ght is on for 20 minutes or ask, what is the reasoning Administrator had no events in the facility over the at have caused a slow ay an incident of a staff person reported but was unsure if elation.					

Facility ID: 00148

If continuation sheet Page 67 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 67	F 7	25			
F 758 SS=D	nursing assistant (N Sunday night (9/12 call-light response t previous night but h reason or event tha NA-C said she under on the day shift was form to report it to le The Answering the 2021 indicated staff approximate time it the resident's reques member, notify the request is somethin task within five minu uncertain as to whe fulfilled or if you can request, ask the nu Additionally, the pro- should document at resident and the red addressed. Free from Unnec Per CFR(s): 483.45(c)(3) §483.45(c)(3) A psy affects brain activitie processes and behavior	Call Light policy revised March f should "indicate the will take for you to respond, if est requires another staff individual. If the resident's ng you can fulfill, complete the utes if possible. If you are ether or not a request can be nnot fulfill the resident's rse supervisor for assistance." ocedure indicates that staff ny complaints made by quest or complaint was sychotropic Meds/PRN Use 3)(e)(1)-(5) tropic Drugs. ychotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following	F 7	758			10/29/21

Facility ID: 00148

If continuation sheet Page 68 of 97

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT				E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
						(C
		245359	B. WING _			09/*	16/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	VEN CARE CENTER I	NC			0 NORTHWEST 3RD STREET		
				PI	INE ISLAND, MN 55963		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 758	Continued From pa	ge 68	F 7	58			
	Deceder commu	hencing concernent of a					
		hensive assessment of a must ensure that					
		dents who have not used					
		are not given these drugs					
		on is necessary to treat a signal decomposed and documented					
	in the clinical record						
		-,					
		dents who use psychotropic					
		ual dose reductions, and tions, unless clinically					
		an effort to discontinue these					
	drugs;						
		dents do not receive pursuant to a PRN order					
		tion is necessary to treat a					
		condition that is documented					
	in the clinical record	d; and					
	\$492 45(a)(4) DDN	ordoro for povebetropie druge					
		orders for psychotropic drugs ys. Except as provided in					
		e attending physician or					
	prescribing practitio	oner believes that it is					
		PRN order to be extended					
		e or she should document their					
		dent's medical record and n for the PRN order.					
		orders for anti-psychotic					
		14 days and cannot be					
		e attending physician or oner evaluates the resident for					
		s of that medication.					
		NT is not met as evidenced					
	by:						
	Based on interview	/ and document review the			1.It is policy of Pine Haven Comm	unity to	

Facility ID: 00148

If continuation sheet Page 69 of 97

PRINTED: 11/01/2021

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		245359	A. BUILDING	3	(0	
	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	16/2021	
		NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 758	interventions prior t (PRN) psychotropic reviewed for unnec Findings include: R171's face sheet it to the facility on 9/8 included generalize moderate major de insomnia. R171's physician of Ativan (antianxiety) by mouth every 8 h vomiting/withdrawa R171's progress no administration reco through 9/11/21 ide Ativan, the record of administration how was effective and d of non-pharmacolog or offered prior to a identified Ativan wa 9:04 p.m., 9/9/21 at p.m. and 9/11/21, at R171's Ativan order on 9/11/21; the order Ativan 1 mg by mout for anxiety and/or v record did not ident was removed as just	r/attempt non-pharmacological o administration of as needed c medications for 1 of 5 (R171) essary medications ndicated R171 was admitted //21 with diagnoses that ed anxiety disorder, recurrent pressive disorder, and rder dated 9/8/21 indicated medication) 1 milligram (mg) ours as needed for intractable I for 3 days. otes and medication rd reviewed between 9/8/21 ntified R171 was administered lid not identify reason for ever indicated the medication id not include documentation gical interventions attempted dministration. The record s administered on 9/8/21, at t 8:20 p.m., 9/10/21, at 1:47	F 758	 ensure to offer/attempt non pharmacological interventions p administration of as needed (PR psychotropic medications. Resided discharged from the facility on 09/20/2021. 2. This has the potential to affect residents. all residents who have psychotropic medication will be to ensure we offer/attempt nonpharmacological intervention use 3. Staff re-education will be complicensed nursing staff on 10/21/2 10/25/2021 to ensure compliance non-pharmacological intervention use of prn psychotropic medicated 4. Nursing Management or desig conduct audits to ensure care pl orders include necessary component psychotropic medication prn me have appropriate non-pharmacco interventions in place for use pri administration of prn medication 10, weekly x 6 and then monthly compliance. Results will be revie our Quality committee for further recommendation 	N) lent R171 all 69 e a (PRN) reviewed as prior to bleted with 2021 and e with ns prior to ions. nee will ans and onents of dications logical or to . Daily x x 1 for ewed by		

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
			A. BUILD	ING	<u> </u>		С
		245359	B. WING				_ 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	VEN CARE CENTER I	NC		2	210 NORTHWEST 3RD STREET		
	VEN CARE CENTER I	NC .		F	PINE ISLAND, MN 55963		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
TAG	REGULATORTOR		TAG		DEFICIENCY)		
					-		
F 758	Continued From pa	ae 70	F 7	50			
1 100	-	•	F /	50	3		
		resident have anxiety or npairs his/her quality of life or					
		n activities. The Note Section					
		has rx [prescription] for					
		ation indicated the mediation					
		ents' symptoms. The					
		lescribe R171's anxiety or					
	nervousness and d						
	non-pharmacologic	al interventions.					
	P171's caro plan di	d not identify diagnoses of					
	anxiety with goals c						
	non-pharmacologic						
	nen pharmaeologie						
	R171's record on 9/	/12/21, identified target					
	behaviors for use o	f Ativan as 1. Nervousness 2.					
	Withdrawal/refusal	of care 3 nausea/vomiting.					
		too and madiaation					
	R171's progress no	rd reviewed between 9/12/21					
		ntified R171 was administered					
		lid not identify reason for					
		ever indicated the medication					
		id not include documentation					
		gical interventions attempted					
		dministration. The record					
		ministered on 9/12/21 at 8:07					
	p.m., 9/13/21 at 9:2	5 p.m., and 9/14/21 at 8:33					
	p.m.						
	During on interview	an 0/15/21 at 10.02 a m					
		on 9/15/21, at 10:02 a.m. NA)-G stated he had not					
		ors and R171 did not display					
	anxiety that he had						
	,						
		on 9/16/21, at 8:44 a.m.					
		N)-D reviewed R171's record					
		cumentation did not identify					
	how R171's nervou	sness/anxiety/withdrawal					

If continuation sheet Page 71 of 97

PRINTED: 11/01/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758 F 761 SS=D	symptoms presenter should be defined st to staff. RN-D indication identify non-pharmation may help relieve and documentation did in non-pharmacologic attempted prior to the During an interview nursing (DON) revies stated the target be the behaviors really anxiety differently. If medications should specifically prescrib and attempt non-ph first, documentation interventions were the refusals need to be Label/Store Drugs at CFR(s): 483.45(g)(If §483.45(g) Labeling Drugs and biologication instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In ac Federal laws, the fa- biologicals in locked	ad and stated the behaviors so they could be recognizable ated the care plan did not acological interventions that ixiety symptoms and not reflect attempts of al interventions utilized or he administration. on 9/16/21, director of ewed R171's record and haviors does not identify what or are, and everybody displayed DON stated as needed be given for what they are bed for and staff should offer harmacological intervention in should identify which used and if which ones were resident refused then the documented. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nee with currently accepted les, and include the		758			10/29/21

If continuation sheet Page 72 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245359	B. WING _				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•••	
				21	0 NORTHWEST 3RD STREET		
	VEN CARE CENTER I	NC		PI	NE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From pa personnel to have a §483.45(h)(2) The f locked, permanenti storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, facility failed were properly labely residents (R54) obs of nebulized/aeroso Findings include: According to R54's (EHR) Admission R diagnoses of emph respiratory failure a According to a 5/11 could self-administe meter dose inhalers	ge 72 access to the keys. facility must provide separately y affixed compartments for d drugs listed in Schedule II of e Drug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced tion, interview and document d to ensure that medications ed and secured for 1 of 2 served for self-administration blized medications. electronic health record Record/face sheet, R54 had ysema, acute and chronic	F 76	61	1.It is policy of Pine Haven Commu ensure medications were properly la and secured. Resident R54 dischar from the facility on 10/18/2021. 2.This has the potential to affect all residents. All residents who self-administer medications were reviewed to ensure compliance. 3.Staff re-education will be complete licensed nursing staff on 10/21/2021 10/25/2021 to ensure respiratory medications are managed according policy and not left in resident rooms resident self-administration. 4.Nursing Management or designee conduct audits for compliance with oxygen and respiratory policy to ensure respiratory medications are managed	inity to abeled ged 69 ed with 1 and g to for e will sure ed	
	area (not dated) tha self-administer med plan did not indicate at bedside.	he EHR had a focus problem at indicated R54 could dications; however, the care e R54 could keep medications m. R54 stated she was able			according to policy and not left in re rooms for resident self-administration daily x 10, weekly x 6 and monthly x Results will be reviewed by our Qua committee for further recommendat	on (1. ality	

Facility ID: 00148

If continuation sheet Page 73 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	to self-administer m taken a dose of her medication of aeros next to, and behind container of respira aerosolization was l and R54 stated the it whenever she got would not have to c did not have a phar directions and did n manufacture's stam it contained lpratrop confirmed she did n time. According to an inter registered nurse (R medication vial in R did not need an as t time. RN-C stated h because R54 "know During an interview the unit manager st medications at a res RN-D, if a resident medication, the nurs in at the time it is or PRN the nurse musi- not before. RN-D sa bedside could resul at the proper time. A provide the next PR soon, or "back-to-ba nurse should bring to the second the second the second the should bring to	nedications and she had last medication at noon. An empty sol solution was observed lying the nebulizer. An unopened tory medication for laying on the counter as well, nurse left it so she could take t short of breath, and she sall the nurse. The plastic vial macy label attached with any not have R54's name on it. A np on the plastic vial indicated bium-Albuterol Solution. R54 not need the medication at that erview 9/14/21, 2:27 p.m. a .N-C) confirmed he had left the 254's room even though she needed (PRN) dose at that ne was able to leave it there	F 7	761			

If continuation sheet Page 74 of 97

		& MEDICAID SERVICES			O		APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	Сом	E SURVEY PLETED
		245359	B. WING				_ 16/2021
NAME OF	PROVIDER OR SUPPLIER		·		REET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			0 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	A review of R54's m record (MAR) for 9/ documented giving Ipratropium-Albuter No PRN dose of Ipr documented on 9/1 documented on R5- nurse for the evenir documented admin but no PRN dose. According to an inte director of nursing (self-administer med physician's order ar being able to do so not to be left at bed order, and the facili place to store the m medications must b the resident's name locked at bedside. The Storage of Med November 2020 ind used in the facility a compartments unde and humidity contro prepare and admini- to locked medicatio have missing, incor	nedication administration (14/21 showed RN-C R54 a scheduled dose of ol at 8:00 a.m. and at noon. ratropium-Albuterol was 4/21 and none were 4's MAR since 9/10/21. The ng shift on 9/14/21 istering the 4:00 p.m. dose, erview 9/15/21, 11:05 a.m. the (DON) stated residents could dications if they had a nd had been assessed as . DON said medications were side unless there was an ty had provided them a safe nedications. DON indicated be appropriately labeled with a and a pharmacy label if kept dications policy revised dicated "drugs and biologicals	F 7	61			
F 791 SS=D		y Dental Srvcs in NFs 1)-(5)	F 7	91			10/29/21

If continuation sheet Page 75 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING	i			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	·	
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 791	Continued From pa	ge 75	F7	791			
		rvices sist residents in obtaining r emergency dental care.					
	§483.55(b) Nursing The facility-	Facilities.					
	outside resource, ir of this part, the follo the needs of each r	ervices (to the extent covered n); and					
	assist the resident- (i) In making appoir	ntments; and transportation to and from the					
	residents with lost of dental services. If a 3 days, the facility r what they did to ens and drink adequate	promptly, within 3 days, refer or damaged dentures for a referral does not occur within must provide documentation of sure the resident could still eat by while awaiting dental tenuating circumstances that					
	circumstances whe dentures is the facil charge a resident for dentures determine	have a policy identifying those on the loss or damage of lity's responsibility and may not or the loss or damage of ed in accordance with facility lity's responsibility; and					

Facility ID: 00148

If continuation sheet Page 76 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER		I	S	IREET ADDRESS, CITY, STATE, ZIP CODE		10/2021
				21	10 NORTHWEST 3RD STREET		
	VEN CARE CENTER I	NC		Ρ	INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 791	 §483.55(b)(5) Must eligible and wish to reimbursement of comedical expense un This REQUIREMEN by: Based on interview facility failed to ensign R3) were offered reamintain oral comformation. Findings include: According to the election of the election. Findings include: According to the election of the election. Findings include: According to the election of the election of the election. Findings include: According to the election of the election. A facility "Long Terre 6/30/21 done to information abore and no other evaluation in the EHR. According to R24's problem area (not corrisk for alteration in related to being edea and lower dentures the dentures had be indicate when that he problem area was constructed of the election offer is madeental appointment. During an interview 	age 76 assist residents who are participate to apply for dental services as an incurred nder the State plan. NT is not met as evidenced //s and document review, ure 2 of 2 residents (R24 and egular dental appointments to port and reduce the risk of ectronic health record (EHR) ace sheet, R24 had a diagnosis ulty swallowing) of the se (near mouth/throat). In Care Evaluation'' dated form the MDS did not include but R24's oral or dental status, ation of oral status was found care plan in the EHR, a focus dated) indicated R24 was at oral hygiene, and health entulous (no teeth), has upper . The focus problem indicated een re-lined but did not nad occurred. The goal for this dated as having been initiated sponding intervention included: ade to resident/family to set up s and PRN (as needed).	F 7	91	 1.It is policy of Pine Haven Communesure residents are offered regula dental appointments to maintain co and reduce risk of infection. Reside and R24 were offered dental appointments. 2.This has a potential to affect all 69 residents. All residents were review ensure they were offered routine deservices. 3.Staff re-education will be complet licensed nursing staff on 10/21/202 10/25/2021 to ensure accuracy and completion of routine oral assessmand follow through. 4.Nursing Management or designed perform audits for accuracy and completion of routine oral assessmand follow daily x 10, weekly x 6 an monthly x 1. Results will be reviewed our Quality committee for further recommendation 	r mfort ents R3 9 red to ental ed with 1 and ents e will ents d	

If continuation sheet Page 77 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 791	her admission to the She said the dentur have not been adjus- stated she frequent mouth in-between r had started to irritat had four children bu family was unable to appointment or ass She did not recall b appointments. According to an inte a registered nurse (stated the facility was dental visits but was time R24 had receive RN-D stated such se quarterly care confer record that such se declined by R24. According to an intel licensed social work should offer dental know if R24 had ha this should be offer conferences. LSW documentation indic been offered to or co According to an inten nursing assistant (N dentures in to eat h in between because irritates her." NA-C	e facility some six years ago. res had to be re-lined twice but sted in recent years. She dy had to take them out of her meals because the dentures the her gums. She stated she ut was concerned that her o assist with making any isting her to an appointment. eing offered any dental erview on 9/15/21, 10:37 a.m. (RN-D) managing the unit as able to provide R24 with s unable to record on the last ved any dental assessment. services should be offered at erences but was unable to find rvices had been offered to or erview 9/15/21, 11:46 a.m. the ker (LSW) stated the facility visits as needed. LSW did not d any dental visit but stated ed at quarterly care was unable to find cating any such services had declined by R24. erview 9/15/21, 12:14 p.m. a NA-C) stated R24 puts her er meals but will take them out e "there is a little spot that stated nurses were supposed t oral status and set up dental	F 7	791			

Facility ID: 00148

If continuation sheet Page 78 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT COM	E SURVEY IPLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 791	On 9/16/21, 8:30 a. (DON) confirmed the recent documentatic current oral status. to find any docume dental appointment that vision, hearing every care conferent this offer and the re- documented. DON not documented. DON not documented, or had been done. The Dental Service 2016 indicated that available to provide services will assist and transportation a indicates that all de recorded in the resident The Dental Examinaries The Dental Examinaries The Dental Examinaries Shall be offered der upon conducting a needing dental servito a dentist. R3 R3's annual Minimu 6/3/21, indicated R3 impairment and wa known. R3's face sheet dat	age 78 m. the director of nursing hat the EHR did not contain ion by nursing staff of R24's DON stated she was unable ntation that R24 was offered at t. DON stated an expectation and dental visits be offered at nce and as needed, and stated esident response should be stated if the information was ne could not assume that it as policy revised December selected dentists must be follow up care, and social residents with appointments arrangements. The policy also ental services should be ident's medial record. hation/Assessment policy 2013 indicated that residents ntal services as needed and dental examination, a resident vices will be promptly referred um Data Set (MDS) dated 3 had moderate cognitive s able to make his needs ted 9/15/21, indicated R43's I diabetes mellitus, heart	F	791			

If continuation sheet Page 79 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 791	Continued From par failure and seizure of R3's care plan date to offer resident or dental appointment R3's Clinical Admiss indicated R3 had of broken natural teett indicate the provide dental status to obt R3's progress notes failed to address R3 dental appointment On 9/13/21, at 1:21 offered to see in a of dentist due to seven On 9/15/21, at 10:2 stated if a resident staff would make he medical records kn She could also be r assessment proces assessment d had cavities or brok not notified of R3's On 9/15/21, at 2:42 (DON) stated she e	ge 79 disorder. d 9/15/21, provided direction family to periodically offer s as needed. sion Evaluation dated 5/3/21 ovious or likely cavity or n. This assessment did not er should be notified of R3's ain dental consult. s dated 5/27/20 thru 9/14/21, 3's dental needs and if a was offered. p.m. R3 stated he was not dentist but would like to see a ral missing and broken teeth. 6 a.m. registered nurse (RN)-I wanted a dental appointment, er aware and she would let ow to make the appointment. notified through the s. The nurse completing the I let RN-I know about the see a dentist. RN-I confirmed ated 5/3/21, indicated R3 likely ten teeth. RN-I stated she was	F 7		DEFICIENCY)		
	update the resident possible cavities or	ng the assessment would 's provider if concerns such as broken teeth were noted. <i>v</i> ices were important as					

If continuation sheet Page 80 of 97

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245359	B. WING			С
	PROVIDER OR SUPPLIER	240009	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•	/16/2021
		NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 791	cavities can cause	ge 80 pain, increases the resident's duding sepsis (an infection of	F 79	91		
	the blood stream). Hospice Services CFR(s): 483.70(o)(F 84	19		10/29/21
	do either of the follo (i) Arrange for the p through an agreem Medicare-certified H (ii) Not arrange for services at the facil a Medicare-certified resident in transfer	g-term care (LTC) facility may owing: provision of hospice services ent with one or more nospices. the provision of hospice ity through an agreement with d hospice and assist the ring to a facility that will vision of hospice services				
	LTC facility through paragraph (o)(1)(i) the LTC facility must requirements: (i) Ensure that the h professional standa to individuals provid to the timeliness of (ii) Have a written a	spice care is furnished in an an agreement as specified in of this section with a hospice, at meet the following hospice services meet ards and principles that apply ding services in the facility, and the services. Igreement with the hospice authorized representative of				
	the hospice and an the LTC facility before any resident. The v at least the followin (A) The services th (B) The hospice's r	authorized representative of pre hospice care is furnished to written agreement must set out g: e hospice will provide. esponsibilities for determining spice plan of care as specified				

If continuation sheet Page 81 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245359	B. WING	i			_ 16/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 849	 (C) The services the provide based on e. (D) A communication will LTC facility and the that the needs of the met 24 hours per data (E) A provision that notifies the hospice (1) A significant charmental, social, or enditional, social of the provided is approprimesident's needs. (G) An agreement the resident's needs. (H) A delineation or including but not limit direction and mana counseling (including but not limit direction and mana counseling (including but not limit bereavement); social supplies, durable minecessary for the provided with the conditions; and all or social and an anticologia and anticologia and anticologia and anticologia and anticologia a	e LTC facility will continue to ach resident's plan of care. on process, including how the be documented between the hospice provider, to ensure e resident are addressed and ay. the LTC facility immediately about the following: ange in the resident's physical, motional status. ations that suggest a need to e. er the resident from the facility eath. ng that the hospice assumes termining the appropriate	Fξ	349			

If continuation sheet Page 82 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245359	B. WING	i			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 849	personnel are response of prescribed therage determined appropries delineated in the host facility personnel m where permitted by the LTC facility. (J) A provision stat report all alleged vio mistreatment, negled and physical abuse source, and misapp by hospice personn administrator imme becomes aware of (K) A delineation of hospice and the LTC bereavement service §483.70(o)(3) Each provision of hospice agreement must de facility's interdiscipli for working with host coordinate care to t LTC facility staff and interdisciplinary tea clinical background scope of practice ac assess the resident that has the skills a resident. The designated inter (i) Collaborating with	conditions. when the LTC facility possible for the administration bies, including those therapies rate by the hospice and spice plan of care, the LTC ay administer the therapies State law and as specified by and that the LTC facility must blations involving ect, or verbal, mental, sexual, , including injuries of unknown propriation of patient property el, to the hospice diately when the LTC facility the alleged violation. The responsibilities of the C facility to provide tes to LTC facility staff. LTC facility arranging for the e care under a written signate a member of the nary team who is responsible spice representatives to he resident provided by the d hospice staff. The m member must have a , function within their State ct, and have the ability to or have access to someone and capabilities to assess the erdisciplinary team member is	F٤	349			

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED C
		245359	B. WING				_ 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 849	Continued From pa the hospice care pla residents receiving (ii) Communicating and other healthcar provision of care for conditions, and othe of care for the patie (iii) Ensuring that th with the hospice me attending physician participating in the p as needed to coord medical care provid (iv) Obtaining the for hospice: (A) The most recer to each patient. (B) Hospice election (C) Physician certifi the terminal illness (D) Names and con personnel involved patient. (E) Instructions on 24-hour on-call syst (F) Hospice physic any) orders specific (v) Ensuring that the orientation in the po facility, including pa and record keeping furnishing care to L §483.70(o)(4) Each	Ige 83 anning process for those these services. with hospice representatives re providers participating in the r the terminal illness, related er conditions, to ensure quality ent and family. he LTC facility communicates edical director, the patient's , and other practitioners provision of care to the patient inate the hospice care with the led by other physicians. ollowing information from the int hospice plan of care specific on form. fication and recertification of specific to each patient. ntact information for hospice in hospice care of each how to access the hospice's tem. ation information specific to cian and attending physician (if c to each patient. e LTC facility staff provides olicies and procedures of the tient rights, appropriate forms, requirements, to hospice staff TC residents.	1	349	DEFICIENCY)		
	care under a writter	n agreement must ensure that ten plan of care includes both					

If continuation sheet Page 84 of 97

		& MEDICAID SERVICES				0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY IPLETED
		245359	B. WING _			C 16/2021
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 849	the most recent ho description of the s facility to attain or r practicable physical well-being, as requ This REQUIREMED by: Based on observat review, facility failed coordination of card provider for 1 of 1 r hospice care. Findings include: According to R54's (HER) Admission F diagnoses of emph respiratory failure, f among other co-mo A focus problem ar plan as follows: "I h related to COPD ar failure. I began hos intervention list incl	spice plan of care and a ervices furnished by the LTC naintain the resident's highest il, mental, and psychosocial ired at §483.24. NT is not met as evidenced tion, interview, and document d to provide a system of e with their contracted hospice resident (R54) reviewed for electronic health record Record/face sheet, R54 had hysema, acute and chronic heart failure and anxiety	F 84	 1.It is policy of Pine Have ensure the facility coordir the contracted Hospice a R54 was discharged from 10/18/2021. 2.This has the potential to residents. All residents or reviewed to ensure Hosp available for residents an parties including the nam Manager, visit nurse, and well as Hospice contact in well as notification if hosp changes. Hospice agence notified and educated on aforementioned process. 3.Staff re-education will b nursing staff on 10/21/20 10/25/2021 to ensure Hos available for residents an 	ates care with gency. Resident the facility on affect all 69 hor Hospice were ice schedule is d responsible es of the Nurse hospice aid, as nformation as bice schedule ises will be the e completed with 21 and spice schedule is	
	physical and social indicate any specifi responsibilities wer were responsibilitie A review of uploade failed to show a ho an August-Septem the schedule show incomplete and did	emotional, intellectual, needs are met," but failed to ic delineation of what e those of hospice and which es of the facility. ed documents in R54's EHR spice care plan but did include ber 2021 schedule. A review of ed that the schedule was not include the name of a sit nurse or hospice aide or		parties including the nam Manager, visit nurse, and well as Hospice contact in well as notification if hosp changes for the next 60 of 4.Nursing Management of conduct audits for new ho and existing hospice resid Hospice schedule is avail residents and responsible including the names of th Manager, visit nurse, and	hospice aid, as nformation as bice schedule lays. or designee will ospice resident dents to ensure able for e parties e Nurse	

Facility ID: 00148

If continuation sheet Page 85 of 97

		& MEDICAID SERVICES	(X2) MULTI	IPLE CONSTRUCTION		. 0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED
						С
		245359	B. WING	·····		/16/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
PINE HA		INC		210 NORTHWEST 3RD STREE PINE ISLAND, MN 55963	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 849	Continued From pa	ige 85	F 84	19		
	R54 confirmed that services, but stated them for." R54 india said she had hoped would help her, but more confusing. Sh issues between the stated, "Peter does On 9/13/21 she wa wraps on her legs (compression wrap dressing, covered th compression wrap week, but is often of weekly if there are understood hospice them, but no-one fr she didn't know if a She said there had from hospice in to leg wraps, and he we there would be som provide those cares received any scheot hospice service. Not observed in her root and compression wa any instruction and	erview on 9/13/21, 4:34 p.m. she was receiving hospice d, "I don't know what we pay cated she felt very anxious and d having hospice services said it seemed to make things he reported communication e facility and hospice and n't know what Paul has done." s particularly concerned about Unna boots- a layered that contains a gauze zinc by a dry dressing, covered by a that can be left on for up to a changed two to three times open wounds) stating she was in-charge of applying om hospice had arrived and nyone would wrap her legs. been a massage therapist visit, but he didn't care for her wasn't able to tell her when heone from hospice in to s. R54 said she had not fulle or calendar from the o such document could be om. A basket with roller gauze vraps was in the room without without any indication of a gs were not wrapped at that		well as Hospice contact well as notification if ho changes daily x 10, wee monthly x 1. Results wil our Quality committee f recommendation	spice schedule ekly x 6 and Il be reviewed by	
	R54 was upset, sta her legs so she cou had come to replace	erview on 9/14/21, 2:26 p.m. ting her wraps were taken off Ild have a bath, but no one them. She again said she was supposed to apply the				

If continuation sheet Page 86 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY IPLETED
		245359	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 849	come. R54's legs v	ge 86 not know when they would vere observed to be swollen. on-slip socks, but no wraps.	F٤	349			
	According to an interegistered nurse (R the hospice should then the facility wou the EHR. RN-D did receive a copy of the if the hospice agene when they visited. F hospice schedule for nurse was schedule think they knew a s changed days of vis come up. RN-D did nurse manager, and RN-D thought a hos come twice weekly on Mondays and Th if anyone had been said it was expecte communicate with t usually talked to the where the resident unit manager. RN-E care plan had not b On 9/14/21, 2:46 p. to the hospice agene manager or someo information. The per	erview 9/14/21, 2:29 p.m. a N-D), the unit manager stated fax the facility a schedule and uld upload that schedule into not believe the resident would hat schedule and did not know cy would provide them one RN-D was unsure of the or R54, stating she thought a ed twice a week, but did not pecific date as hospice often sits if something else would not think R54 had a hospice d various nurses came to visit. spice aide was supposed to and she thought it would be nursdays, but she was unsure there the day before. RN-D d for the hospice nurse to the facility staff, but said they e nurse responsible for the hall lives rather than coming to the D confirmed that a hospice een uploaded into the HER. m. a telephone call was made ney to reach out to R54's nurse ne who could provide erson who took the phone call anager was not on duty and					
	call. Unknown indiv manager was sche week and would vis	her person who could take the idual stated the nurse duled to visit the facility twice a sit R54 on 9/15 and 9/16/21 hursday) this week, and then					

If continuation sheet Page 87 of 97

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED		
		IDENTIFICATION NUMBER.		NG		C		
		245359	B. WING		09	/16/2021		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 849	Thursday), but stat schedule if they ne According to an int hospice nurse mar would know when would tell them. Sh any training to prov- resident, merely to which she did verb have a little leeway change their sched same with hospice aid had been sick f resigned so she, R when she came to would talk with the other nurses would by looking for any r documentation in t should be a care p but stated there way who was supposed plan and any other chart, and she did sent. RN-F also stat make a note in the	age 87 2/21 and 9/23/21 (Tuesday and ted they do change the ed to send a nurse elsewhere. erview 9/15/21, 1:42 p.m. a hager, RN-F stated a resident she was coming because she he stated she had not received vide a written schedule to the provide a frequency of visits ally. She stated she liked to v as they sometimes had to dule. RN-F stated they did the aid visits, but currently their for some time and now had N-F, would do the aid work visit R54. RN-F said she nurse who was on duty, and d be able to gather information new orders or by looking for he EHR. RN-F confirmed there lan from the hospice agency as someone at the main office d to send the facility the care documentation for the facility not know if anything had been ated the hospice nurse should facility EHR after visiting but ter password so had not been	F 84	49				
	meet with the facili concerns regarding the order said to ch that hospice would there for a visit. According to R54's was provided the fo	RN-F said she did not regularly ty unit manager. As to R54's g her leg wraps, RN-F stated hange them as needed, and change them when they were a physician orders, the facility following order on 9/10/21: "Una left extremity). Hospice to						

If continuation sheet Page 88 of 97

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 849	change on visits. C Contradictory order physician's orders s and apply Aveeno of compression garme for edema" 9/3/21. According to an inte facility licensed soc social service is the for clinical aspects communication wor manager. According to intervit director of nursing of agency should provide the box and the schedule box stated the point per facility was the unit of their job respons manager should be schedule and know information. Addition manager should be schedule and know information. Addition manager should be communicate with the confirmed that the f the hospice plan of and facility should of what. DON stated t also provide this infi information about the was not included in confirmed R54's Effective Confirmed R54's Effective	hange when needed." is were found in the stating: "remove ace wraps cream and tubi strips [grips] (a ent cut to length) at bedtime erview 9/15/21, 2:12 p.m. the tial worker (LSW) stated that a point person for hospice but of care, the point person for uld be the facility unit ew 9/16/21, 8:17 a.m. the (DON) stated a hospice vide the facility with a schedule when the nurse and hospice members would be visiting. the residents were provided ut said they should be. DON ison for communication in the clinical manager, "that's part ibility." DON stated the facility a ware of the hospice how to access the mally, DON stated the unit	F	349			

Facility ID: 00148

If continuation sheet Page 89 of 97

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	. 0938-039 TE SURVEY MPLETED	
				G		С	
		245359	B. WING _			/16/2021	
	PROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 849	• • • • • • • • • • • • • • • • • • •	age 89 dule of hospice visits.	F 84	9			
	coordination of care not provide one.	le for a policy related to e with hospice, but facility did					
	Infection Prevention CFR(s): 483.80(a)(F 88	0		10/29/21	
	infection prevention designed to provide comfortable environ	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable					
	program. The facility must es	n prevention and control stablish an infection prevention m (IPCP) that must include, at lowing elements:					
	reporting, investiga and communicable staff, volunteers, vi providing services arrangement based	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards;					
	procedures for the but are not limited t (i) A system of surv possible communic	veillance designed to identify cable diseases or vey can spread to other					

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM A	11/01/2021 PPROVED 938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			3) DATE S COMPL	SURVEY
		245359	B. WING			C 09/16	6/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET VINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 880	communicable dise reported; (iii) Standard and tra- to be followed to pro- (iv)When and how i resident; including k (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos circumstances. (v) The circumstance must prohibit emplo disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in o §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must har transport linens so a infection. §483.80(f) Annual r The facility will cond IPCP and update the This REQUIREMEN by: Based on observat review the facility fa- when performing we	om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a but not limited to: uration of the isolation, infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. them for recording incidents facility's IPCP and the aken by the facility.	F٤	380	1.It is policy of Pine Haven Communit ensure that all staff perform proper hal hygiene. Resident R61 discharged from the facility on 10/4/2021.	and	

Facility ID: 00148

If continuation sheet Page 91 of 97

(EACH DEFICIENC' REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING	G STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	(09/ TION JLD BE	PLETED C 16/2021 (X5) COMPLETION
EN CARE CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa residents (R61) wh	INC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 91	ID PREFIX	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	TION JLD BE	(X5) COMPLETIO
EN CARE CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa residents (R61) wh	INC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 91	ID PREFIX	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	FION JLD BE	(X5) COMPLETIO
EN CARE CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa residents (R61) wh	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa residents (R61) wh	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PINE ISLAND, MN 55963 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETIO
(EACH DEFICIENC' REGULATORY OR L Continued From pa residents (R61) wh	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETIO
residents (R61) wh	-	1	Denoienery		DATE
residents (R61) wh	-	F 880	0		
	ose treatments were observed .		2.This has a potential to affect a residents. The facility s Quality	II 69	
Findings include			Assurance and Performance Improvement Committee with as from the Infection Preventionist,		
diagnosis of left bu and pressure-induc	ttock pressure ulcer stage 2		Governing Body oversight must root cause analysis (RCA) to ide problem(s) that resulted in this o	conduct a entify the leficiency	
R61's admission M assessment dated one stage 2 pressu	8/18/21, identified R61 had		action plan to prevent recurrence Information regarding RCAs is a the Guidance for Performing Ro Analysis (RCA) with Performance	e. vailable in ot Cause	
R61's physician ord -Leg Buttocks Pres Cleanse affected a gauze, apply nickel entire wound bed (l	sure Injury Treatment: rea daily w/ normal saline and I thick layer of Santyl covering black soft eschar), cover w/		3. The Infection Preventionist, Di Nursing or designee must imple competency assessments for st proper hand hygiene and develo system to ensure all staff have r the training and are competent.	ment aff on p a eceived	
9/13/21) -Leg Pressure Injur area daily w/ norma nickel thick layer of bed (black soft esc	ry Treatment: Cleanse affected al saline and gauze, apply Santyl covering entire wound har), cover w/ mepilex border		Preventionist and/or other facility leadership will conduct audits or every day for one week, then ma decrease the frequency based u compliance. Audits should contin 100% compliance is met. The D	/ all shifts, ay pon nue until irector of	
licensed practical n R61 he was going t change on his left o donned gloves, ren of the dressing, the then used a pen to dressing and donne	aurse (LPN)-D explained to to complete the dressing calf; R61 gave consent. LPN-D noved the dressing, disposed en removed gloves. LPN-D write the date on the new ed new gloves without		designee will review the results of and monitoring with the Quality A	of audits Assurance	
	diagnosis of left bu and pressure-induce other site. R61's admission M assessment dated one stage 2 pressu- pressure ulcer. R61's physician ord Leg Buttocks Press Cleanse affected a gauze, apply nickel entire wound bed (mepilex border (sa gauze, a	R61's admission Minimum Data Set (MDS) assessment dated 8/18/21, identified R61 had one stage 2 pressure ulcer and one unstageable pressure ulcer. R61's physician orders included: Leg Buttocks Pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size) (start date	diagnosis of left buttock pressure ulcer stage 2 and pressure-induced deep tissue damage of other site. R61's admission Minimum Data Set (MDS) assessment dated 8/18/21, identified R61 had one stage 2 pressure ulcer and one unstageable pressure ulcer. R61's physician orders included: Leg Buttocks Pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size) (start date 9/13/21) Leg Pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size (start date 8/12/21) During an observation on 9/14/21, at 9:21 a.m. icensed practical nurse (LPN)-D explained to R61 he was going to complete the dressing change on his left calf; R61 gave consent. LPN-D donned gloves, removed the dressing, disposed of the dressing, then removed gloves. LPN-D then used a pen to write the date on the new dressing and donned new gloves without performing hand hygiene. LPN-D completed the dressing change per physician orders, removed	Ref1's face sheet dated 9/16/21, included diagnosis of left buttock pressure ulcer stage 2 and pressure-induced deep tissue damage of other site. Ref1's admission Minimum Data Set (MDS) assessment dated 8/18/21, identified Ref1 had one stage 2 pressure ulcer and one unstageable oressure ulcer. Ref1's physician orders included: Leg Buttocks Pressure lnjury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size) (start date 9/13/21) Leg Pressure lnjury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size) (start date 8/13/21) Leg Pressure lnjury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size (start date 8/12/21) During an observation on 9/14/21, at 9:21 a.m. iccensed practical nurse (LPN)-D explained to Ref1 he was going to complete the dressing change on his left calf; Ref1 gave consent. LPN-D donned gloves, removed the dressing, disposed of the dressing, then removed gloves. LPN-D then used a pen to write the date on the new dressing and donned new gloves without performing hand hygiene. LPN-D completed the dressing change per physician orders, removed	Ref1's face sheet dated 9/16/21, included diagnosis of left buttock pressure ulcer stage 2 and pressure-induced deep tissue damage of other site. Ref1's admission Minimum Data Set (MDS) assessment dated 8/18/21, identified Ref1 had one stage 2 pressure ulcer and one unstageable pressure ulcer. Ref1's physician orders included: Leg Buttocks Pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size) (start date 9/13/21) Leg Pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size) (start date 9/13/21) Leg pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size (start date 8/12/21) During an observation on 9/14/21, at 9:21 a.m. icensed practical nurse (LPN)-D explained to Ref1 he was going to complete the dressing change on his left calf; Ref1 gave consent. LPN-D donned gloves, removed the dressing, disposed of the dressing, then removed gloves. LPN-D hen used a pen to write the date on the new tressing and donned new gloves without performing hand hygiene. LPN-D completed the tressing change per physician orders, removed

If continuation sheet Page 92 of 97

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	VEN CARE CENTER I	NC		2	10 NORTHWEST 3RD STREET		
	VEN CARE CENTER I	NC		Ρ	PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 92	F 8	80			
	During an interview on 9/14/21, at 9:26 a.m. LPN-D stated he should have done hand hygiene between glove changes.						
	During an observati RN-B explained to I the dressings on his gave consent. RN-E donned gloves, RN- dressing from the le dressings on the flo cap from the saline the wound in the car depressor, and stirr RN-B then removed and cut the non-stic wound. RN-B then singer on throughout the p had not disinfected the completion of the then picked up the singer floor, took off gloves RN-B then informed change on his left b and undid R61's ind incontinent of stool, care, used an incor gloves, walked to the another pair of glove the gloves he alread buttock dressing per During an interview RN-B stated he sho	ion on 9/15/21, at 1:16 p.m. R61 he was going to change is left calf and left buttock; R61 B washed his hands and B then removed R61's wound eft calf and through the bor. RN-B then removed the bottle, put the ointments for up, opened a tongue red the ointments together. d scissors from his left pocket ck dressing to the size of the used a Q-tip to spread the s onto the wound and applied b. RN-B had the same gloves procedure, in addition RN-B the scissors prior to or after the dressing change. RN-B soiled dressings from the s, and sanitized his hands. d R61 of the next dressing puttock. RN-B donned gloves continent brief, R61 was RN-B performed incontinent thinent wipe to clean his the bathroom and donned es (without disinfecting) over dy had on and applied the left					

Facility ID: 00148

If continuation sheet Page 93 of 97

PRINTED: 11/01/2021

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	FUCKECHON	IDENTIFICATION NOWBEN.	A. BUILDIN	G		C
		245359	B. WING			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HAV	VEN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 880	Continued From pa	ge 93	F 88	0		
	double gloving was appropriate for the procedure.					
	director of nursing (hygiene was expect gloves should be re removal and cleans should be performe DON stated soiled of garbage can and no	on 9/16/21, at 11:44 p.m. (DON) stated appropriate hand ted during dressing changes, emoved after dressing and sing the wound, hand hygiene ed after each glove change. dressings need to go into a ot on the floor, and scissors ed prior to using on a clean				
F 883	included Steps in th 5) Wash and dry yo 6) Put on clean glow soiled dressing 7) Pull glove over d plastic or biohazard 8) Wash and dry yo 9) Open dry, clean d 10) Labe tape or dr initials. 11) Wash and dry y 12) Put on clean glo 15) Cleans the wou 17) Apply the order 23) Wash and dry h	our hands thoroughly ves. Loosen tape and remove ressing and discard into l bag our hands thoroughly. dressings. essing with date, time, and rour hands thoroughly. oves ind ed dressing	F 88	3		10/29/21
SS=D	CFR(s): 483.80(d)(§483.80(d) Influenz immunizations §483.80(d)(1) Influe policies and proced (i) Before offering th		F 00	.5		10/29/21

Facility ID: 00148

If continuation sheet Page 94 of 97

PRINTED: 11/01/2021

		AND HUMAN SERVICES				FORM	11/01/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	Сом	E SURVEY PLETED
		245359	B. WING				C 16/2021
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET VINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	receives education potential side effect (ii) Each resident is immunization Octob annually, unless the contraindicated or t immunized during th (iii) The resident or has the opportunity (iv)The resident's m documentation that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider immunization or did immunization due to refusal. §483.80(d)(2) Pneu must develop polici that- (i) Before offering th immunization, each representative rece benefits and potent immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or has the opportunity (iv)The resident's m	regarding the benefits and ts of the immunization; offered an influenza ber 1 through March 31 e immunization is medically he resident has already been his time period; the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the ht or resident's representative ation regarding the benefits effects of influenza in either received the influenza d not receive the influenza o medical contraindications or imococcal disease. The facility es and procedures to ensure he pneumococcal a resident or the resident's sives education regarding the ial side effects of the offered a pneumococcal ss the immunization is icated or the resident has	F 8	383			

		E & MEDICAID SERVICES	0.00				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>		SURVEY PLETED	
		245359	B. WING			09/1) 6/2021	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/1	0/2021	
	VEN CARE CENTER	INC		2	10 NORTHWEST 3RD STREET INE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 883	-	-	F 8	83				
	was provided educ and potential side e immunization; and (B) That the reside pneumococcal imm the pneumococcal contraindication or This REQUIREME by:	nt or resident's representative ation regarding the benefits effects of pneumococcal nt either received the nunization or did not receive immunization due to medical refusal. NT is not met as evidenced v and document review the						
	facility failed to ens were offered or rec vaccinations in acc	evand document review the sure 1 of 5 residents (R43) evived pneumococcal ordance with the Center for DC) recommendations.			1.It is policy of Pine Haven Communensure all residents are offered or repneumococcal vaccinations in accord with the Center for Disease Control (recommendations. Resident R43 wa offered the pneumococcal vaccinations)	eceive dance (CDC) is		
	Findings include:				will receive the vaccination by 10/31/ 2.This has the potential to affect all 6	/2021.		
	7/30/21, R43 had s	nimum Data Set (MDS) dated severe cognitive impairment.			residents. All residents were reviewe any resident needing the pneumococ vaccinations in accordance with the			
		ord failed to address R43's for pneumococcal and if these offered to R43.			Center for Disease Control (CDC) recommendations were offered the vaccination. 3.Staff re-education will be complete	d with		
	(LPN)-E confirmed indicate R43 received	59 p.m. licensed practical nurse documentation that would ved the option for the cinations were offered at time			licensed nursing staff to ensure all residents are offered or have receive Influenza and Pneumococcal immunizations on 10/21/2021 and 10/25/2021. 4.Nursing Management or designee	ed		
	confirmed she was when R43 was adm not given the option	a.m. family member (FM)-A R43's guardian. FM-A stated nitted to this facility, she was n for R43 to receive the			conduct audits new admissions and residents who have scheduled assessments/MDSs to ensure Influer and Pneumococcal immunizations and	nza re		
	On 9/15/21, at 10:3	cinations while in the facility. 33 a.m. directory of nursing expected unvaccinated			offered to residents daily x 10, weekl and monthly x 1. Results will be revie by our Quality committee for further recommendation			

Facility ID: 00148

		AND HUMAN SERVICES			FORM	D: 11/01/2021 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245359	B. WING _		09	/16/2021
NAME OF F	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP (
PINE HA	VEN CARE CENTER	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 883	the pneumococcal was refused, then t would receive educe factors to an educa Facility policy, Influe Immunizations, rev pneumococcal imm	red vaccines which included vaccinations. If a vaccination he resident and their family ation which include risk ted decision could be made. enza and Pneumococcal iew date 2/2020, noted nunization status of all termined on admission.	F 88	83		

Facility ID: 00148

If continuation sheet Page 97 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES	F53590)33	3	FORM	11/08/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245359	B. WING			09/	14/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	VEN CARE CENTER I	NC		2	10 NORTHWEST 3RD STREET		
				F	PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 0	00			
	FIRE SAFETY						
	conducted by the M Public Safety, State 09/14/2021. At the HAVEN CARE CEN found not in complia participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Chapter 19 Existing edition of NFPA 99, THE FACILITY'S P ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. e Fire Inspections Division Suite 145 -5145, OR					
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 10/21/2021

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 - MAIN BUILDING 01 (X3) COMP				
		245359	B. WING			09/14/2021	
NAME OF F	PROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
0(4) 15						4	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	THE RETURN THE FOR THE FIRE SA (K-TAGS) TO: IF PARTICIPATING PAPER COPY OF IS NOT REQUIRED PLAN OF CORREC DEFICIENCY MUS FOLLOWING INFO 1. A detailed desc taken or planned to 2. Address the me place to ensure the 3. Indicate how th future performance sustained. 4. Identify who is r actions and monitor 5. The actual or p the remedy.	E PLAN OF CORRECTION FETY DEFICIENCIES IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D. CTION FOR EACH T INCLUDE ALL OF THE DRMATION: ription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are	κo				
	was constructed at one-story building w constructed in 1964 (111). In 1970, an was constructed an 111). In 1991, an a West Wing and det	three different times. A with a partial basement was and determined to be Type II addition to the North Wing d determined to be Type II (addition was added to the ermined to be Type II (111).					
		al building and additions are ction types allowed for existing					

If continuation sheet Page 2 of 11

		AND HUMAN SERVICES			FORM	11/08/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245359	B. WING	 	09/	14/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA		NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 324 SS=D	buildings of this hei as one building as a National Fire Protect Standard 101, Life 19 Existing Health of The facility is fully p automatic sprinkler system with smoke spaces open to the automatic fire depa The building is atta CENTER - BUILDII to be of Type V (11 2-hour fire-rated wa and will therefore b The facility has a ca census of 67 at the The requirement at NOT MET as evide Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment with NFPA 96, Stan and Fire Protection Operations, unless * residential cooking appliances such as toasters) are used f cooking facilities of compartments with	ght, the facility was surveyed allowed in the 2012 edition of ction Association (NFPA) Safety Code (LSC), Chapter Care Occupancies. Protected throughout by an system and has a fire alarm detection in the corridors, corridors that is monitored for rtment notification. ched to PINE HAVEN CARE NG 02, which was determined 1) construction. There is a all separating the two buildings e surveyed as two buildings. apacity of 70 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is nce by:	K			10/30/21

Facility ID: 00148

If continuation sheet Page 3 of 11

		AND HUMAN SERVICES				FORM	11/08/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245359	B. WING			09/ [,]	14/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 324	30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	in smoke compartments with s comply with conditions under 5.4. rotected according to NFPA 96 equired to be enclosed as but shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through	ĸ	324			
	by: Based on docume the facility failed to unobstructed acces extinguishing equip Life Safety Code N 19.3.2.5, 9.2.3, 19.3 for Ventilation Cont Commercial Cookin section 10.5, 10.5.4	NT is not met as evidenced nt review and staff interview, provide clear visual and as to the Ansul type fire oment in accordance with the FPA 101 - 2012, sections 3.2.5.3(5)(b), and the Standard rol and Fire Protection of ng Operations, NFPA 96-2011, 1. This deficient condition tted impact on the residents			 The boxes were moved on 09/12 Staff were educated on 09/15/20 Dietary and Maintenance Director monitor for compliance monthly x 3 	21 ⁻ will	
	Findings Include:						
	was revealed durin facility Kitchen that Ansul type fire supp obscured by vertica physical access wa to close on either s						
	This deficient cond	ition was confirmed by the					

If continuation sheet Page 4 of 11

		AND HUMAN SERVICES			FORM	11/08/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	· /	E SURVEY IPLETED
		245359	B. WING _		09/	14/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 324	Continued From pa	age 4	K 32	24		
	Maintenance Direct	tor at the time of discovery.				
	Subdivision of Build CFR(s): NFPA 101	ding Spaces - Smoke Barrie	K 37	74		10/30/21
	Doors 2012 EXISTING Doors in smoke bar bonded wood-core resists fire for 20 m plates of unlimited are permitted to ha assemblies per 8.5 automatic-closing, are not required to egress travel. Door clear width of 32 ind doors. 19.3.7.6, 19.3.7.8, T his REQUIREMEN by: Based on observat facility failed to mai per NFPA 101 (201 sections 19.3.7.3, 1 deficient condition of impact on the resid Findings include: On 09/14/2021 betw was revealed during facility that upon tes smoke barrier door gapping greater that would not resist the	ding Spaces - Smoke Barrier rriers are 1-3/4-inch thick solid doors or of construction that inutes. Nonrated protective height are permitted. Doors ve fixed fire window . Doors are self-closing or do not require latching, and swing in the direction of opening provides a minimum ches for swinging or horizontal 19.3.7.9 NT is not met as evidenced tion and staff interview, the ntain the smoke barrier doors 2 edition), Life Safety Code, 19.3.7.8, and 8.5.4.1. This could have a widespread ents within the facility. ween 08:30 AM to 01:30 PM, it g the walk-through of the sting, the 200 and 300 Wing s exhibited door-to-door an a one-eighth inch which e passage of smoke. ition was confirmed by the		 New brush seal meeting stile as were installed on the door on 09/2 Door will be check annually durin door annual inspection Maintenance Director or design monitor for compliance 	1/2021. ng Fire	

If continuation sheet Page 5 of 11

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FC	DRM /	11/08/202 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (X3)		E SURVEY PLETED
		245359	B. WING			09/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER	l	•		REET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K 374	Continued From pa	age 5	КЗ	874			
K 521 SS=F	HVAC	tor at the time of discovery.	K 5	521			10/30/21
	This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility's heating, ventilation, and air conditioning in compliance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 19.4.1.1, 19.4.9, 19.4.10, and 19.4.11, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, sections 6.5.2, 6.5.11, 6.5.12 and 6.6. This deficient condition could have a widespread impact on the residents within the facility.				 Harris Company conducted dampe testing on 10/04/2021. Administrator and maintenance dire will monitor for compliance to ensure contractor on month 10 is scheduled to preform 4 year inspection. 	ctor	
	was revealed durin the smoke damper	ween 08:30 AM to 01:30 PM, it g documentation review that s were past due to the pection frequency. Dampers 01/24/2017.					

If continuation sheet Page 6 of 11

		AND HUMAN SERVICES				FORM	: 11/08/2021 APPROVED . 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED	
		245359	B. WING			09/14/2021		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PINE HA	VEN CARE CENTER	NC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 521	Continued From pa	ge 6	K	521				
	Maintenance Direct	ition was confirmed by the tor at the time of discovery. - Essential Electric Syste	KS	918			11/24/21	
	Maintenance and T The generator or of and associated equ service within 10 se criterion is not met process shall be pr capability for the life Maintenance and te transfer switches at with NFPA 110. Generator sets are under load 30 minu day intervals, and e months for 4 contin under load conditio simulated cold start transfer of all EES competent personn stored energy powe accordance with NF circuit breakers are program for periodi components is estar manufacturer requi maintenance and te readily available. El circuits are marked separate from norm the possibility of da	ther alternate power source aipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this a safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 exercised once every 36 uous hours. Scheduled test ns include a complete t and automatic or manual loads, and are conducted by tel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a						

Facility ID: 00148

If continuation sheet Page 7 of 11

		AND HUMAN SERVICES			FORM	11/08/202 APPROVE <u>0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED
		245359	B. WING		09/ [,]	14/2021
	PROVIDER OR SUPPLIER	INC		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PINE ISLAND, MN 55963 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
	 6.4.4, 6.5.4, 6.6.4 (111, 700.10 (NFPA This REQUIREME by: Based on observa documents, and st to maintain facility systems and comp edition), Health Ca 6.4.1.1.13, and NF Emergency and St sections 5.6.4.5.1, These deficient conwidespread impact facility. Findings include: 1. On 09/14/2021 the PM, it was revealed the emergency pow document review the batteries for the en- which services Buinot be determined. 2. On 09/14/2021 the PM, it was revealed and staff interview inspection and test facility emergency service Building 01 These deficient comparison 	NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced tion, a review of the available aff interview, the facility failed emergency power supply onents per NFPA 99 (2012 re Facilities Code, section PA 110 (2010), Standard for andby Power Systems, 8.3.7, 8.3.8, 8.4.2.3, and 8.4.7. nditions could have a to n the residents within the between 08:30 AM to 01:30 d during visual inspection of wer supply systems and during nat the installation date of the nergency power supply system Iding 01 (210 generator) could between 08:30 AM to 01:30 d during documentation review that there was no annual ing documentation for the power supply systems which (210, Kato generators). nditions were confirmed by the tor at the time of discovery. nt - Power Cords and Extens	К 918	 1.contract signed with Ziegler on 10/07/2021 to preform these task 2. Administrator and maintenance will monitor for compliance. 3. contractor was 6 weeks out to perform these task on 10/7/2021 	e director	11/24/21

		AND HUMAN SERVICES			F	ORM	11/08/202 APPROVEI 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION (X 01 - MAIN BUILDING 01	,	ATE SURVEY OMPLETED	
		245359	B. WING	i		09/1	14/2021	
NAME OF F	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PINE HA		INC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
K 920	Continued From pa	ige 8	K	920				
	Electrical Equipmer Extension Cords	nt - Power Cords and						
	used for component patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power star may not be used for electronics), except rooms that do not u PCREE meet UL 13 strips for non-PCRI (outside of vicinity) care rooms, power standards. All pow precautions. Exten substitute for fixed Extension cords us immediately upon of which it was installed 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 (E This REQUIREMENT by: Based on observation facility failed to imp strips in accordance Health Care Facilitii 10.2.4 and NFPA 70 Electrical Code, set deficient condition of on the residents wite Findings include: On 09/14/2021 betw	d electrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal t in long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general usion cords are not used as a wiring of a structure. ed temporarily are removed completion of the purpose for ed and meets the conditions of 0, 10.2.4 (NFPA 99), 400-8 0) (NFPA 70), TIA 12-5 NT is not met as evidenced tion and staff interview, the lement the usage of power e with NFPA 99 (2012 edition), es Code, section 10.2.3.6, 0, (2011 edition), National ctions 400-8, 590.3(D). This could have an isolated impact			Electricians called to come out and a outlets. we are waiting on quotes to completes this task. most electricians a couple months out of completing the work. 2.Administrator and maintenance direct will monitor for compliance	s are is		

If continuation sheet Page 9 of 11

		AND HUMAN SERVICES				FORM	: 11/08/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>′</i>		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245359	B. WING	i		09/14/2021	
NAME OF F	PROVIDER OR SUPPLIER	I	1	2	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA		INC					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 920	Continued From pa	ae 9	КS	920	0		
	the facility the use	of daisy-chained power-strips Telephone Communications					
	Maintenance Direct	ition was confirmed by the tor at the time of discovery. ylinder and Container Storag	KS	923	3		10/30/21
	Greater than or equ Storage locations a ventilated in accord 5.1.3.3.3. >300 but <3,000 cu Storage locations a within an enclosed limited- combustible gates outdoors) that gases are not store separated from cord sprinklered) or enclored noncombustible co 1/2 hr. fire protection Less than or equal In a single smoke of cylinders available care areas with an or equal to 300 cub stored in an enclos handled with preca A precautionary sig each door or gate of where the sign inclu- minimum "CAUTIO STORED WITHIN Storage is planned	re outdoors in an enclosure or interior space of non- or e construction, with door (or at can be secured. Oxidizing ed with flammables, and are nbustibles by 20 feet (5 feet if losed in a cabinet of nstruction having a minimum on rating. to 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than nic feet are not required to be ure. Cylinders must be utions as specified in 11.6.2. n readable from 5 feet is on of a cylinder storage room, udes the wording as a N: OXIDIZING GAS(ES)					

Facility ID: 00148

If continuation sheet Page 10 of 11

		AND HUMAN SERVICES			FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,	LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED	
		245359	B. WING		00/	14/2024	
NAME OF	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP CODE	- 09/14/2021		
				210 NORTHWEST 3RD STREET			
PINE HA	VEN CARE CENTER I	NC		PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
К 923	Empty cylinders are cylinders. When fa integral pressure ga considered empty is are marked to avoid in the open are prot 11.3.1, 11.3.2, 11.3. This REQUIREMEN by: Based on observat facility failed to stor NFPA 99 (2012 edit Code, sections 11.3 11.6.5. This deficier isolated impact on t Findings include: On 09/14/2021 betw was revealed the w Room 100L - Med O storage of cylinders and was missing sig empties from full cy	e segregated from full cility employs cylinders with auge, a threshold pressure s established. Empty cylinders d confusion. Cylinders stored tected from weather. 3, 11.3.4, 11.6.5 (NFPA 99) NT is not met as evidenced tion and staff interview, the e medical gas equipment per tion), Health Care Facilities 8.2.3, 11.3.4, 11.6.2.3, and at condition could have an the residents within the facility.	K 923	 The Med Gas storage room was separated for full and empty cylinde be in separate storage spaces. Staff were re-educated on 10/21, and 10/25/2021 on the facility policy ensure Med gas tanks are separate The Director of Nursing or design monitor for compliance daily x 10, v x 6 and monthly x1. 	ers to /2021 y to ed. nee will		

Facility ID: 00148

If continuation sheet Page 11 of 11

		AND HUMAN SERVICES	F5359()33		FORM	11/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 02 - PINE HAVEN CARE CENTER	(X3) DATE	E SURVEY PLETED
		245359	B. WING			09/	14/2021
NAME OF F	PROVIDER OR SUPPLIER		[S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	10 NORTHWEST 3RD STREET		
PINE HA	VEN CARE CENTER I	NC		Ρ	PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	КC	000			
	FIRE SAFETY						
	conducted by the M Public Safety, State 09/14/2021. At the HAVEN CARE CEM found not in compli- participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Chapter 18 New He edition of NFPA 99, THE FACILITY'S P ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO: 6 IN THE E-POC PROCESS, A THE PLAN OF CORRECTION					
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE
Electron	ically Signed						10/21/2021

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.

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` <i>′</i>		E CONSTRUCTION	(X3) DATE	0938-0391
AND PLAN U	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 - PINE HAVEN CARE CENTER				PLETED
		245359	B. WING			09/14/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC			10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa Healthcare Fire Ins State Fire Marshall 445 Minnesota St., St. Paul, MN 55101 By email to: FM.HC.Inspections THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFC 6. A detailed desc taken or planned to 7. Address the me place to ensure the 8. Indicate how th future performance sustained. 9. Identify who is r actions and monitor 10. The actual or p the remedy. PINE HAVEN CARR was constructed at with no basement w determined to be Ty Because of the date was surveyed per th	Inge 1 pections Division Suite 145 1-5145, OR @state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: cription of the corrective action o correct the deficiency. easures that will be put in a deficiency does not reoccur. I deficiency does not reoccur. e facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. roposed date for completion of E CENTER - BUILDING 02 one time. A one-story building vas constructed in 2016 and ype V (111). e of construction, the building he 2012 edition of National	K 01	1			
		ociation (NFPA) Standard 101, SC), Chapter 18 New Health					

If continuation sheet Page 2 of 10

		AND HUMAN SERVICES			FORM): 11/08/202 1 APPROVE 0. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 02 - PINE HAVEN CARE CENTER		TE SURVEY MPLETED
		245359	B. WING _		09	/14/2021
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000 K 353 SS=D	The facility is fully p automatic sprinkler system with smoke spaces open to the automatic fire depa The building is attact CENTER - BUILDIN to be of Type II (111 2-hour fire-rated wa and will therefore bu The facility has a ca census of 67 at the The requirement at NOT MET as evide Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s	 Protected throughout by an system and has a fire alarm detection in the corridors, corridors that is monitored for rtment notification. Ched to PINE HAVEN CARE NG 01, which was determined 1) construction. There is a all separating the two buildings e surveyed as two buildings. Apacity of 70 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is nce by: Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, anining of Water-based Fire 5. Records of system design, action and testing are sure location and readily System last checked as the survey. 	К 00			10/30/21

If continuation sheet Page 3 of 10

		AND HUMAN SERVICES			FORM	: 11/08/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 02 - PINE HAVEN CARE CENTER		E SURVEY IPLETED
		245359	B. WING _		09/	14/2021
	PROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO) BE	(X5) COMPLETION DATE
	9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by: Based on observat facility failed to mai accordance with NI Safety Code, section (2011 edition) Stand Testing, and Mainte Protection Systems 5.2.1.1.2, 5.2.1.1.4, edition), Standard f Systems, sections a condition could hav residents within the Findings include: On 09/14/2021 betw was revealed durin facility that items w 18 inches, from spi Room 537 and Root This deficient pract Facility Maintenance discovery. HVAC CFR(s): NFPA 101 HVAC Heating, ventilation	and NFPA 25 NT is not met as evidenced tion and staff interview, the ntain the sprinkler system in FPA 101 (2012 edition), Life ons 9.7.5, 9.7.6, and NFPA 25 dard for the Inspection, enance of Water-Based Fire s, sections 5.2, 5.2.1.1.1, , 5.2.1.2. NFPA 13 (2010 for the Installation of Sprinkler 8.5.6, 8.5.6.1. This deficient re an isolated impact on the e facility. ween 08:30 AM to 01:30 PM, it g the walk-through of the ere stacked too high, less than rinkler heads in the closets of om 646. ice was confirmed by the e Director at the time of	K 3	 These items were removed on 09/15/2021 for compliance Staff were educated on 09/15/20 Dietary and maintenance director monitor for compliance monthly x 3 	or will	10/30/21

Facility ID: 00148

If continuation sheet Page 4 of 10

		AND HUMAN SERVICES			FORM	: 11/08/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION DING 02 - PINE HAVEN CARE CENTER	(X3) DAT	E SURVEY IPLETED
		245359	B. WING	·	09/	14/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	/EN CARE CENTER I	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
K 521	Continued From pa	ge 4	K	521		
	by: Based on a review and staff interview, the facility's heating conditioning in com edition), Life Safety 9.2.1, and NFPA 80 Fire Doors and Oth sections 19.4.1.1, 1 and NFPA 105 (201 Smoke Door Assen Protectives, section 6.6. This deficient of	NT is not met as evidenced of available documentation the facility failed to maintain y, ventilation, and air pliance with NFPA 101 (2012 Code, sections 19.5.2.1 and (2010 edition), Standard for er Opening Protectives, 9.4.9, 19.4.10, and 19.4.11, 0 edition), Standard for hblies and Other Opening to 6.5.2, 6.5.11, 6.5.12 and condition could have a on the residents within the		 Harris Company conducted datesting on 10/04/2021. Administrator and maintenance will monitor for compliance to ension contractor on month 10 is schedu preform 4 year inspection. 	e director ure	
	was revealed during the smoke dampers required 4-year insp were last tested on This deficient condi Maintenance Direct	ween 08:30 AM to 01:30 PM, it g documentation review that s were past due to the bection frequency. Dampers 01/24/2017. tion was confirmed by the tor at the time of discovery. - Essential Electric Syste	KS	918		11/24/21
	Maintenance and T The generator or o and associated equ service within 10 se	- Essential Electric System esting ther alternate power source lipment is capable of supplying econds. If the 10-second during the monthly test, a				

Facility ID: 00148

If continuation sheet Page 5 of 10

		AND HUMAN SERVICES				FORM	11/08/202 APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 02 - PINE HAVEN CARE CENTER		E SURVEY PLETED
		245359	B. WING			09/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 918	capability for the life Maintenance and te transfer switches a with NFPA 110. Generator sets are under load 30 minu day intervals, and e months for 4 contin under load conditio simulated cold star transfer of all EES competent person stored energy powe accordance with NE circuit breakers are program for periodi components is esta manufacturer requi maintenance and te readily available. E circuits are marked separate from norm the possibility of da source is a design installations. 6.4.4, 6.5.4, 6.6.4 (111, 700.10 (NFPA This REQUIREMEI by: Based on observa documents, and sta to maintain facility of systems and comp edition), Health Cat 6.4.1.1.13, and NFI Emergency and Sta sections 5.6.4.5.1,	inspected weekly, exercised inspected weekly, exercised ites 12 times a year in 20-40 exercised once every 36 muous hours. Scheduled test ins include a complete t and automatic or manual loads, and are conducted by hel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder e inspected annually, and a ically exercising the ablished according to irements. Written records of esting are maintained and ES electrical panels and I, readily identifiable, and nal power circuits. Minimizing image of the emergency power consideration for new NFPA 99), NFPA 110, NFPA	K	918			

Facility ID: 00148

If continuation sheet Page 6 of 10

		AND HUMAN SERVICES			FORM	: 11/08/2021 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 02 - PINE HAVEN CARE CENTER		E SURVEY IPLETED
		245359	B. WING		09/	14/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	NC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 918	facility. Findings include:	on the residents within the	К 9	18		
	PM, it was revealed the emergency pow document review th batteries for the em which services Buil not be determined. 2. On 09/14/2021 b PM, it was revealed and staff interview to inspection and test facility emergency p services Building 02 This deficient pract Maintenance Direct Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Extension Cords Power strips in a pa used for component patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power strimay not be used for electronics), except	ice was confirmed by the tor at the time of discovery. ht - Power Cords and Extens ht - Power Cords and atient care vicinity are only	К 9	20		11/24/21

Facility ID: 00148

If continuation sheet Page 7 of 10

		AND HUMAN SERVICES			RINTED: 11/08 FORM APPR <u>/IB NO. 0938</u>	ROVE	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G 02 - PINE HAVEN CARE CENTER	(X3) DATE SUR\ COMPLETE		
		245359	B. WING		09/14/20	21	
	PROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			14/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMP	(X5) PLETIO PATE	
	care rooms, power standards. All pow precautions. Exter substitute for fixed Extension cords us immediately upon of which it was installed 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 (D This REQUIREMEN by: Based on observa facility failed to imp strips in accordance Health Care Faciliti 10.2.4 and NFPA 7 Electrical Code, se deficient conditions on the residents wi Findings include: 1. On 09/14/2021 to PM, it was revealed the facility the use of in Room 534. 2. On 09/14/2021 to PM, it was revealed the facility the use of outlet adapter in Room These deficient cor Maintenance Direct	meet UL 1363. In non-patient strips meet other UL ver strips are used with general asion cords are not used as a wiring of a structure. sed temporarily are removed completion of the purpose for ed and meets the conditions of 0, 10.2.4 (NFPA 99), 400-8 0) (NFPA 70), TIA 12-5 NT is not met as evidenced tion and staff interview, the element the usage of power e with NFPA 99 (2012 edition), ies Code, section 10.2.3.6, 0, (2011 edition), National ctions 400-8, 590.3(D). These a could have an isolated impact thin the facility.	K 920	 Power strip removed from 534 o 9/15/2021. the multiple plug was rer on 9/14/2021. Electricians called to out and add outlets. we are waiting quotes to completes this task. most electricians are a couple months ou completing this work. Administrator and maintenance di will monitor for compliance 	moved come on t of	0/21	

If continuation sheet Page 8 of 10

	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NC	D: 11/08/2021 APPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION 3 02 - PINE HAVEN CARE CENTER		TE SURVEY MPLETED
		245359	B. WING			09	/14/2021
NAME OF F	PROVIDER OR SUPPLIER	•	•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC			210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 923	Continued From pa	ige 8	K	923	3		
	Greater than or equ Storage locations a ventilated in accord 5.1.3.3.3. >300 but <3,000 cu Storage locations a within an enclosed limited- combustible gates outdoors) tha gases are not store separated from cor sprinklered) or encl noncombustible cor 1/2 hr. fire protection Less than or equal In a single smoke of cylinders available care areas with an or equal to 300 cub stored in an enclos handled with precar A precautionary sig each door or gate of where the sign inclu- minimum "CAUTIO STORED WITHIN Storage is planned of which they are re Empty cylinders are cylinders. When fai integral pressure ga considered empty if are marked to avoid in the open are pro- 11.3.1, 11.3.2, 11.3	re outdoors in an enclosure or interior space of non- or e construction, with door (or at can be secured. Oxidizing ed with flammables, and are nbustibles by 20 feet (5 feet if losed in a cabinet of nstruction having a minimum on rating. to 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than nic feet are not required to be ure. Cylinders must be utions as specified in 11.6.2. n readable from 5 feet is on of a cylinder storage room, udes the wording as a N: OXIDIZING GAS(ES)					

Facility ID: 00148

If continuation sheet Page 9 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		
ND PLAN (JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING 02 - PINE HAVEN CARE CENTER	COM	PLETED
		245359	B. WING		09/	14/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
K 923	Based on observa facility failed to ma storage and manage edition), Health Ca 11.3.2.3, 11.3.4, 11 deficient condition impact on the reside Findings include: On 09/14/2021 bet was revealed durin facility that Room 5 mixed storage of c cylinders and was separating empties This deficient cond	age 9 tion and staff interview, the intain proper medical gas gement per NFPA 99 (2012 re Facilities Code, sections .6.2.3 and 11.6.5. This could have a widespread dents within the facility. ween 08:30 AM to 01:30 PM, it og the walk-through of the 541 - Med Gas Storage had ylinders of empties with full missing signage physically a from full cylinders. Notice the time of discovery.	K9	 1. The Med Gas storage room v separated for full and empty cylir be in separate storage spaces. 2. Staff were re-educated on 10/and 10/25/2021 on the facility po ensure Med gas tanks are separ 3. The Director of Nursing or desmonitor for compliance daily x 10 x 6 and monthly x1. 	nders to 21/2021 licy to ated. signee will	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 11, 2021

Administrator Pine Haven Care Center Inc 210 Northwest 3rd Street Pine Island, MN 55963

Re: State Nursing Home Licensing Orders Event ID: 6EF511

Dear Administrator:

The above facility was surveyed on September 13, 2021 through September 16, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Pine Haven Care Center Inc October 11, 2021 Page 2 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

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.

Mighing

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minneso	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00148	B. WING		09/1) 6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		210 NORT	HWEST 3RI	DSTREET		
	VEN CARE CENTER I	PINE ISLA	ND, MN 55	963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	survey was conduc surveyors from the Health (MDH). In ad were also complete in compliance with	⁻ S: ugh 09/16/2021, a licensing ted at your facility by Minnesota Department of ddition, complaint surveys d. Your facility was found NOT the MN State Licensure and tion orders are issued. Please				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 10/21/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 69

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	- (X3) DATE SURVEY COMPLETED C	
		00148	B. WING		09/	16/2021
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
		ctronic plan of correction you se orders and identify the date ompleted.				
	SUBSTANTIATED: H5359065C (MN67 F725 H5359071C (MN48	7309) with a deficiency cited at 3800) with no current lue to actions implementd by				
	UNSUBSTANTIAT H5359066C (MN71	blaints were found to be ED: H5359064C, (MN73478) 1083), H5359067C (MN59840) 3715), H5359069C (MN63604) 3692),				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far I Tag." The state sta listed in the "Summ column and replace the correction orde the findings which a statute after the sta as evidence by." Fo	nent of Health is documenting of Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is nary Statement of Deficiencies es the "To Comply" portion of r. This column also includes are in violation of the state atement, "This Rule is not met ollowing the surveyors findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Dep Informational Bulle https://www.health.					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COM	E SURVEY PLETED
		00148	B. WING			16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	RTHWEST 3RI LAND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	ed on the attached Minnesota alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available fo n indicate in the electronic cess, under the heading ne date your orders will be electronically submitting to the nent of Health.	1			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF IR VIOLATIONS OF TE STATUTES/RULES.				
2 270	MN Rule 4658.009	0 Use of Oxygen	2 270			10/29/2 ⁻
		ust develop and implement dures for the safe storage and				
	by: Based on observat review, facility failed equipment was ma for 3 of 4 residents for aerosolized med failed to ensure cle	ent is not met as evidenced ions, interview and document d to ensure that respiratory intained in a sanitary manner (R6, R54 and R64) reviewed dications and oxygen use and ear and accurate orders for ion for 1 of 3 residents (R44) xygen use.		Corrected		
	Findings include:					

Minnesota Department of Health STATE FORM

6899

6EF511

If continuation sheet 3 of 69

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		COM	E SURVEY PLETED	
		00148	B. WING			C 09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
PINE HA		INC	THWEST 3RD AND, MN 559				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 270	Continued From pa	ige 3	2 270				
	Admission Record/ of shortness of brea (congestive) heart f systolic (congestive acute and chronic r and with hypercapr	ectronic health record (EHR) face sheet, R6 had diagnoses ath, acute on chronic diastolic failure, chronic combined a) and diastolic heart failure, respiratory failure with hypoxia hia, as well as a diagnosis of pulmonary disease and					
	R6 was able to self medications and in Physician orders al Budesonide Suspe reduce respiratory the evening and in had a physician ord	sician's order dated 6/3/2021, -administer nebulized halers after set-up by a nurse. so included an order for nsion 1mg/2mL (a steroid to inflammation), inhale orally in the morning. Additionally, R6 ler for Ipratropium-albuterol ulmonary airways) 0.5-2.5 four times a day.					
	area (not dated) tha self-administer med	e EHR had a focus problem at indicated R6 could dications; however, the care te who was responsible for nent clean.					
	up the medication of medication aerosol the bedside stand a nebulization machin appear to be clean	m. R6 was observed to pick cup and mouthpiece for ization that had been lying on and attached to her ne by tubing. The cup did not as it had some signs of container. R6 opened the cup					
	and poured in a sol stated the nurse ha self-administer, and self-administer any	ution from a plastic vial. She id given her the medication to d she had been okayed to aerosolized medication. The e room. R6 confirmed that she					

If continuation sheet 4 of 69

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
00148		00148	B. WING	B. WING		C 16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 270	Continued From pa	age 4	2 270			
	staff had cleaned the last had her treatm the room when R6 cup and started the On 9/15/21, 8:40 a cup with mouthpied be laying inside R6 of various personal lotion bottles, etc. T that extended up o attached to the new she had not used the evening before and anyone coming into equipment. She co the cup inside her o not fall on the floor	.m. R6's nebulizer medication ce attached were observed to 's bedside stand drawer on top I items such as old letters, The cup was attached to tubing ut of the drawer and was pulization machine. R6 said he equipment since the d stated she had not observed o her room to clean the infirmed that she had placed drawer after using it so it would	3			
	sheet, R54 had dia	EHR Admission Record/face gnoses of emphysema, acute atory failure and heart failure.				
	could self-administ	I/2020 physician order, R54 er nebulized medications and s once set up by the nurse.				
	area (not dated) the self-administer me	the EHR had a focus problem at indicated R54 could dications; however, the care ate who was responsible for nent clean.				
	aerosolization of m remain connected administration and	.m. R54's medication cup for edication was observed to to the face mask for connected to the nebulization The cup and mask were				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 270	Continued From pa	age 5	2 270			
	was not sure if staf could not confirm if The mask looked v specks and smudg mask, the cup had On 9/14/21, 2:20 p aerosolization of m remain connected soiled, and to tubin nebulization machi was sitting next to cup and mask were counter. R54 states self-administer me used the machine a the medication cup cleaned. An unope medication for aero counter as well, an so she could take i breath, and she wo R54 confirmed she at that time. According to an int registered nurse (F resident was done the nurse should re cub and the mouth confirmed he had r clean the equipmen medication adminis RN-C had provideo aerosolized solutio	.m. R54's medication cup for edication was observed to to a face mask that appeared g connected to R54's ne. An empty medication vial and behind the nebulizer. The e laying on their side on the d she was able to dications and she had last around noon. R54 confirmed o and mask had not been ned container of respiratory osolization was laying on the d R54 stated the nurse left it t whenever she got short of buld not have to call the nurse. e did not need the medication erview 9/14/21, 2:27 p.m. a RN-C) stated that when a with a nebulization treatment eturn and clean the medication piece or facemask. RN-C not returned to R54's room to nt. A review of R54's stration record (MAR) indicated a R54 her last dose of				

STATEME	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING			C 16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 270	clean even if a resid medication. LPN-C or facemask should and then washed. L mouthpiece/mask s fresh towel after even On 9/15/21, 8:35 a. remained on the co- tubing connected to mask which were la white crusty area of directly under the m A review of R54's M nebulization treatme morning. This was documented dose of be given using the 10:00 p.m. on 9/14/ According to an inte RN-D, unit manage mask and medication from the nebulizer at then set out to dry. as nebulization was resident could turn nurse know they had the nurse should re possible after the tr completed. R44 According to the Ef- record/face sheet, f facility with a primar combined systolic ((congestive) heart f	dent self-administers said the cup and mouthpiece, a be detached from the tubing PN-C said the med cup and should then be left to dry on a ery use. m. R54's nebulizing machine unter at her side with the o a medication cup and face aying on their side. A small f dried solution was observed nedication cup, on the counter. NAR at that time indicated no ent had yet been given that confirmed by R54. The last of any medication that would nebulizing equipment was at 21. erview 9/15/21, 10:28 a.m. r said the mouthpiece or face on cup should be detached after treatment, rinsed off and This was to be done as soon a complete. RN-D said a on the call-light to let the d finished their treatment, or turn to the room as soon as eatment was likely to be	2 270			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00148		B. WING	B. WING		C 16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	RTHWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 270	Continued From pa	age 7	2 270			
	dysfunction with a obstructive pulmor breath, a depender and a history of ple among many other According to a qua assessment dated medical condition v "medically complex R44 had a physicia indicating "supplen oxygen saturations	aterly Minimum Data Set (MDS 7/30/2021, R44's primary was considered to be a c condition." an's order dated 7/29/21 nental oxygen to maintain s >90%; document in progress er minute) and O2 saturations)			
	(TAR) for 9/01/21 t had signed each s but not further doc saturations or rate TAR. A review of R 9/01/21 through 9/ nurse documentati	reatment administration record hrough 9/14/21 showed nurses hift acknowledging the order, umentation of oxygen of oxygen flow was seen in the 244's progress notes from 14/21 failed to show daily shift on on this same information, hed such notes only on 9/4/21 9/14/21, 3:42 p.m.	5			
	in his bed and had nasal cannula. R44 his oxygen, but the thought his O2 ord	.m. R44 was observed resting oxygen running at 1.5 lpm via 4 shrugged when asked about en wrote a note indicating he er was for 1.1 LPM (the or did not have increments to				
	LPN-C stated R44	erview 9/14/21, 3:50 p.m. does not use his oxygen all the d she did not remember R44	e			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00148		A. BUILDING:		с	
		00148	B. WING		09/	16/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 270	Continued From pa	age 8	2 270			
	when she was work him using his oxyg document his oxyg of oxygen he was u confirmed the orde of oxygen per minu was "pretty normal order." LPN-C thou order to start reside oxygen but was un stated that if R44 h less than 90% she and then titrate it de maintained his satu LPN-C also indicate equipment clean be order to change R4	saturation lower than 90% king but stated she had seen en. LPN-C said they should en saturation and the amount using each shift. LPN-C er did not say how many liters the to apply, but thought 2 LPM , but it doesn't stay that in the ught the facility had a standing ents on 2 LPM if they needed able to find this order. LPN-C had an oxygen saturation level would start oxygen at 2 LPM own until he was stable and urations greater than 90%. ed they should keep the ut confirmed there was no t4's tubing. LPN-C did not pxygen tubing or nasal canula				
	RN-D stated it was resident's oxygen s they required oxyge physician's order s saturations above a should use betwee nasal cannula. RN- recommendation "i me check on that fo she thought an LPI what level of oxyge they should alert ar well. RN-D said if a not clear, a nurse s new order.	erview 9/15/21, 10:33 a.m. the expectation to check a saturation levels each shift if en use. RN-D said if a aid to keep a resident's a certain percent, the nurse n 1 LPM and 5 LPM using a -D said the 1-5 LPM t's in my brain somehow, let or the procedure." RN-D stated N could make the decision on en to start a resident on, but n RN to do an assessment as a resident's oxygen order was should call the provider to get a				
		erview 9/15/21, 11:05 a.m. the (DON) stated an expectation				

Op148 B. WINC Op16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 308 STREET PINE HAVEN CARE CENTER INC 210 NORTHWEST 308 STREET PREVIDENCE ON STREET OWING RECENTER INC 210 NORTHWEST 308 STREET PREVIDENCE ON STREET OWING RECENTER INC 2270 PREVIDENCE TO THE EXPRECIENCE TO STREET PREVIDENCE TO THE APPROPRIATE CONTENT 2270 Continued From page 9 2270 Continued From page 9 2270 2270 Continued From page 9 2270 Continued From page 9 Construction and/or condensation and this must be promptly cleaned. DON said the cup chambers and the face mask/mouthpices bould be cleaned and then inverted onto a clean dry paper towel. DON also stated this was not a resident's responsibility, and although a resident may choose to clean the equipment. Final State	STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	СОМ	E SURVEY PLETED
Description 210 NORTHWEST 3RD STREET INTERIAND, NM 55863 MAID PREFX SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL Recent DEFICIENCY MUST BE PRECEDED BY FULL TAG PROVIDENS FLAN OF CORRECTION (EACH CORRECTIVE ACTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM- CONSTREET (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFX PREFX PROVIDENS FLAN OF CORRECTION (EACH CORRECTIVE ACTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM- CONSTREET (EACH DEFICIENCY) 2 270 Continued From page 9 2270 2270 C notinued From page 9 2270 2270 If the face mask/mouthpices bould be promptly cleaned. DON said the cup chambers and the face mask/mouthpices bould be cleaned and then inverted onto a clean dry paper towel. DON also stated this was not a resident's responsibility, and although a resident may choose to clean the equipment, it really should be done by a nurse. DON also state the mount of oxygen to be provided in LPM. In an emergency. DON said an LPN cannot make the decision as to what level of oxygen administration. Oxygen orders should also include instructions for cleaning and changing equipment such as tubing. The Administering Medications through a Small Volume (handheld) nebulizer policy revised October 2010 provided the following directions related to cleaning the equipment: "Rinse and disinfect the nebulizer register 5 minutes(d) rinse all pieces with serie water (NOT tap. bottled or distilled): and (cover with isopropy (tubbing) alcohol. Soak for 5 minutes(d) rinse all pieces with serie water (NOT tap. bottled or distilled): and (c) allow to air dry on a paper towel." The policy in			00148	B. WING		09/	16/2021
PINE HAVEN CARE CENTER INC PINE ISLAND, MN 55963 (24) ID PREYX SUMMARY STATEMENT OF DEFICIENCES REGULTIONY OR LSC IDENTIFYING INFORMATION) ID PREYX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRACEDED BY FULL REGULTIONY OR LSC IDENTIFYING INFORMATION) ID PREYX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCEY) COMET 2270 Continued From page 9 2 270 Continued From page 9 2 270 for nurses to clean the medication nebulization equipment after a dose was provided. DON said the medication cup could contain residual medication and/or condensation and this must be promptly cleaned. DON said the cup chambers and the face mask/mouthpiece should be cleaned and then inverted onto a clean dry paper towel. DON also stated this was not a resident may choose to clean the equipment, it really should be done by a nurse. DON also said an LPN cannot make the decision as to whalt level of oxygen a resident should be started on, and it is not within an LPN scope of practice to titrate. DON said an order for oxygen should clearly state the amount of oxygen to be provided in LPM. In an emergency. DON said nurses could follow the facility policy to initiate oxygen, but then they should seek out an order for on-going administration. Oxygen orders should also include instructions for cleaning and changing equipment such as tubing. The Administering Medications through a Small Volume (handheld) nebulizer policy revised October 2010 provided the following directions related to cleaning the equipment according to facility protocol, or (a) wash pieced with warm scapy water; (b) rinse with isopropyl (rubbing) alcohol. Soak for 5 minutes;(d) rinse all pieces with sterile water (NOT tap, bottled or distilled); and (e) allow to air dry on a paper towel." The policy indi	NAME OF F	PROVIDER OR SUPPLIER					
PREFIX TAG CEACH CORRECIPE ACTIVE ACTION SHOULD BE RECULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECIPE ACTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued DEFICIENCY) 2.270 Continued From page 9 2.270 7 for nurses to clean the medication nebulization equipment after a dose was provided. DON said the medication and to condensation and this must be promptly cleaned. DON said the cup chambers and the face mask/mouthpiece should be cleaned and then inverted onto a clean dry paper towel. DON also stated this was not a resident may choose to clean the equipment, it really should be done by a nurse. DON also said an LPN cannot make the decision as to what level of oxygen a resident should be started on, and it is not within an LEPN scope of practice to titrate. DON said an order for oxygen should clearly state the amount of oxygen to be provided in LPN. In an emergency, DON said nurses could follow the facility policy to initiate oxygen, but then they should seek out an order for on-going administration. Oxygen orders should also include instructions for cleaning and changing equipment such as tubing. The Administering Medications through a Small Volume (handheld) nebulizer policy revised October 2010 provided the following directions related to cleaning the equipment: "Rinse and disinfect the nebulizer quipment according to facility protocol, or (a) wash pieced with warm scapy water; (b) rinse with hot water; (c) place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for 5 minutes;(d) rinse all pieces with sterile water dry on a paper towel." The policy indicated, "when equipment is completely dry, store in a plastic bag	PINE HA	VEN CARE CENTER	INC				
for nurses to clean the medication nebulization equipment after a dose was provided. DON said the medication and/or condensation and this must be promptly cleaned. DON said the cup chambers and the face max/mouthpiece shoul be cleaned and then inverted onto a clean dry paper towel. DON also stated this was not a resident's responsibility, and although a resident may choose to clean the equipment, it really should be done by a nurse. DON also said an LPN cannot make the decision as to what level of oxygen a resident should be started on, and it is not within an LPN scope of practice to titrate. DON said an order for oxygen should clearly state the amount of oxygen to be provided in LPM. In an emergency, DON said nurses could follow the facility policy to initiate oxygen, but then they should seek out an order for on-going administration. Oxygen orders should also include instructions for cleaning and changing equipment such as tubing. The Administering Medications through a Small Volume (handheld) nebulizer policy revised October 2010 provided the following directions related to cleaning the equipment: "Rinse and disinfect the nebulizer equipment according to facility protocol, or (a) wash pieced with warm scoapy water; (b) rinse with hot water; (c) place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for 5 minutes;(d) rinse all pieces with sterile water (NOT tap, bottled or distilled); and (e) allow to air dry on a paper towel." The policy indicated, "when equipment is completely dry, store in a plastic bag	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	COMPLET
equipment after a dose was provided. DON said the medication and/or condensation and this must be promptly cleaned. DON said the cup chambers and the face mask/mouthpiece should be cleaned and then inverted onto a clean dry paper towel. DON also stated this was not a resident's responsibility, and although a resident may choose to clean the equipment, it really should be done by a nurse. DON also said an LPN cannot make the decision as to what level of oxygen a resident should be started on, and it is not within an LPN scope of practice to titrate. DON said an order for oxygen should clearly state the amount of oxygen to be provided in LPM. In an emergency, DON said nurses could follow the facility policy to initiate oxygen, but then they should seek out an order for on-going administration. Oxygen orders should also include instructions for cleaning and changing equipment such as tubing. The Administering Medications through a Small Volume (handheld) nebulizer policy revised October 2010 provided the following directions related to cleaning the equipment according to facility protocol, or (a) wash pieced with warm scapy water; (b) rinse with hot water; (c) place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for 5 minutes;(d) rinse all pieces with sterile water (NOT tap, bottled or distilled); and (e) allow to air dry on a paper towel. "The policy indicated, "when equipment is completely dry, store in a plastic bag	2 270	Continued From pa	age 9	2 270			
Volume (handheld) nebulizer policy revised October 2010 provided the following directions related to cleaning the equipment: "Rinse and disinfect the nebulizer equipment according to facility protocol, or (a) wash pieced with warm soapy water; (b) rinse with hot water; (c) place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for 5 minutes;(d) rinse all pieces with sterile water (NOT tap, bottled or distilled); and (e) allow to air dry on a paper towel." The policy indicated, "when equipment is completely dry, store in a plastic bag		equipment after a d the medication cup medication and/or promptly cleaned. I and the face mask and then inverted of DON also stated the responsibility, and a choose to clean the done by a nurse. If make the decision resident should be an LPN scope of pro- order for oxygen sho of oxygen to be pro- emergency, DON s facility policy to initis should seek out an administration. Oxy	dose was provided. DON said could contain residual condensation and this must be DON said the cup chambers (mouthpiece should be cleaned onto a clean dry paper towel. is was not a resident's although a resident may e equipment, it really should be DON also said an LPN cannot as to what level of oxygen a started on, and it is not within ractice to titrate. DON said an hould clearly state the amount ovided in LPM. In an said nurses could follow the iate oxygen, but then they order for on-going /gen orders should also s for cleaning and changing	ł			
The Oxygen Administration policy revised		Volume (handheld) October 2010 prov related to cleaning "Rinse and disinfec according to facility with warm soapy w (c) place all pieces isopropyl (rubbing) minutes;(d) rinse a (NOT tap, bottled of dry on a paper towo equipment is comp "	nebulizer policy revised ided the following directions the equipment: at the nebulizer equipment protocol, or (a) wash pieced rater; (b) rinse with hot water; in a bowl and cover with alcohol. Soak for 5 Il pieces with sterile water or distilled); and (e) allow to air el." The policy indicated, "wher letely dry, store in a plastic bag				

If continuation sheet 10 of 69

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	THE APPROPRIATE	DATE
2 270	Continued From pa	age 10	2 270			
	administration. The following directions otherwise ordered, rate of 2 to 3 liter p documentation liste oxygen flow, route duration of the trea also to include reas assessment data of after the procedure information about of for those who require equipment. R64 Oxygen Use R64's admission M R64's cognition wa extensive physical	a's order for oxygen e document included the s, "turn on the oxygen. Unless start the flow of oxygen at the er minute." Required ed: date and time, rate of and rationale, frequency, and thment. Documentation was son for the administration, any obtained before, during and e. The policy did not provide care of the oxygen equipment ire the on-going use of such IDS dated 8/19/21, indicated s intact. R64 required assistance from staff for all ring (ADLs) and received				
	diagnoses included degenerative disea	rinted 9/16/21, indicated R64's d obstructive sleep apnea, use of the nervous system, type , and chronic kidney disease.				
	8/12/21, for Oxyge	ders indicated an order dated n 1 liter every evening and (bedtime) and off in AM for				
	interventions relate	inted 9/16/21, did not indicate ed to oxygen. Additionally, a not indicate interventions nea.				
	Administration Rec	2021, Electronic Treatment cord (ETAR) printed 9/16/21, ygen had been placed on every	/			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00148	B. WING			C 16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA		INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 270	Continued From pa	age 11	2 270			
	through 9/15/21. A indicated a start da date oxygen tubing record lacked docu oxygen tubing had On 9/14/21, at 8:31 with nasal cannula under a chair in R6 On 9/15/21, at 7:48 with nasal cannula the same location, On 9/15/21, at 12:5 with nasal cannula the same location, On 9/15/21, at 3:25 with nasal cannula	off every AM from 9/1/21 additionally, R64's ETAR te of 9/20/21, to change and every Monday evening. The imentation indicating the been changed prior to 9/16/21 a.m. R64's oxygen tubing was observed on the floor, 4's room. B a.m. R64's oxygen tubing was observed on the floor in under a chair in R64's room. 55 p.m. R64's oxygen tubing was observed on the floor in under a chair in R64's room. 5 p.m. R64's oxygen tubing was observed on the floor in under a chair in R64's room.				
	During an interview licensed practical n oxygen tubing with floor, under a chair "That's not good, th LPN-F picked up th oxygen concentrator replace it with a new tubing. When LPN- cannula should not "because of infection asked what should tubing when not in should have been p	on 9/15/21, at 3:42 p.m. nurse (LPN)-F confirmed R64's nasal cannula was on the in R64's room. LPN-F stated, nat should not be on the floor." ne tubing, removed it from the or and stated that he would w nasal cannula and new F was asked why the nasal be on the floor, LPN-F stated, on control". When LPN-F was have been done with the use, he stated the tubing placed on the hook located concentrator, not on the floor.				

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED C
		00148	B. WING			16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 270	Continued From pa	age 12	2 270			
	oxygen was not in the been wrapped up a concentrator, not o LPN-E stated that it used after it had be infection, staph, Mit things". Facility policy, Oxyg 10/10, did not addr tubing when not in	nist (LPN)-E stated when use, the tubing should have and placed on the oxygen n the floor or bed. Additionally, f the nasal cannula had been een on the floor, "it could cause RSA, E-coli, a lot of bad gen Administration revised ess placement of the oxygen use. Additionally, the policy y changing of oxygen tubing.				
	The Director of Nur develop, review, ar procedures to ensu- equipment is mana could educate all a and procedures. Th develop monitoring compliance.	THOD OF CORRECTION: rsing (DON) or designee could ad/or revise policies and ure residents' oxygen ged. The DON or designee ppropriate staff on the policies ne DON or designee could systems to ensure ongoing R CORRECTION: Twenty-one				
2 302	(21) days.	44.6503 Alzheimer's disease	2 302			10/29/2 ²
	DISORDER TRAIN MN St. Statute 144 (a) If a nursing faci Alzheimer's disease or related of					

Minnesota Department of Health STATE FORM

6899

6EF511

If continuation sheet 13 of 69

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING	:		С	
		00148	B. WING			16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3R AND, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
2 302	Continued From pa	age 13	2 302				
	care staff and their superviso care.	rs must be trained in dementia					
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shal written or electronic training program, th trained, the frequer topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;					
	by: Based on interview failed to ensure tha Alzheimer's/demen	ent is not met as evidenced and document review, facility at 1 of 8 staff persons finished tia training as required.		Corrected			
	front line staff, and for having complete training. One regist 10/20/20, complete areas on 11/20/20 a	le for the training records of 5 3 supervisors and reviewed ed Alzheimer's/dementia ered nurse (RN-E) hired on ed one of four required training and a second on 12/2/20, but have record the remainder					
nocoto D		erview on 9/16/21, 2:10 p.m. ing (DON) stated an					
ATE FORI			6899	6EF511	If continuati	on sheet 14 o	

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00148	B. WING		09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLET DATE
2 302	expectation for all r comprehensive Alz prior to starting thei DON stated all staff training prior to star that facility did not r completion of the tr SUGGESTED MET The DON or design compliance/comple within the facility. T employees do not b	aursing staff to complete a heimer's/dementia training r work with the residents. f must complete a basic ting to work. DON confirmed have record of RN-E's aining. THOD OF CORRECTION: hee could monitor for tion of planned education he DON could assure that new begin working with residents dementia training is	2 302			
2 560	Plan of Care; Contents Subp. 2. Contents comprehensive plan objectives and time long- and short-terr and mental and psy identified in the con assessment. The con assessment. The con must include the ind required by Minnes subdivision 14, para This MN Requireme by: Based on observati review the facility fac comprehensive car	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, /chosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b). ent is not met as evidenced on, interview, and document niled to ensure a e plan was developed for atheter for 1 of 1 resident		Corrected		10/29/2

Minnesota Department of Health STATE FORM

6899

6EF511

If continuation sheet 15 of 69

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 15	2 560			
	R61 laid in bed, R6 urine collection bag his bed. R61 stated hospitalized becaus infection from his c another facility. R61's face sheet da was admitted to the diagnoses that inclu- sepsis, acute renal R61's hospital disc the section Lines/D included "Indwelling Coude [curved type summary did not id	tion on 9/13/21, at 2:55 p.m. at was observed to have a g secured to the right side of the had been recently se of a bad urinary tract atheter being mismanaged at ated 9/16/21, identified R61 e facility on 8/11/21, with uded urinary tract infection, failure, and urinary retention. harge summary dated 8/11/21 orains/Airways/Wounds g Urinary Catheter Latex; e] 16 Fr [French]". The lentify the size of the catheter hold catheter inside the				
		linimum Data Set (MDS) dated R61 had an indwelling urinary				
		e plan dated 8/11/21, also did e and type of catheter R61				
	order for an indwell	ician orders did not identify an ling catheter. The physician 1, directed staff to change ry 30 days.				
		Iministration record indicated changed on 8/30/21.				
		ot identify what size or type of ed, nor the size of the balloon.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
NE HA	VEN CARE CENTER	INC	THWEST 3RD			
			AND, MN 559	PROVIDER'S PLAN OF		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 16	2 560			
	During an interview on 9/15/21, at 7:05 a.m. RN-B was asked what size and type of catheter did R61 have, RN-B stated an unawareness of size and type of catheter. RN-B reviewed R61's physician orders and care plan and stated there was not a physician order for the indwelling urinary catheter, nor was the information in the R61's care plan. RN-B stated there had to be a physician order for the catheter that included the size and type of catheter and balloon size. During an interview on 9/15/21, at 10:29 a.m. RN-B indicated he had checked R61's catheter, the size that was printed on the catheter was 16 Fr (French), however, the print did not identify th type.					
	licensed practical r record and confirm size and type of ca stated she would h an order. At 8:38 a catheter and stated indicated the size a identify the type or	v on 9/16/21, at 7:52 a.m. hurse (LPN)-A reviewed R61's red there was not an order for theter R61 required. LPN-A ave to call the physician to get .m. LPN-A observed R61's d the print on the catheter as 16 Fr, however, did not balloon size. LPN-A indicated by to tell if R61 had the correct				
	director of nursing required a physicia size and type of ca	v on 9/16/21, at 11:44 a.m. (DON) stated a catheter in's order that identified the theter and balloon size and been an order obtained prior to eter.				
	Centered policy da	plans, Comprehensive Persor ted 12/2016, included, The ions are derived from a				

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00148	B. WING			09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
2 560	thorough analysis of part of a thorough of The comprehensive will describe the se to attain or maintain practicable physica well-being. Incorpor reflect treatment go in measurable outo person centered ca seven days of the of MDS. Assessment care plans are revise	age 17 of the information gathered as comprehensive assessment. e, person centered care plan rvices that are to be furnished in the resident's highest il, mental, and psychosocial prate identified problem areas, bals, timetables, and objectives comes. The comprehensive, are plan is developed within completion of the required ts of residents are ongoing and sed as information about the sident's conditions change.					
	The director of nurs review and revise p to plan of care. The designee could dev and develop a mon individual care plan developed.	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related director of nursing or velop a system to educate staff itoring system to ensure is are comprehensively R CORRECTION: Twenty-one					
2 570	MN Rule 4658.040 Plan of Care; Revision care must be reviev interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent	5 Subp. 4 Comprehensive sion . A comprehensive plan of wed and revised by an um that includes the attending ered nurse with responsibility d other appropriate staff in mined by the resident's needs practicable, with the resident, the resident's legal	2 570			10/29/21	

Minnesc	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00148	B. WING		09/1) 6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	quarterly and within the comprehensive by part 4658.0400, This MN Requireme by: Based on observati review the facility fa care plan for activiti the completion of s Data Set (MDS) wa residents reviewed Findings include: R175's Restorative 7/14/21, indicated F bed mobility and re- assistance for trans R175's care plan for mobility/positioning, included "Transfers wheeled walker] an longer distances ou plan for transfers da required assist of o dressing care plan of one. R175's significant of indicated R175 had The MDS identified assistance from two	representative at least seven days of the revision of resident assessment required subpart 3, item B. ent is not met as evidenced on, interview, and document illed to ensure revision of the les of daily living (ADLs) after ignificant change Minimum s completed for 1 of 2 (R175) for bowel and bladder. Nursing Screener dated R175 was independent with quired supervision or touching ofers.	2 570	Corrected		
Ainmas ata D		d not identify the level of				
Minnesota D STATE FOR	epartment of Health M		6899	6EF511	If continuatio	n sheet 19 of 69

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED C
		00148	B. WING		09/	16/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S			
PINE HA		INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 19	2 570			
	assistance in accor	assistance in accordance with the MDS.				
	R175 sat in her who station. Nursing ass practical nurse (LPL LPN-D stated an ur would call therapy; stated to NA-A, R1 gait belt and a walk her room, NA-D fol a gait belt around F attempted to assist however, R175 was not cooperative with LPN-D entered the with transferring R1 attempted to assist and again R175 was LPN-D entered the with transferring R1 attempted to assist and again R175 was LPN-D stated he was therapist to assist. a full body mechani entered the room. F up with NA-A and N able to stand, PT-A mechanical lift. PT- R175 into bed using During an interview director of nursing of record, DON indica changed within the care plan was incor change MDS and s Facility policy Care Centered policy dat care plan interventi thorough analysis of	ion on 9/14/21, at 12:32 p.m. eelchair in front of the nursing sistant (NA)-A asked licensed N)-D how R175 transferred. hawareness and stated he LPN-D called therapy and 75 required two assist with a ter. NA-A wheeled R175 into lowed into the room. NA-A put R175, NA-A and NA-B R175 to a standing position, s not able to stand up and was h the NAs. At 12:38 p.m. room to try and assist NAs 175 to bed. NA-A and LPN-D R175 to a standing position as not able to stand up and as going to go get a physical At 12:49 p.m. NA-A pushed in ical lift into R175's room, PT-A PT attempted to stand R175 NA-B however, R175 was not a then instructed to use the A and NAs then transferred g the full body mechanical lift. (DON) reviewed R175's ited R175's mobility had last month. DON verified the nsistent with the significant should have been revised. plans, Comprehensive Person ted 12/2016, included, The ons are derived from a of the information gathered as comprehensive assessment.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00148	B. WING		09/	16/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559(
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 570	will describe the se to attain or maintair practicable physica well-being. Incorpor reflect treatment go in measurable outc person centered ca seven days of the of MDS. Assessments care plans are revis resident and the res SUGGESTED MET The director of nurs review and revise p to revision of the ca needs of each indiv nursing or designed educate staff and d ensure individual ca necessary.	ge 20 e, person centered care plan rvices that are to be furnished of the resident's highest l, mental, and psychosocial rate identified problem areas pals, timetables and objectives omes. The comprehensive, re plan is developed within completion of the required s of residents are ongoing and sed as information about the sident's conditions change. THOD OF CORRECTION: sing (DON) or designee could olicies and procedures related are plan as needed to meet the ridual resident. The director of e could develop a system to evelop a monitoring system to are plans are revised as R CORRECTION: Twenty-one	2 570			
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			10/29/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				

Minneso	ta Department of He	alth			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00148	B. WING		C 09/16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
		210 NOR1	THWEST 3R	D STREET	
PINE HA	VEN CARE CENTER I	NC PINE ISLA	AND, MN 55	963	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 830	Continued From pa	ge 21	2 830		
	prefers to remain in	bed.			
	by: Based on observati review, the facility fa assessment, monito were completed for R44). This resulted required re-hospital	ent is not met as evidenced on, interview, and document ailed to ensure appropriate oring and physician notification 3 of 3 residents (R48, R36, in actual harm when R48 ization with fluid overload ory failure and acute on heart failure.		Corrected	
	admitted to the faci of heart failure, chro	heet identified R48 was lity on 7/30/21, with diagnoses onic obstructive pulmonary capnic respiratory failure.			
	had leg swelling an (pounds). Plan was milligrams [mg], wil monitor weight, Che	it dated 7/30/21, included R48 d his weight was 333.8 lbs. to continue Lasix 40 l adjust if needed, nursing to eck daily weight notify provider y or 5 lb. in a week.			
Ainposeto D	following -Daily weights, notif over 2 lbs. (pounds (start date 8/2/21) -Lasix 40 mg (millig congestive heart fa -Occupational there	lers reviewed, included the y physician for weight gain) in a day OR 5 lbs. in a week grams) one time a day for ilure (start date 7/31/21) apy wrap bilateral lower y through Friday (start date			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00148	B. WING			C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559				
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 22	2 830				
	R48's Admission Assessment dated 7/30/21, indicated R48 had +3 pitting edema in both lower extremities; location in the lower extremities was not identified.						
	8/6/2021, identified impairment, require or more staff mem that involved mobil staff for personal h	linimum Data Set (MDS) dated I R48 did not have cognitive ed extensive assistance of two bers for activities of daily living ity and extensive assist of one ygiene and dressing. The MDS administered diuretic					
	a diagnoses of con corresponding inte stockings on in the physician to assess periodically, medic observe for signs a edema, significant shortness of breath notify physician as	ted 8/6/21, indicated R48 had agestive heart failure with rventions, compression morning off and night, s medication program ations as ordered, staff to and symptoms of increased weight changes, increase n/new shortness of breath, and needed, and weight at least red by physician, notify cant weight gain.					
	ordered a chest X- R48's chest X-ray i R48 had patching o replaced with other bacteria) in the righ effusion (water on included " Patchy r	ated on 8/6/21, physician ray to rule out tuberculosis. results on 8/11/21, indicated opacification (air in lungs r material such as fluid or to lower lobe, and small pleural the lungs). The report also ight lower lobe infiltrate is am recommended)."					
		d identified over 2 lb. weight ut evidence of physician					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	COM	E SURVEY PLETED C	
		00148	B. WING	3. WING		09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PINE HA		INC	THWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
	8/10/21, 8/11/21, 8/ R48's progress not included, "Resident shortness of breath appeared pale/cyar head of bed elevate liters per minute (LI clear/diminished. V 146/85, Pulse of 90 saturations 80%. R placed in a tripod p to position, and one	sician order. was 330.4 lbs. was 334.2 lbs. was 339.0 lbs. was 343.0 lbs. was 343.0 lbs. d evidence of daily weights on (12/21, and 8/13/21. e dated 8/13/21, at 7:39 a.m. t had a sudden onset of a around 4:00 a.m. Resident notic. Resident initially had ed, and oxygen increased to 3					
	Resident requested head of bed elevate initiated, morning s sent physician notif R48's progress not indicated R48 was ambulance related oxygen saturations R48's discharge su	e dated 8/13/21, at 10:30 a.m. transferred to the hospital via to shortness of breath and low mmary dated 8/25/21,					
nnosota D	hypercarbic (increa bloodstream)respir chronic congestive indicated between and hospital admis	iagnosis for admission was se in carbon dioxide in the atory failure and acute on heart failure. The summary hospital discharge on 7/25/21 sion on 8/13/21, R48 had an The summary indicated 1.5					

	ota Department of He						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
				A. BUILDING:			
		00148	B. WING			C 09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	VEN CARE CENTER	210 NOR	THWEST 3RD	STREET			
	VEN CARE CENTER	PINE ISL	AND, MN 559	63			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ige 24	2 830				
	discharge summary	emoved from R48's lungs. The y included new orders to m Lasix to Torsemide and add on.					
	9/13/21 included: -Daily weights, notifiover 2 lbs. in a day 8/25/21) -Fluid Restriction: 2 note with total 24-h Date 8/25/21) -Torsemide 60 mg of failure (start date 8/ -Compression Stoce getting out of bed. I bed (start date 8/25) R48's weight record to 9/13/21; record la accordance with ph -On 8/25/21, weigh -On 8/26/21, weigh -On 8/28/21, weight -On 9/2/21, weight -On 9/3/21, weight	kings: Donn in a.m. prior to Remove in evening once in 5/21) d was reviewed from 8/25/21 acked physician notification in hysician orders until 9/7/21. t was 303.0 lbs. t was 308 lbs. t was 307.2 lbs. was 310.0 lbs. was 312.6 lbs. orded on 9/4/21 according to					
	indicated R48 had a 8/31/21 with no oth indicated R48 had extremities. The no have some compla exertion but is able	was 315.0 lbs. tification dated 9/7/21, a 13 lb. weight increase since er symptoms. The note +2 pitting edema to both lower te also included, He does ints of shortness of breath with to catch his breath when at ar bilaterally anterior and					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
	VEN CARE CENTER	INC	THWEST 3RD			
		PINE ISL	AND, MN 559	63		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 25	2 830			
	posterior.					
	nursing progress n intake evaluation. I consistently docum of documented inta	ecord was reviewed along with otes for the 24-hour fluid Fluid intake was not nented every shift; with the lack ake on the 24-hour fluid intake ulated/reviewed in accordance on.				
		fied between 9 different shift as not monitored or 8/25/21 to 9/13/21.				
	at 1:43 p.m. R48 s stated he was in th ago for fluid overlo liters of fluid. R48 s the hospital, he we again to 315 lbs. R the hospital, he had R48 stated he had fluid was removed, progressing over ti	tion and interview on 9/13/21, at up in his wheelchair. R48 e hospital a couple of weeks ad and they had removed 24 stated when he got back from ighed 303 lbs. but was back up 48 stated before he went to d been around 330 to 335 lbs. felt so much better after all the and thought it had steadily me, and indicated he would attention to his weight gains.				
	medical director st expectations nursin there was a weight physician order. Me most objective mea monitoring is weigh nursing needed to	v on 9/15/21, at 8:24 a.m. ated there were clear ng notify the physician when gain in accordance with edical director indicated the asurement for fluid volume nt gain. Medical director stated be monitoring/evaluating ctiveness of the treatments and	8			
		v on 9/15/21, director of ed she expected the physician				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00148	B. WING	·····	09/	09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
PINE HA		INC	THWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	be notified of weigh physician orders. D monitoring edema accurately. DON st gain, an evaluation determine if the we the evaluation shour respiratory assessing assessing for edem abdomen. DON inco the physician need the episode of shor been documented in	at gain in accordance with DON stated the expectation of daily and findings documented ated if there was a weight needed to be done to hight gain was related to fluid, uld include a complete ment, resident interview, and ha in extremities, hips, and dicated if there was a change ed to be notified. DON stated theres of breath should have in its entirety with a complete assed along in shift report for	2 830				
	the facility on 7/20/2	idicated R36 was admitted to 21, with diagnoses of ilure, chronic kidney disease kalemia.					
	indicated R36 was overload with a prin hyperkalemia (high of hospitalization for with the last visit in summary included, rehab to allow for c weights/fluid status dosing of diuretic in summary indicated The discharge sum	harge summary dated 7/20/21, admitted in part related to fluid nary diagnosis of potassium) and had a history or heart failure exacerbation May 2021. The discharge "would recommend short term loser monitoring of his to determine appropriate the outpatient setting." The R36's dry weight of 303.6 lbs. mary also included an order th close monitoring.					
		ders included: y physician for weight gain of or over 5 lbs. in a week (start					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00148		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/16/2021		
	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE				
	NOVIDER ON OUT FIER		RTHWEST 3RD				
PINE HA		INC	LAND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	the morning for fluid 7/23/21). R36's care plan dat diagnosis of conge- interventions includ up in chair to help p monitor for signs at hypovolemia/hyper when you have too body], monitor/doct the following signs/ gain of over 2 lbs. a difficulty breathing; blood pressure; ski breath sounds for c	dication) 10 mg (milligrams) in d retention's (start date ted 7/25/21, identified R36's stive heart failure. Associated led, elevate feet when sitting prevent dependent edema, nd symptoms of volemia [medical condition little/too much fluid in your ument/report to MD as needed symptoms: Edema; weight a day; neck vein distention; increased heart rate; elevated n temperatures; monitor	Ŀ				
	weight was 299.6 ll was 298 lbs. R36's weight record and 9/13/21, identif 2 lbs. in a day or ov	t was 302.2 lbs. t was 302.8 lbs.	r				
	-On 9/3/21, weight -On 9/4/21, weight -On 9/6/21, weight -On 9/7/21, weight -On 9/9/21, weight -On 9/11/21, weight -On 9/12/21, weight -On 9/13/21, weight -On 9/13/21, weight	was 306.6 lbs. was 308.0 lbs. was 308.4 lbs. was 310.0 lbs. was 313.4 lbs. t was 315.0 lbs. t was 315.4 lbs.					

Minnesota Department of Health STATE FORM

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	RTHWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 28	2 830			
	R36 sat in his when the floor. R36 was and was observed just below the knee of congestive hear hospital for it. During an observat at 8:13 a.m. R36 si elevated. R36 was both legs from ank stated that he had he woke up short of called for staff to a stated the shortnes was sitting up. R36	tion on 9/13/21, at 3:21 p.m. elchair with his feet down on wearing regular cotton socks to have edema from ankle to e. R36 stated he had a history t failure and had been in the tion and interview on 9/14/21, at in his recliner with his feet observed to have edema in le to just below the knee. R36 not slept very well last night, of breath and indicated he ssist him to his recliner. R36 as of breath resolved once he o stated, "according to my ny legs is making it hard for me	9			
	did not address R3 breath and indicate present. R36's doc	te dated 9/14/21, at 3:56 a.m. 66's episode of shortness of ed R36 did not have edema cumented oxygen saturations a air, which was below R36's o.				
	licensed practical r often do you meas had never measure facility, stated he w if the resident had	v on 9/14/21, at 12:05 p.m. hurse (LPN)-D was asked, how ure edema, LPN-D stated he ed edema while working at this yould only measure the edema ace wraps or if physical ed concerns of edema.				
	at 12:11 p.m. LPN was sitting in his w	tion and interview on 9/14/21, -D entered R36's room, R36 heelchair with his feet down on quested permission to	n			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00148	B. WING		09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 29	2 830			
	R36 had 2+ pitting left ankles and 3+ t just below the knee R36's progress not entered by LPN-D, present" even thou edema at 12:11 p.m surveyor. R44 According to R44's (EHR) admission re diagnosis of chroni cardiomyopathy (da blood pressure, chi disease, shortness supplemental oxyg effusion (fluid in lur R44's quarterly Min assessment dated	nimum Data Set (MDS) 7/30/2021, R44's primary vas considered to be a				
	monitor and evalua reduce the risk of fl orders included: 2 L (liters) fluid rest consumed each sh every day shift,	ders instructed nursing staff to the R44 for fluid overload and luid overload. The following triction-document total ift. NOC (night shift) will total				
	consumed; Daily weights>not morning; Document progres pitting edema noted lung sounds, weigh practitioner] followe	s note with total 24 hour fluids tify provider if >189 lbs in the ss note on edema location, d, skin intact (fluid weeping) nt, CNP [certified nurse ed up on 8/13/21 and le [diuretic]. Edema to BLE				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 30	2 830			
	until resolved,	remities]. Every evening shift th ACE bandages on in am and	I			
	heart, blood pressu Metoprolol succina 25 mg, give 12.5 b Spironolactone tab time a day, Torsemide tablet 2 two times a day. R increased on 8/13/	ncluded medications to control ure and to relieve edema: te capsule ER 24 hour sprinkle y mouth in the morning, let, give 50 mg by mouth one 0 mg, give 40 mg by mouth 44's Torsemide dose had 21 from 20 mg to 40 mg and n 8/16/21 to be taken twice a e per day.				
		daily weight was not recorded 9/11. On 9/12, 9/13 and 9/14 ed 189 pounds.				
	instructions for a p on R44's edema lo skin intact (fluid we weight. A review of identified missing p	dated 8/14/21 included rogress note to be written daily ocation, pitting edema noted, eeping), lung sounds and f R44's record for September progress notes for note related to edema, weight,				
	9/12/21-"weight wa reweight [sic] tomo asymptomatic." No to edema or lung s 9/13/21-no note re	as taken after lunch. Will prrow and reassess. Resident is additional information related pounds. lated to edema, weight, or lung				
	resident is alert an 92-93% on 1 L, wh 4+ edema of R and	n. "assessment conducted: d oriented x3, oxygen levels leezing auscultated bilaterally, d L extremities. Weight for rse manger notified of change				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00148	B. WING			C 09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
		210 NOR	THWEST 3RD				
PINE HA	VEN CARE CENTER I	PINE ISL	AND, MN 559	63			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 31	2 830				
	in weight, ACE wra for scheduled appo	p applied, resident left building intment."					
	in bed in his room, and limbs was red a ice water was noted An oxygen concent was running, but R4 cannula in his nose On 9/14/21, at 8:43 sitting on the side o and swollen from th difficulty speaking, I through short phras and answering yes, had noticed his legs	a.m. R44 was observed f his bed. His legs were bare he knees down. R44 had but was able to communicate ses, gestures, some writing no questions. He indicated he s were swollen and gestured to					
	his abdomen. He in	ting bigger. He also tapped on dicated his legs should be s were slightly swollen and he seen.					
	lying in bed with his (RN)-C entered the compression wraps have his legs wrapp day. RN-C started toes and performed asked, "do you like After reaching R44"	b.m. R44 was observed to be legs bare. Registered nurse room with two elastic and informed R44 he should bed before going out for the wrapping R44's right leg at the l a figure eight wrap. He it tight? No, just a little loose?" s knee, there was a					
	RN-C proceeded to the ankle. Following the left leg in the sa wraps were too long	nt of wrap still on the roll, so wrap the leg back down to g the right leg, RN-C wrapped ame manner. RN-C stated the g, and that he should have nt wraps; however, RN-C did er wrap.					

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA		NC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	At 9/14/21, 12:15 p been weighed. RN- weighed every day. nursing assistant (N been weighed. Ano stated daily weights morning as soon as confirmed that R44 unknown reasons. reported a weight of During an interview RN-C confirmed that edema. He stated t was to "squeeze the indent would occur' done this but would weight should be re- more than the day I had been working t documented a weight order to call the pro- 189 lbs. RN-C state edema indicated a According to an inter weight was to be do	m. R44 indicated he had not C stated R44 was to be RN-C called to a passing IA-F) who said R44 had not ther nursing assistant, NA-C s were to be done every s possible, before eating and had not yet been weighed for NA-C weighed R44 and				
	monitoring, RN-D c accomplished prior compression wraps find a shorter set of ones they had were should notify medic has a change in co	e early in the morning. Edema onfirmed, should be to the application of the c. RN-D stated a nurse should compression wraps if the too long. RN-D said a nurse al providers when a resident ndition or when an order was to be done. The expectation				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00148	B. WING			C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 33	2 830				
	result/request) forr immediately, but an call a provider with of any guidelines s manger to call. RN order for a daily we review of his EHR daily." RN-D stated document on R44's note as outlined in edema, changes in information was not like there is no doo According to an int the director of nurs expectation that da same time each da rising before break expectation for cor before getting up for monitoring edema, like to have edema as in the afternoon progresses when t general, edema mor monitoring a reside excess it was exper- weights, monitor lu- sometimes abdom stated any orders s	baseline, assessment, n and send it to the provider ny nurse should also be able to a report. RN-D was not aware aying it must be the nurse -D confirmed that R44 had an eight to be done, but upon stated, "it has not been done d an expectation of nurses to s condition in a daily progress his orders with lung sounds, n weight, but confirmed that this of done daily, saying, "it looks cumentation since the 12th." rerview 9/14/21, 12:57 p.m. with sing (DON) the DON stated an ally weights be done at the ay, preferably right away upon fast. DON also stated an mpression wraps to be applied or the day. In relation to both stated some physicians a checked later in the day, such to see if the condition he resident is up, but in onitoring should be done in the e application of the s. DON said that when ent for problems with fluid ected that nurses would do dail ing sounds, vital signs and inal girth if ordered. DON should be initialed as being eatment administration record ess note should be written as	s n				
		v 9/15/21, 8:46 a.m. with the ector (MD-A), he stated he was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00148	B. WING			09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 34	2 830				
	"perplexing present not been fully succe trajectory continues unchecked fluid inte although he was cu concern for R44, are exacerbation of his A request was mad fluid/edema manag was not provided. The Heart Failure-0	le of the facility for a policy on gement and monitoring, but this Clinical Protocol policy revised	5				
	physicians and did SUGGESTED MET The director of nurs audit orders for res ensure they are cle or designee could e education on fluid to monitoring and door done to ensure cor	overed only expectations of not address nursing care. THOD OF CORRECTION: sing (DON) or designee could idents with fluid imbalance and ear and understandable. DON ensure all nursing staff receive palance issues, edema cumentation. Audits could be npliance of proper daily ponitoring, documentation of oper reporting.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one					
2 850	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 D Adequate and re; Shaving	2 850			10/29/2	
	proper care. The adequate and prop D. Assistance	or determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean					

Minnesota Department of STATE FORM

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE S COMPL	
		00148	B. WING		C 09/1	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		210 NOR1	THWEST 3R	D STREET		
PINE HA	VEN CARE CENTER I	PINE ISLA	AND, MN 55	963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 35	2 850			
	and well-groomed.					
	by:	ent is not met as evidenced on, interview, and document		Corrected		
	review, the facility	ailed to provide personal care ote dignity for 1 of 2 female o depended on staff for				
	(MDS) completed 8 cognition was seven dependent on phys	ange Minimum Date Set /6/21, indicated R49's rely impaired. R49 was ical assistance from staff for living (ADLs) including nd grooming.				
		inted on 9/15/21, indicated cluded depression, dementia,				
	indicated R49 requi	t review date 6/25/21, red total assistance with hich included shaving facial				
	seated in her wheel greater than 30, coa	5 p.m. R49 was observed Ichair in her room. R49 had arse, white hairs that were nch in length on her chin and				
	wheelchair in the di than 30 coarse, wh	a.m. R49 was seated in her ning room. R49 had greater ite hairs that were nch in length on her chin and				
<i>l</i> innesota D	On 9/15/21, at 7:31 epartment of Health	a.m. nursing assistant (NA)-D				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA		INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 850	Continued From pa	age 36	2 850			
	assisting R49 with assisted out of bed washed R49's face R49's hair then bro Neither NA-D nor F shaving her facial h		1			
	required full physical personal hygiene a shaving facial hair. assisted a female r would do it if it was did not check R49's that R49 did have a observed R49 in th	a.m. NA-D stated R49 al assistance from staff for nd grooming which included NA-D stated he had never resident with facial hair but needed. NA-D confirmed he s face with morning cares and a shaver in her room. NA-D e dining room then confirmed rse, white hairs on her chin and ere's a lot there."	ł			
	had several coarse and upper lip. RN-, residents were ass as needed. RN-J si have long chin hair are in a hurry." RN- embarrassed and u	a.m. RN-J confirmed R49 e, long, white hairs on her chin J stated she expected isted with shaving facial hair tated, "There are a lot who s, we aren't doing it and staff -J indicated she would feel uncomfortable if she was ents and had long facial hair.				
	able to speak for he	a.m. RN-H stated if R49 was erself, she would be bothered nair when around other ors.				
	(DON) stated she e care of on bath day DON expected fem	29 a.m. director of nursing expected facial hair was taken /s and as needed in between. nale residents received aving facial hair for dignity, "I				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED	
		00148	D. WING		09/	09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
PINE HA	VEN CARE CENTER I	NC	RTHWEST 3RD LAND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 850	would anticipate if t the mirror, the whis to them." DON com of the house withou Facility policy, "Digr indicated each resid manner that promo sense of well-being	ge 37 hey were to see themselves ir kers would not be acceptable pared it to herself walking out it her hair being combed. hity" revision date 2/2021, dent shall be cared for in a tes and enhances his or her , level of satisfaction in life, -worth and self-esteem.					
	The director of nurs develop a system to monitoring system a receive assistance the care plan. The l develop and implen services, including as needed when co) n				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			10/29/2	
	comprehensive res of nursing services	sores. Based on the ident assessment, the directo must coordinate the ursing care plan which	r				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					

If continuation sheet 38 of 69

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00148					(X3) DATE SURVEY COMPLETED C	
		00148	B. WING		09/	16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
PINE HA		INC	THWEST 3R AND, MN 55			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET
2 900	Continued From pa	age 38	2 900			
	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 comprehensively assess risk for pressure ulcers, and develop and implement interventions to prevent pressure ulcer injuries for 1 of 2 residents (R175). The facility's failures resulted in harm when R175 developed a stage 2 pressure ulcer and a deep tissue pressure ulcer. In addition, the facility failed to complete comprehensive assessments for pressure ulcers and failed to follow physician orders for 1 of 4 residents (R61) reviewed for pressure ulcers.			Corrected		
	Findings include					
	diagnoses of deme	dated 9/16/21, included ntia with behavioral ngestive heart failure.				
	(MDS) assessment R175 had severe c identified R175 req from two or more s dressing, toilet use	change minimum data set t dated 8/23/21, indicated ognitive impairment. The MDS uired extensive assistance taff for bed mobility, transfers, , and personal hygiene. The '5 was occasionally incontinent				
	at risk for pressure pressure ulcers or i	The MDS identified R175 was ulcers and did not have moisture associated skin of the assessment. The MDS				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _ B. WING	E CONSTRUCTION	COM	E SURVEY PLETED	
		00148				09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From page 39		2 900				
	device was used for	nowever a pressure reducing or bed and identified R175 did and repositioning program.					
	R175's record lacked a comprehensive assessment for risk of skin breakdown after R175 became dependent on staff for mobility.		5				
	assistance in accor toileting care plan of toilet R175 upon ris and [after] all other rounds, and as nee dated 10/17/2019, potential for pressu [related to] immobil prone to bruising, s petechiae (pinpoint the skin as a result interventions includ	id not identify the level of rdance with the MDS. R175's dated 9/1/20, directed staff to sing, after breakfast, before meals, at bedtime, on night eded. R175's skin care plan indicated R175 "has the irre ulcer development r/t lity. [R175] has thin, fragile skir skin tears, and age related s, round spots that appear on of bleeding)." Associated led follow facility or the prevention of skin	n				
	11:44 p.m. indicate	Evaluation dated 9/10/21, at d skin warm and dry, normal Il, and had a skin tag on right					
	R175 laid on her ba smelled of urine. R (NA)-H were at bec over to allow them incontinent garmen	tion on 9/13/21, at 7:40 p.m. ack in bed. R175's room N-H and nursing assistant dside encouraging R175 to roll to change her saturated at. R175's mattress protectors so be urine soaked.					
	10:41 p.m. included	ogress note dated 9/13/21, at d tonight nurse and nursing out of bed. Pain medication					

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
IAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	was offered at the k did not understand. she yelled out in pa morphine was given about the process w attempts to motivat her side, washed at During an observat R175 sat in her who 7:50 a.m. licensed R175 had been in t because she had b unawareness of the toileted or changed During an observat R175 was given he R175 continued to a nursing station with During an observat at 12:04 p.m. R175 wheelchair by the n practical nurse (LPI sitting there since h stated he was not a incontinent brief or stated R175 had "n two" in her chair. During an observat R175 remained by NA-A asked LPN-D stated an unawarer therapy. NA-A was been toileted, NA-A between 6:00 a.m.	beginning of the process, she It was attempted to roll R175 in and started hitting. The mand more communication was provided. After several e the patient we rolled her on nd laid new pads down. ion on 9/14/21, at 7:00 a.m. eelchair in a hospital gown. At practical nurse (LPN)-D stated he wheelchair all night een restless, stated an e last time R175 had been				

(EACH DEFICIENCY REGULATORY OR L Continued From pa bed by NA-A and N R175's incontinent be heavily saturated onto her right side,	NC 210 NORT PINE ISLA TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 41 A-B. When NAs removed garment, it was observed to	B. WING DRESS, CITY, ST THWEST 3RD AND, MN 559 ID PREFIX TAG 2 900	STREET	ECTION HOULD BE	C 16/2021 (X5) COMPLET DATE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa bed by NA-A and N R175's incontinent be heavily saturated onto her right side,	NC 210 NORT PINE ISLA TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 41 A-B. When NAs removed garment, it was observed to	ID PREFIX TAG	STREET 63 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa bed by NA-A and N R175's incontinent be heavily saturated onto her right side,	NC PINE ISLA TEMENT OF DEFICIENCIES (* MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 41 A-B. When NAs removed garment, it was observed to	ND, MN 559 ID PREFIX TAG	63 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLET
(EACH DEFICIENCY REGULATORY OR L Continued From pa bed by NA-A and N R175's incontinent be heavily saturated onto her right side,	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 41 A-B. When NAs removed garment, it was observed to	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLET
(EACH DEFICIENCY REGULATORY OR L Continued From pa bed by NA-A and N R175's incontinent be heavily saturated onto her right side,	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 41 A-B. When NAs removed garment, it was observed to	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLET
ed by NA-A and N R175's incontinent he heavily saturated onto her right side,	A-B. When NAs removed garment, it was observed to	2 900			
R175 [°] s incontinent be heavily saturated onto her right side,	garment, it was observed to				
er lower left buttoo vas observed on he exited the room to g RN-D entered the r mpaired skin integri tage 1 pressure ul eft buttock wound v o do further evalua issue injury. RN-D nore redness than ritated. R175 was	get registered nurse (RN)-D. oom, RN-D observed the rity, and indicated R175 had a cer to the right buttock and the was a stage 2 and would have tion if the wound was a deep stated the left buttock had the right and appeared very cooperative with RN-D				
RN-D stated the work leep tissue injury, N njury. RN-D stated nember who thoug pressure ulcer to the vithin the last seve increased need to findependent with be rereaded to findependent with be rereaded the care plate evel of care R175 in research care replate evel of care R175 in research care replate evel of care R175 in research care replate research care replate research care replate research care replate research care replate repositioned are repositioned are repositioned are repositioned are replated and been complate replation. RN-D state replated are replated and the repositioned are replated and the repositioned are replated and the replated are replated and the repositioned are replated and the replated are replated and the replated are replated and the replated are replated and the replated are replated and the replated are replated and the replated are replated and the replated are replated are replated and the replated are replated are replated and the replated are replated a	bund on her left buttock was a with an open stage 2 pressure she had conversed with family ht that R175 had a history of a e same area. RN-D stated ral weeks R175 had an or assistance; she used to be ed mobility and positioning wed R175's care plan and an was not consistent with the required and the MDS confirmed the care plan did en R175 needed to be turned and an assessment to sponse to pressure over time leted after R175's change in ited the nurse should have ed or directed NAs to				
	tited the room to g N-D entered the r paired skin integr age 1 pressure ul ft buttock wound v do further evalua sue injury. RN-D ore redness than itated. R175 was uring the assessme w brief. Uring an interview N-D stated the wo exp tissue injury, v ury. RN-D stated ember who thoug essure ulcer to th thin the last seve creased need to f dependent with be erself. RN-D revie erified the care play vel of care R175 in sessment. RN-D ot identify how often determine tissue re ad not been comp position. RN-D states position R175 if the position R175 if the position R175 if the pair of the care play of the the care play of the tissue re ad not been comp	uring an interview on 9/14/21, at 3:38 p.m. N-D stated the wound on her left buttock was a eep tissue injury, with an open stage 2 pressure fury. RN-D stated she had conversed with family ember who thought that R175 had a history of a essure ulcer to the same area. RN-D stated thin the last several weeks R175 had an creased need to for assistance; she used to be dependent with bed mobility and positioning erself. RN-D reviewed R175's care plan and erified the care plan was not consistent with the vel of care R175 required and the MDS assessment. RN-D confirmed the care plan did of identify how often R175 needed to be turned and repositioned and an assessment to etermine tissue response to pressure over time ad not been completed after R175's change in ondition. RN-D stated the nurse should have uestioned/prompted or directed NAs to position R175 if there was a question of how ng R175 was sitting in her chair next to the	tited the room to get registered nurse (RN)-D. N-D entered the room, RN-D observed the upaired skin integrity, and indicated R175 had a age 1 pressure ulcer to the right buttock and the It buttock wound was a stage 2 and would have do further evaluation if the wound was a deep isue injury. RN-D stated the left buttock had ore redness than the right and appeared itated. R175 was very cooperative with RN-D uring the assessment and with application of w brief. uring an interview on 9/14/21, at 3:38 p.m. N-D stated the wound on her left buttock was a seep tissue injury, with an open stage 2 pressure ury. RN-D stated she had conversed with family ember who thought that R175 had a history of a essure ulcer to the same area. RN-D stated thin the last several weeks R175 had an creased need to for assistance; she used to be dependent with bed mobility and positioning erself. RN-D reviewed R175's care plan and wrified the care plan was not consistent with the vel of care R175 required and the MDS sessment. RN-D confirmed the care plan did ot identify how often R175 needed to be turned id repositioned and an assessment to deremine tissue response to pressure over time ad not been completed after R175's change in ondition. RN-D stated the nurse should have uestioned/prompted or directed NAs to position R175 if there was a question of how ang R175 was sitting in her chair next to the	ited the room to get registered nurse (RN)-D. N-D entered the room, RN-D observed the ipaired skin integrity, and indicated R175 had a age 1 pressure ulcer to the right buttock and the It buttock wound was a stage 2 and would have do further evaluation if the wound was a deep isue injury. RN-D stated the left buttock had ore redness than the right and appeared tated. R175 was very cooperative with RN-D uring the assessment and with application of iw brief. uring an interview on 9/14/21, at 3:38 p.m. N-D stated the wound on her left buttock was a sep tissue injury, with an open stage 2 pressure ury. RN-D stated she had conversed with family ember who thought that R175 had a history of a essure ulcer to the same area. RN-D stated thin the last several weeks R175 had an creased need to for assistance; she used to be dependent with bed mobility and positioning rrself. RN-D reviewed R175's care plan and rified the care plan was not consistent with the vel of care R175 required and the MDS issessment. RN-D confirmed the care plan did to identify how often R175 needed to be turned d repositioned and an assessment to termine tissue response to pressure over time ad not been completed after R175's change in indition. RN-D stated the nurse should have iestioned/prompted or directed NAs to position R175 if there was a question of how ng R175 was sitting in her chair next to the	itted the room to get registered nurse (RN)-D. N-D entered the room, RN-D observed the paired skin integrity, and indicated R175 had a age 1 pressure ulcer to the right buttock and the ft buttock wound was a stage 2 and would have do further evaluation if the wound was a deep sue injury, RN-D stated the left buttock had ore redness than the right and appeared itated. R175 was very cooperative with RN-D ring the assessment and with application of wo brief. auring an interview on 9/14/21, at 3:38 p.m. N-D stated the wound on her left buttock was a beep tissue injury, with an open stage 2 pressure ury. RN-D stated she had conversed with family ember who thought that R175 had a history of a essure ulcer to the same area. RN-D stated the bed mobility and positioning sreeff. RN-D reviewed R175's care plan and rified the care plan was not consistent with the vel of care R175 required and the MDS seessment. RN-D confirmed the care plan did ti dentify how often R175 needed to be turned do repositioned and an assessment to the remine tissue response to pressure over time and not been completed after R175's change in and r175 if there was a question of how ng R175 was sitting in her chair next to the

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00148	B. WING			09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
PINE HA		INC	THWEST 3RD AND, MN 559				
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 42	2 900				
	nursing desk. RN-E	D stated if R175 was refusing					
		pected the NA's reattempt or					
		to attempt, report to the nurse					
		should then attempt and notify					
		f continued refusals. RN-D					
		ary, the physician should be					
		er medical management if					
		unsuccessful. RN-D stated the entions and the effectiveness					
		needed to be documented.					
	R175's progress no	ote dated 9/14/21, 9:24 p.m.					
	identified R175 had left buttock stage 2 deep						
		imeters (cm) x 0.9 cm. Injury is	i l				
		, small tear which had fresh					
		ne edges, less than 0.5 cm in					
		ed blood in center of injury.					
		cated dietary would be e plan revised to include					
		dule and behavior plan for					
		cares including barrier cream					
		n for dry skin for comfort.					
		/ on 9/15/21, at 8:24 a.m.					
		ated a familiarity with R175 and	1				
		worsening heart failure and					
	0	a; goals of care were					
	awareness of R175	cal director indicated an					
	rejection/refusals of						
		igement for edema, however,					
		ejection/refusals for					
		ng. Medical director indicated					
		outine skin assessments and a					
		be in place for the prevention					
		Medical director stated if a					
		ated self-neglecting behaviors					
		ospice) needed to be notified;					
		n their own urine, it would need					
	epartment of Health	When asked if the duration of					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C	
		00148	B. WING			09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 43	2 900				
	positioning or chan contributed to the p	er wheelchair without ging incontinent brief pressure ulcers, medical s, that would be the definition ."					
	director of nursing have been assesse repositioning progr DON stated the ex toileted in accordar stated if residents of the nurse be notified	v on 9/15/21, at 11:34 a.m. (DON) indicated R175 should ed for a turning and am after her mobility declined. pectation residents were nce with their care plan. DON refused, the expectation was ed, and ultimately the physician ther medical intervention.					
	R61						
	indicated R61 had ulcer that had beer treatment included cleanser, pat dry, a dressing, change of The discharge sum	harge summary dated 8/11/21, a left buttock stage 2 pressure in identified on 7/16/21; plan for cleanse skin with wound and cover with foam boarder fressing daily and as needed. Imary also identified an ure ulcer on a leg with orders					
	did not identify pres note indicated resid	kin assessment dated 8/11/21, sence of pressure ulcers. The dent refused with no further ventions for refusal.					
	left buttock pressu	der dated 8/11/21, identified the re ulcer as outlined by the summary, however had a stop					
		der dated 8/11/21 included: Leo eatment: Cleanse affected area					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
						С
		00148	B. WING		09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 44	2 900			
	thick layer of Santy (soft black eschar)	daily with normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (soft black eschar), cover with mepilex border (sacral or large size).				
	Daily skin monitorir skin alterations and Wound: pressure ir	der dated 8/14/21 included: ng. If changes, document in d wounds progress note. njury to left lower able, left buttock pressure				
	pressure ulcer was assessed until 8/16 physician orders up record lacked evide pressure ulcer had assessed after faci there was a physic wound upon admis	fied the left lower extremity not comprehensively 5/21, even though there were bon admission. In addition, the ence R61's left buttock not been comprehensively lity admission, even though ian ordered treatment for the sion and an order that directed rs be monitored daily.				
	R61 had an unstag left lower extremity identified) that mea	on dated 8/16/21, indicated leable pressure ulcer on the (location on extremity was not asured 1.5 cm (centimeters) x valuation did not identify the e 2 pressure ulcer.				
	assessment dated	linimum Data Set (MDS) 8/18/21, identified R61 had ire ulcer and one unstageable				
		on dated 8/23/21 and 8/31/21, stage 2 pressure ulcer.				
		ot indicate why the physician to the left buttock was				

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING			0 16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 45	2 900			
	discontinued on 9/2	2/21.				
		ons dated 9/7/21 and 9/8/21, left buttock pressure ulcer.				
	"Leg Buttocks Pres Cleanse affected and and gauze, apply ni covering entire wou	ler dated 9/13/21, included, sure Injury Treatment": rea daily with normal saline ickel thick layer of Santyl ınd bed (black soft eschar), border (sacral or large size).				
	licensed practical n	on 9/14/21, at 9:15 a.m. urse (LPN)-D indicated R61 d treatment to complete; the on the left calf.				
	licensed practical n R61 he was going t change on his left of donned gloves, rem of the dressing, the then used a pen to dressing and donne performing hand hy	ion on 9/14/21, at 9:21 a.m. urse (LPN)-D explained to to complete the dressing calf; R61 gave consent. LPN-D noved the dressing, disposed on removed gloves. LPN-D write the date on the new ed new gloves without vgiene. LPN-D completed the er physician orders, removed d hands.				
		r on 9/14/21, at 9:26 a.m. nould have done hand hygiene nges.				
	RN-B explained to the dressings on his gave consent. RN-I donned gloves, RN	ion on 9/15/21, at 1:16 p.m. R61 he was going to change s left calf and left buttock; R61 B washed his hands and -B then removed R61's wound eft calf and through the				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Multiple A. Building: _	CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA		INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A		ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page 46		2 900			
	the wound in the ca depressor, and stirr RN-B then removed and cut the non-stice wound. RN-B then mixture of ointment the cover dressings on throughout the p had not disinfected the completion of th then picked up the floor, took off glove RN-B then informed change on his left b and undid R61's ind incontinent of stool care (a dressing wa buttock where there wound that was rec wipe to clean his gl and donned another disinfecting) over th and applied the left physician order.	bottle, put the ointments for ap, opened a tongue red the ointments together. d scissors from his left pocket ck dressing to the size of the used a Q-tip to spread the ts onto the wound and applied s. RN-B had the same gloves procedure, in addition RN-B the scissors prior to or after ne dressing change. RN-B soiled dressings from the s, and sanitized his hands. d R61 of the next dressing puttock. RN-B donned gloves continent brief, R61 was , RN-B performed incontinent as not observed on R61's left e was a nickel sized superficial idened), used an incontinent oves, walked to the bathroom er pair of gloves (without ne gloves he already had on buttock dressing per				
	buttock wound and RN-B stated if the v not anymore. RN-B changed his gloves after taking off the	there should have been, wound had been resolved it's stated he should have and performed hand hygiene old dressing. RN-B stated an uble gloving was appropriate				
	director of nursing that pressure ulcers	on 9/16/21, at 11:44 p.m. (DON) stated an expectation s were comprehensively nission, weekly thereafter and				

	NT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00148	B. WING			09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
PINE HA	VEN CARE CENTER I	NC	HWEST 3RD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	as need, should be worsening daily with stated the expectat according to physic appropriate hand hy dressing changes, g after dressing and r wound, hand hygier each glove change, need to go into a ga floor, and scissors a using on a clean dra Facility policy Press dated 3/2020, inclue pressure injury risk risk factors and the modified and which immediately address to modify. 2) Risk fa resident's susceptik PU's include b) imp decreased function previously healed P fecal incontinence of altered skin status of cognitive impairmer conducted and risk characterized, a res be created to address pressure injuries. Facility policy Press Breakdown-Clinical not identify frequen comprehensive wor	monitored for improvement or h dressing changes. DON ion dressings were applied ian order. DON indicated ygiene was expected during gloves should be removed removal and cleansing the he should be performed after DON stated soiled dressings arbage can and not on the should be disinfected prior to essing. Sure Injury Risk Assessment ded 1) The purpose of assessment is to identify all n determine which can be cannot, or which can be seed, and which will take time actors that increase a bility to develop or to not heal aired/decreased mobility and al ability, the presence of PU, exposure to urinary and or other source of moisture, over pressure points, and ht 6) once the assessment is factors are identified and sident centered care plan can ess the modifiable risks for sure Ulcers/Skin Protocol dated 4/2018, did cy of monitoring or completing und assessments. The skin examine would be	2 900				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.		с	
		00148	B. WING		09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RE AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 48	2 900			
	The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. T designee, could co delivery of care; to services are impler pressure ulcer deve	to prevent pressure ulcers ad to promote healing of he director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920			10/29/2
	by: Based on observat review the facility fa 1 of 2 residents (R bladder. In addition grooming assistant	ent is not met as evidenced ion, interview, and document ailed to follow the care plan for 175) reviewed for bowel and the facility failed to ensure be was provided to 2 of 2 9) who were dependent on		Corrected		
	R175 toileting R175's face sheet diagnosis of demer	dated 9/16/21, included ntia with behavioral				

STATE FORM

6EF511

If continuation sheet 49 of 69

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 49	2 920			
	disturbance and m	uscle weakness.				
	R175's significant change Minimum Date Set (MDS) dated 8/23/21, indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for toilet use and personal hygiene. The MDS indicated R175 was occasionally incontinent of urine and bowel.					
	staff to toilet R175	re plan dated 9/1/20, directed upon rising, after breakfast, all other meals, at bedtime, on as needed.				
	R175 laid on her bas smelled of urine. R assistant were at b roll over to allow th incontinent garmer	tion on 9/13/21, at 7:40 p.m. ack in bed. R175's room N-H and unidentified nursing redside encouraging R175 to em to change her saturated nt. R175's mattress protectors also be urine soaked.				
	R175 sat in her wh 7:50 a.m. licensed R175 had been in t because she had b	tion on 9/14/21, at 7:00 a.m. eelchair in a hospital gown. At practical nurse (LPN)-D stated the wheelchair all night been restless, stated an e last time R175 had been d.				
	R175 was given he R175 continued sit	tion on 9/14/21, at 8:50 a.m. er breakfast tray. At 9:27 a.m. in her wheelchair by the her breakfast in front of her.				
	R175 remained by NA-A asked LPN-E	tion on 9/14/21, at 12:20 p.m. the nursing station. At 12:32) how R175 transferred. LPN-D ness and stated he would call				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C	
		00148	B. WING			09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	therapy. NA-A was been toileted, NA-A between 6:00 a.m. assisted the night s was transferred via bed by NA-A and N R175's incontinent heavily saturated w had not been toilet morning. During an interview director of nursing was residents were their care plan. DC the expectation wa	asked when R175 had last A stated the last time was and 7:00 a.m. when she shift aide. At 12:49 p.m. R175 a full body mechanical lift to her IA-B. When NA's exposed garment it was observed to be vith urine. NA-A stated R175 ed since 6-7:00 a.m. that v on 9/15/21, at 11:34 a.m. (DON) stated the expectation e toileted in accordance with N stated if residents refused, s the nurse be notified, and ician if necessary for further	-				
	indicated R49's co R49 was dependent staff for all activitie including personal R49's care plan las indicated R49 requ	nange MDS completed 8/6/21, gnition was severely impaired. nt on physical assistance from s of daily living (ADLs) hygiene. st review date 6/25/21, hired total assistance with which included shaving facial					
		rinted on 9/15/21, indicated icluded depression, dementia,					
	seated in her whee	25 p.m. R49 was observed Achair in her room. R49 had barse, white hairs that were					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED C
		00148	B. WING	B. WING		16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCE			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 51	2 920			
	approximately 1/4 inch in length on her chin and upper lip.					
	On 9/14/21, at 8:23 a.m. R49 was seated in her wheelchair in the dining room. R49 had greater than 30 coarse, while hairs that were approximately 1/4 inch in length on her chin and upper lip.					
	and registered nurs assisting R49 with r assisted out of bed washed R49's face R49's hair then pus	a.m. nursing assistant (NA)-D e (RN)-H were observed morning cares. R49 was , into her wheelchair. RN-H and dried it. NA-D combed hed R49 to the dining room. RN-H offered to assist R49 with pair.				
	required full physical personal hygiene at shaving facial hair. assisted a female re would do it if it was did not check R49's that R49 did have a observed R49 in the	a.m. NA-D stated R49 al assistance from staff for nd grooming which included NA-D stated he had never esident with facial hair but needed. NA-D confirmed he face with morning cares and a shaver in her room. NA-D e dining room then confirmed se, white hairs on her chin and ere's a lot there."				
	had several coarse and upper lip. RN-H who require physica hair, received the a stated she noticed assisted with morni	a.m. RN-H confirmed R49 , long, white hairs on her chin I expected female residents al assist with shaving facial ssistance as needed. RN-H R49's facial hair when she ng cares and R49 had a , "it was right in front of my				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00148	B. WING			C 16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	RTHWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	On 9/15/21, at 10:2 (DON) stated she o	age 52 29 a.m. director of nursing expected facial hair was taken and as needed in between.	2 920			
	R64's cognition wa extensive physical	IDS dated 8/19/21, indicated is intact. R64 required assistance from staff for all <i>r</i> ing (ADLs), including persona				
	diagnoses included	rinted 9/16/21, indicated R64's d degenerative disease of the /pe 2 diabetes mellitus, and ease.				
	indicated R64 requ	st review date 8/12/21, lired assist of one staff with vhich included shaving facial				
	R64's Point-of-Car for section labeled Performance - How hygiene, including shaving, applying r	or 8/16/21 through 9/14/21, of e (POC) Tasks documentation , "Personal Hygiene: Self v resident maintains personal combing hair, brushing teeth, nakeup, washing/drying face ted resident needed extensive				
	hallway as she was staff. R64 had blac	I p.m. R64 was observed in the s escorted in her wheelchair by k and white hairs that were inch in length that thickly nd upper lip.				
		a and interview on 9/14/21, at s sitting in her bed in her room.				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	R64 acknowledged hairs that were app that thickly covered they were due to he that she had always and she wanted sta On 9/15/21, at 7:48 bed in her room and black and white hai inch in length that the upper lip. On 9/16/21, at 1:03 stated if she had se resident, she would NA-B further stated very much and had R64. On 9/16/21, at 1:35 considered a part of further stated if a fe whiskers, assistand provided. Facility policy, "Sha 2/2018 provided dir resident with shavir frequency. Accordir the procedure was provide skin care. SUGGESTED MET The director of nurs educate responsible residents' dependat	that she had black and white roximately 1/8 inch in length her chin and upper lip, and er hormone levels. R64 stated s shaved them every other day		DEFICIENC		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00148	B. WING		C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PINE HA		NC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPL	
2 920	Continued From pa	ge 54	2 920			
	hygiene needs are	met consistently.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21335	MN Rule 4658.072 Routine & Emerger	5 Subp. 3 A&B Providing ncy Oral Health Ser	21335		10/29/	
	Subp. 3. Emergen	cy dental services.				
	from an outside res services to meet th Emergency dental s needed to treat: an teeth, gums, or pala damaged teeth; or cavity, appropriately requires immediate B. When emer- nursing home mus hours, describe the	ome must provide, or obtain source, emergency dental e needs of each resident. services include services n episode of acute pain in ate; broken or otherwise any other problem of the oral y treated by a dentist, that e attention. gency dental problems arise, a t contact a dentist within 24 dental problem, and ement the dentist's plans and				
	by: Based on interview failed to ensure 2 o were offered regula	ent is not met as evidenced s and document review, facility f 2 residents (R24 and R3) ir dental appointments to ort and reduce the risk of		Corrected		
	Findings include:					
	Admission Sheet/fa	ectronic health record (EHR) ice sheet, R24 had a diagnosis ulty swallowing) of the				

Minnesota Department of Health STATE FORM

6EF511

If continuation sheet 55 of 69

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00148				16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 5590			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY F					
21335	Continued From pa	age 55	21335			
	oropharyngeal pha	se (near mouth/throat).				
	A facility "Long Term Care Evaluation" dated 6/30/21 done to inform the MDS did not include any information about R24's oral or dental status, and no other evaluation of oral status was found in the EHR.					
	problem area (not or risk for alteration in related to being edu and lower dentures the dentures had b indicate when that problem area was 6/01/2016. A corres "periodic offer is ma	care plan in the EHR, a focus dated) indicated R24 was at oral hygiene, and health entulous (no teeth), has upper a. The focus problem indicated een re-lined but did not had occurred. The goal for this dated as having been initiated sponding intervention included: ade to resident/family to set up ts and PRN (as needed).				
	she was fitted with her admission to th She said the dentu have not been adju stated she frequent mouth in-between thad started to irrita had four children by family was unable to appointment or ass	y 9/13/21, 3:12 p.m. R24 stated her current dentures prior to be facility some six years ago. res had to be re-lined twice but isted in recent years. She tly had to take them out of her meals because the dentures te her gums. She stated she ut was concerned that her to assist with making any sisting her to an appointment. being offered any dental				
	a registered nurse stated the facility w dental visits but wa	erview on 9/15/21, 10:37 a.m. (RN-D) managing the unit as able to provide R24 with s unable to record on the last ved any dental assessment.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00148	B. WING	B. WING		16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21335	Continued From pa	age 56	21335			
		quarterly care conferences but was unable to find record that such services had been offered to or declined by R24.				
	licensed social wor should offer dental know if R24 had ha this should be offer conferences. LSW	cating any such services had				
	nursing assistant (I dentures in to eat h in between becaus irritates her." NA-C	erview 9/15/21, 12:14 p.m. a NA-C) stated R24 puts her her meals but will take them ou e "there is a little spot that stated nurses were supposed t oral status and set up dental by see a problem.	t			
	(DON) confirmed the recent documentate current oral status. to find any document dental appointment that vision, hearing every care conferent this offer and the re- documented. DON	m. the director of nursing that the EHR did not contain ion by nursing staff of R24's DON stated she was unable intation that R24 was offered a t. DON stated an expectation and dental visits be offered at nce and as needed, and stated esident response should be stated if the information was ne could not assume that it				
	2016 indicated that available to provide services will assist and transportation	es policy revised December selected dentists must be follow up care, and social residents with appointments arrangements. The policy also ental services should be				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PINE HA		INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21335	Continued From pa	age 57	21335			
	recorded in the res	ident's medial record.				
	The Dental Examination/Assessment policy revised December 2013 indicated that residents shall be offered dental services as needed and upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist.					
	R3 R3's annual Minimum Data Set (MDS) dated 6/3/21, indicated R3 had moderate cognitive impairment and was able to make his needs known.					
	R3's face sheet dated 9/15/21, indicated R43's diagnoses included diabetes mellitus, heart failure and seizure disorder.					
		ed 9/15/21, provided direction family to periodically offer is as needed.				
	indicated R3 had ol broken natural teet	sion Evaluation dated 5/3/21 bvious or likely cavity or h. This assessment did not er should be notified of R3's ain dental consult.				
		s dated 5/27/20 thru 9/14/21, 3's dental needs and if a t was offered.				
	offered to see in a o	p.m. R3 stated he was not dentist but would like to see a ral missing and broken teeth.				
	stated if a resident	26 a.m. registered nurse (RN)-I wanted a dental appointment, er aware and she would let				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED C		
		00148	D. WING	<u> </u>	09/	09/16/2021	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
PINE HA		INC	THWEST 3RD				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21335	Continued From pa	ige 58	21335				
	She could also be r assessment process assessment should resident's need to s R3's assessment d had cavities or brok not notified of R3's On 9/15/21, at 2:42 (DON) stated she e offered if any issue the nurse completin update the resident possible cavities or Offering dental services can cause	ss. The nurse completing the I let RN-I know about the see a dentist. RN-I confirmed ated 5/3/21, indicated R3 likely ken teeth. RN-I stated she was					
	The director of nurs (SW) could review either external or in documented to resi educate assigned s effectiveness of an						
21426		A.04 Subd. 3 Tuberculosis ntrol	21426			10/29/22	
	maintain a comprel infection control pro current tuberculosis	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease					

If continuation sheet 59 of 69

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTITION TON NOMBER.	A. BUILDING:			
		00148	B. WING		C 09/16/2021	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	VEN CARE CENTER	INC	THWEST 3R			
		PINE ISL	AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 59	21426			
21426	Continued From page 59 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 mus be maintained by the nursing home.		t			
	by: Based on interview facility failed to cor skin test (TST) for	ent is not met as evidenced and document review, the nplete a two step tuberculin 1 of 6 residents (R10) and a two step TST for 1 of 6 staff.		Corrected		
	Findings include:					
	had an admission	rint date 9/15/21, showed R10 date of 6/8/21. Staff read the /22/21. However, a 2nd step recorded.				
		A's personnel file, DA-A's hire DA-A's file did not have record a two step TST.				
	(LPN)-E stated R1	5 a.m. licensed practical nurse 0 refused the first attempt to				
nesota De	epartment of Health ⁄I		6899	6EF511	If continuati	on sheet 60 o

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING		09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21426	administer the TST attempt. A third atte	age 60 but accepted the second empt should have been should have had a chest x-ray.	21426			
	(DON) stated she e their first step, of th admission. The res second step 14 day refused the TST, th completed. Staff we step TST upon hire	88 a.m. director of nursing expected residents received he two step TST, upon sident should receive their ys after the first. If a resident hen a chest x-ray needed to be ere expected to have their first with their second step mately 14 days after the first.				
	Tuberculosis dated hired employee is s	loyee Screening for 9/2019, indicated each newly screened for latent and active an employment offer has been ne employee's duty				
	Tuberculosis dated	ening Residents for 8/2019, indicated the facility idents for tuberculosis infectior	1			
	director of nursing review and/or revis procedures to ensu for physical signs a disease on admiss could educate the a policies/procedures	THOD OF CORRECTION: The (DON) or designee could e the current TB policies and ure all residents are screened and symptoms of active TB ion. The DON or designee appropriate staff on the s, and could develop a by auditing residents' charts to mpliance.				

Minneso	ota Department of He	alth			FORM	1 APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		00148	B. WING		C 09/16/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
		210 NORT	HWEST 3RD	STREET		
PINE HA	VEN CARE CENTER I	NC PINE ISLA	ND, MN 559	963		
(X4) ID		TEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF			(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETE DATE
21426	Continued From pa	ge 61	21426			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21530	MN Rule 4658.1310	0 A.B.C Drug Regimen Review	21530			10/29/21
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finand This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or su pharmacist. For pu upon" means the at report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to to if the medical direct physician. If the me the attending physic justification for the o	en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary Ioan object to frequent change. director of nursing services hysician, and these reports in by the time of the next conner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ing physician does not concur t's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter				

6EF511

If continuation sheet 62 of 69

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	00148	B. WING			09/16/2021	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
	INC					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
Continued From para must be referred for assessment and as by part 4658.0070. the medical director must refer the matt assessment and as This MN Requireme by: Based on interview facility failed to offer interventions prior to (PRN) psychotropion reviewed for unnector Findings include: R171's face sheet it to the facility on 9/8 included generalized moderate major de insomnia. R171's physician of Ativan (antianxiety by mouth every 8 h vomiting/withdrawa R171's progress no administration record through 9/11/21 ide Ativan, the record of administration how	nge 62 r review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist er directly to the quality ssurance committee. ent is not met as evidenced and document review the r/attempt non-pharmacologica to administration of as needed e medications for 1 of 5 (R171) essary medications indicated R171 was admitted a/21 with diagnoses that ed anxiety disorder, recurrent pressive disorder, and rder dated 9/8/21 indicated medication) 1 milligram (mg) ours as needed for intractable I for 3 days. otes and medication rd reviewed between 9/8/21 intified R171 was administered did not identify reason for ever indicated the medication	21530	Corrected	Υ)		
	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER VEN CARE CENTER (EACH DEFICIENC) REGULATORY OR L Continued From pa must be referred fo assessment and as by part 4658.0070. the medical director must refer the matt assessment and as This MN Requirem by: Based on interview facility failed to offe interventions prior t (PRN) psychotropio reviewed for unnec Findings include: R171's face sheet it to the facility on 9/8 included generalize moderate major de insomnia. R171's physician of Ativan (antianxiety by mouth every 8 h vomiting/withdrawa R171's progress no administration reco through 9/11/21 ide Ativan, the record of administration how was effective and of	OF CORRECTION IDENTIFICATION NUMBER: 00148 00148 PROVIDER OR SUPPLIER STREET AI 210 NOR PINE ISL VEN CARE CENTER INC 210 NOR PINE ISL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 62 Must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to offer/attempt non-pharmacologica interventions prior to administration of as needed (PRN) psychotropic medications for 1 of 5 (R171) reviewed for unnecessary medications Findings include: R171's face sheet indicated R171 was admitted to the facility on 9/8/21 with diagnoses that included generalized anxiety disorder, recurrent moderate major depressive disorder, and insomnia. R171's physician order dated 9/8/21 indicated Ativan (antianxiety medication) 1 milligram (mg) by mouth every 8 hours as needed for intractable vomiting/withdrawal for 3 days. R171's progress notes and medication administration necord reviewed between 9/8/21 through 9/11/21 identified R171 was administered Ativan, the record did not identify reason for administration however indicated the medication was effective and did not include documentation	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING O0148 B. WING	TO F DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 00148 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE VEN CARE CENTER INC 210 NORTHWEST 3RD STREET PINE ISLAND, NN 55963 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) precision Continued From page 62 21530 Continued From page 62 21530 This MN Requirement is not met as evidenced by: Corrected Based on interview and document review the facility failed to offer/attempt non-pharmacological interventions prior to administration of as needed (PRN) psychotropic medications for 1 of 5 (R171) reviewed for unnecessary medications Corrected Findings include: R171's face sheet indicated R171 was admitted to the facility on 9/8/21 with diagnoses that included generalized anxiety disorder, recurrent moderate major depressive disorder, and insormia. R171's progress notes and medication administration record reviewed between 9/8/21 through 9/11/21 identified R171 was administered Ativan (antianxiety medication) 1 milligram (mg) by mouth every 8 hours as needed for intractable vomiting/withdrawal for 3 days. R171's progress notes and medication administration however indicated the medication	TO FDEFICIENCIES (M) PROVDERSUPPLIERCLIA (A2) MULTIPLE CONSTRUCTION (A3) DATA OPTOPICIER 00148 B. WING (A) UNDERS PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VEN CARE CENTER INC 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 SUMMARY STATEMENT OF DEFICIENCIES 10 PREVIDE RECEDED BY FLL PREVIDERS PLAN OF CORRECTION (EACH OPENDEWY MUST REPRECIDED BY FLL) REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PREFX TAG PREFX CONSREPTENCED TO THE APPROPRIATE DEFICIENCY Continued From page 62 21530 21530 must be referred for review to the quality assessment and assurance committee required by part 4656,0070. If the eathending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. Corrected This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to offer/attempt non-pharmacological interventions prior to administration of as needed (PRN) psychotropic medications for 1 of 5 (R171) reviewed for unnecessary medications Corrected R171's face sheet indicated R171 was admitted to the facility on 9/8/21 with diagnoses that included generalized anxiety disorder, recurrent moderate major depressive disorder, and insomnia. R171's physician order dated 9/8/21 indicated Ativan, the record directori reviewed between 9/8/21 through 9/11/21 identiffed R171 was administered Ativan, the reco	

Minnesota Department of Health STATE FORM

6EF511

If continuation sheet 63 of 69

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		СОМ	E SURVEY PLETED C
		00148 B. W		B. WING		0 16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER I	NC	THWEST 3RD AND, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLET DATE
21530	Continued From pa	ge 63	21530			
	R171's Ativan order dated 9/8/21, was chang on 9/11/21; the order dated 9/11/21, indicated Ativan 1 mg by mouth every 12 hours as nee- for anxiety and/or vomiting for 14 days. The record did not identify why "withdrawal" symp was removed as justification for administratio R171's psychotropic Evaluation tool dated 9/11/21, had a checked box in response to th question, Does the resident have anxiety or nervousness that impairs his/her quality of life limits participation in activities. The Note Sec- included "currently has rx [prescription] for Ativan.". The evaluation indicated the mediati improved the residents' symptoms. The evaluation did not describe R171's anxiety or nervousness and did not identify non-pharmacological interventions.					
	R171's care plan di anxiety with goals c non-pharmacologic					
	behaviors for use o	/12/21, identified target f Ativan as 1. Nervousness 2. of care 3 nausea/vomiting.				
	through 9/14/21 ide Ativan, the record d administration, how was effective and d of non-pharmacolog or offered prior to a identified Ativan administration	tes and medication rd reviewed between 9/12/21 ntified R171 was administered id not identify reason for ever indicated the medication id not include documentation gical interventions attempted dministration. The record ministered on 9/12/21 at 8:07 5 p.m., and 9/14/21 at 8:33				

If continuation sheet 64 of 69

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00148		B. WING			C 16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	VEN CARE CENTER	INC	THWEST 3RD			
		PINE ISL	AND, MN 559	63		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	age 64	21530			
	nursing assistant (N	v on 9/15/21, at 10:02 a.m. NA)-G stated he had not ors and R171 did not display noticed.				
	During an interview on 9/16/21, at 8:44 a.m. registered nurse (RN)-D reviewed R171's record and verified the documentation did not identify how R171's nervousness/anxiety/withdrawal symptoms presented and stated the behaviors should be defined so they could be recognizable to staff. RN-D indicated the care plan did not identify non-pharmacological interventions that may help relieve anxiety symptoms and documentation did not reflect attempts of non-pharmacological interventions utilized or attempted prior to the administration.					
	nursing (DON) revie stated the target be the behaviors really anxiety differently. I medications should specifically prescrib and attempt non-ph first, documentation interventions were	y on 9/16/21, director of ewed R171's record and ehaviors does not identify what y are, and everybody displayed DON stated as needed d be given for what they are bed for and staff should offer narmacological intervention n should identify which used and if which ones were resident refused then the e documented.				
	director of nursing (review and revise p managment of psyd director of nursing (system to educate system to ensure a	THOD OF CORRECTION: The (DON) or designee could policies and procedures for the chotropic medications. The or designee could develop a staff and develop a monitoring is needed psychotropic are opriately The quality				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	- (X3) DATE COMP	
		00148	B. WING			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3R AND, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 65	21530			
	assurance commit measures to ensur	tee could monitor these e compliance.				
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty One				
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610			10/29/27
	must store all drugs under proper temp	e of drugs. A nursing home s in locked compartments erature controls, and permit rsing personnel to have				
	by: Based on observat review, facility faile were properly label	ent is not met as evidenced ion, interview and document d to ensure that medications led and secured for 1 of 2 served for self-administration plized medications.		Corrected		
	Findings include:					
	(EHR) Admission F	electronic health record Record/face sheet, R54 had hysema, acute and chronic and heart failure.				
	could self-administ meter dose inhaler	I/2020 physician order, R54 er nebulized medications and s once set up by the nurse. No r R54 to keep medications at				
		the EHR had a focus problem at indicated R54 could				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00148	B. WING	B. WING		C 16/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PINE HA		INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	ige 66	21610			
		dications; however, the care e R54 could keep medications				
	On 9/14/21, 2:20 p.m. R54 stated she was able to self-administer medications and she had last taken a dose of her medication at noon. An empty medication of aerosol solution was observed lying next to, and behind the nebulizer. An unopened container of respiratory medication for aerosolization was laying on the counter as well, and R54 stated the nurse left it so she could take it whenever she got short of breath, and she would not have to call the nurse. The plastic vial did not have a pharmacy label attached with any directions and did not have R54's name on it. A manufacture's stamp on the plastic vial indicated it contained Ipratropium-Albuterol Solution. R54 confirmed she did not need the medication at that time.					
	registered nurse (R medication vial in R did not need an as	erview 9/14/21, 2:27 p.m. a N-C) confirmed he had left the S4's room even though she needed (PRN) dose at that he was able to leave it there ws how to use it."				
	the unit manager st medications at a re RN-D, if a resident medication, the nur in at the time it is of PRN the nurse mus not before. RN-D st	9/15/21, 10:28 a.m. RN-D, tated a nurse was not to leave sident's bed side. According to can self-administer a se must bring the medication rdered or if the order is for st bring it in when needed and aid, leaving a medication at				
	at the proper time. provide the next PF	It in the dose not being taken Another nurse could potentially RN or scheduled dose too ack doses." RN-D stated the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00148	B. WING			C 16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PINE HA	VEN CARE CENTER	INC	THWEST 3RD AND, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	age 67	21610			
		the medication in when locument the time the PRN				
	A review of R54's medication administration record (MAR) for 9/14/21 showed RN-C documented giving R54 a scheduled dose of Ipratropium-Albuterol at 8:00 a.m. and at noon. No PRN dose of Ipratropium-Albuterol was documented on 9/14/21 and none were documented on R54's MAR since 9/10/21. The nurse for the evening shift on 9/14/21 documented administering the 4:00 p.m. dose, but no PRN dose.					
	director of nursing self-administer med physician's order a being able to do so not to be left at bec order, and the facili place to store the n medications must b	erview 9/15/21, 11:05 a.m. the (DON) stated residents could dications if they had a nd had been assessed as b. DON said medications were lside unless there was an ity had provided them a safe nedications. DON indicated be appropriately labeled with e and a pharmacy label if kept				
	November 2020 ind used in the facility a compartments und and humidity contro prepare and admin to locked medication have missing, income	dications policy revised dicated "drugs and biologicals are stored in locked er proper temperature, light ols. Only persons authorized to ister medications have access onsDrug containers that mplete, improper, or incorrect to the pharmacy for proper				
		THOD OF CORRECTION: rsing (DON) or designee could				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		с		
		00148	B. WING			16/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
INE HA	VEN CARE CENTER	INC	RTHWEST 3RD AND, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21610	Continued From pa	age 68	21610				
	storage of medicat resident bedside. I residents with self- ensure that medica unsupervised wher	n the facility policies for safe ion, specifically storage at DON or designee could audit administration orders to ations are not left with them n not appropriate. R CORRECTION: Twenty one					