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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6EF5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/17/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 12/02/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/02/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/19/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6EF5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

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(L1) **245359**

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

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(L3) **PINE HAVEN CARE CENTER INC**
(L4) **210 NORTHWEST 3RD STREET**
(L5) **PINE ISLAND, MN** (L6) **55963**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/16/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 11/08/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/12/2021 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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: 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.

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	**210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 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 was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 09/13/2021 through 09/16/2021, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5359065C (MN67309) with a deficiency cited at 725 H5359071C (MN48800) with no current deficiencies cited due to actions implementd by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED:H5359066C (MN71083), H5359064C, (MN73478), H5359067C (MN59840), H5359068C (MN68715), H5359069C (MN63604), H5359070C (MN63692).	F 000		

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

Electronically Signed | 10/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	**210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	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. 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 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(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. §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 promote the rights of the resident. §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		10/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal care assistance to promote dignity for 1 of 2 female residents (R49) who depended on staff for assistance with shaving facial hair. R49's significant change Minimum Date Set (MDS) completed 8/6/21, indicated R49's cognition was severely impaired. R49 was dependent on physical assistance from staff for all activities of daily living (ADLs) including personal hygiene and grooming. R49's face sheet printed on 9/15/21, indicated R49's diagnoses included depression, dementia, and Alzheimer's. R49's care plan last review date 6/25/21, indicated R49 required total assistance with personal hygiene which included shaving facial hair.	F 550	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, 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 Community to ensure that all residents are treated with dignity. Resident R49 was shaved on 10/12/2021. 2.This has the potential to affect all 69	

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	245359	A. BUILDING _____ B. WING _____	C 09/16/2021

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F 550	Continued From page 3 On 9/13/21, at 12:25 p.m. R49 was observed seated in her wheelchair in her room. R49 had greater than 30, coarse, white hairs that were 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, white hairs that were approximately 1/4 inch in length on her chin and upper lip. On 9/15/21, at 7:31 a.m. nursing assistant (NA)-D and registered nurse (RN)-H were observed assisting R49 with morning cares. R49 was assisted out of bed, into her wheelchair. RN-H washed R49's face and dried it. NA-D combed R49's hair then brought R49 to the dining room. Neither NA-D nor RN-H offered to assist R49 with shaving her facial hair. On 9/15/21, at 7:43 a.m. NA-D stated R49 required full physical assistance from staff for personal hygiene and grooming which included shaving facial hair. NA-D stated he had never assisted a female resident with facial hair but would do it if it was needed. NA-D confirmed he did not check R49's face with morning cares and that R49 did have a shaver in her room. NA-D observed R49 in the dining room then confirmed R49 had long, coarse, white hairs on her chin and upper lip, "Yeah, there's a lot there." On 9/15/21, at 8:18 a.m. RN-J confirmed R49 had several coarse, long, white hairs on her chin and upper lip. RN-J stated she expected residents were assisted with shaving facial hair as needed. RN-J stated, "There are a lot who	F 550	residents in the facility. All residents were reviewed to ensure they were shaved and that they had a functional shaver by 10/22/2021. If a resident was found to be in need of a shaver the Nursing Management or designee will be contacted to ensure one was provided. 3.Staff re-education will be completed with nursing staff on 10/21/2021 and 10/25/2021 to ensure residents are having shaving of facial hair completed. 4.Audits will be performed at to ensure compliance with resident dignity and residents are properly groomed by Nursing Management or designee daily x 10 days, then weekly x 6, then monthly x 1. Results will be reviewed by our Quality committee for further recommendation	

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F 550	Continued From page 4 have long chin hairs, we aren't doing it and staff are in a hurry." RN-J indicated she would feel embarrassed and uncomfortable if she was around other residents and had long facial hair. On 9/15/21, at 8:56 a.m. RN-H stated if R49 was able to speak for herself, she would be bothered having long facial hair when around other residents and visitors. On 9/15/21, at 10:29 a.m. director of nursing (DON) stated she expected facial hair was taken care of on bath days and as needed in between. DON expected female residents received assistance with shaving facial hair for dignity, "I would anticipate if they were to see themselves in the mirror, the whiskers would not be acceptable to them." DON compared it to herself walking out of the house without her hair being combed. Facility policy, "Dignity" revision date 2/2021, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction in life, and feelings of self-worth and self-esteem.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		10/29/21

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F 623	Continued From page 5	F 623		

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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F 623	Continued From page 6	F 623		

including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 7 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide written hospital transfer notices to the resident and/or resident's representative who had a facility-initiated transfer 1 of 1 resident (R48) reviewed for hospitalizations. Findings include: R48's progress note dated 8/13/21, at 10:30 a.m. indicated R48 was transferred to the emergency at 10:30 a.m. due to an increase in shortness of breath. R48's medical record lacked evidence of notification and/or reason regarding transfer. During an interview on 9/16/21, at 10:15 a.m. social services designee (SSD), licensed social worker (LSW), and registered nurse (RN)-A, indicated the facility had not been providing residents and/or resident's representatives written hospital transfer notices. During an interview on 9/16/21, at 11:42 a.m. director of nursing (DON) was not aware a written reason for transfer was not being provided, stated nursing should have been providing that information.	F 623	1.It is policy of Pine Haven Community to ensure that all residents and/or responsible party receive written hospital transfer notices. Resident R48 was discharged from the facility on 09/17/2021. 2.This has the potential to affect all 69 residents in the facility. 3.Staff re-education will be completed with nursing staff to ensure that the reason for transfer is on the bed hold form on 10/21/2021 and 10/25/2021. 4.Audits will be performed at to ensure compliance with written transfer notices be given to residents and/or responsible party by Nursing Management or designee daily x 10 days, then weekly x 6, then monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		10/29/21

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a comprehensive care plan was developed for urinary indwelling catheter for 1 of 1 resident (R61) reviewed for catheters. Findings include: During an observation on 9/13/21, at 2:55 p.m. R61 laid in bed, R61 was observed to have a 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, also did	F 656	1.It is policy of Pine Haven Community to ensure that all residents have a comprehensive care plan for indwelling catheters. Resident R61 was discharged from the facility on 10/04/2021. 2.This has the potential to affect all 69 residents in the facility. All residents with indwelling catheters were reviewed to ensure there were comprehensive including indwelling catheters on 10/22/2021. 3.Staff re-education will be completed with licensed nurses to ensure comprehensive care plans including indwelling catheter on 10/21/2021 and 10/25/2021. 4.Audits will be performed to ensure compliance with care plans including indwelling catheters by Nursing Management or designee daily x 10 days, then weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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not identify the size and type of catheter R61 required.

R61's current physician orders did not identify an order for an indwelling catheter. The physician order dated 8/15/21, directed staff to change R61's catheter every 30 days.

R61's treatment administration record indicated R61's catheter was changed on 8/30/21.

R61's record did not identify what size or type of catheter was inserted, nor the size of the balloon.

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 the type.

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

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F 656	Continued From page 11 identify the type or balloon size. LPN-A indicated there was not a way to tell if R61 had the correct catheter in place. During an interview on 9/16/21, at 11:44 a.m. director of nursing (DON) stated a catheter required a physician's order that identified the size and type of catheter and balloon size and there should have been an order obtained prior to changing the catheter. Facility policy Care plans, Comprehensive Person Centered policy dated 12/2016, included, The care plan interventions are derived from a thorough analysis of the information gathered as part of a thorough comprehensive assessment. The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Iincorporate identified problem areas, reflect treatment goals, timetables, and objectives in measurable outcomes. The comprehensive, person centered care plan is developed within seven days of the completion of the required MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		10/29/21

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F 657	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure revision of the care plan for activities of daily living (ADLs) after the completion of significant change Minimum Data Set (MDS) was completed for 1 of 2 (R175) residents reviewed for bowel and bladder. Findings include: R175's Restorative Nursing Screener dated 7/14/21, indicated R175 was independent with bed mobility and required supervision or touching assistance for transfers. R175's care plan for mobility/positioning/locomotion dated 5/11/20, included "Transfers/ambulation with FWW [front	F 657	1.It is policy of Pine Haven Community to ensure that all residents care plans are reviewed and revised after an MDS is complete or significant change for ADL in relation to bowel and bladder. Resident R175 care plan will be updated by 10/22/2021. 2.This has the potential to affect all 69 residents in the facility. All residents care plans will be reviewed by 10/22/2021 to ensure they reflect current ADL for bowel and bladder. 3.Staff re-education will be completed for licensed nursing staff on 10/21/2021 and 10/25/2021 on Pine Haven policy on updating and revising care plans for significant changes are addressed and	

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F 657	Continued From page 13 wheeled walker] and gait belt. Use wheelchair for longer distances outside of room." R175's care plan for transfers dated 5/11/20, indicated R175 required assist of one for use with FWW. R175's dressing care plan dated 4/2/21, indicated assist of one. R175's significant change MDS dated 8/23/21, indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R175's care plan did not identify the level of assistance in accordance with the MDS. During an observation on 9/14/21, at 12:32 p.m. R175 sat in her wheelchair in front of the nursing station. Nursing assistant (NA)-A asked licensed practical nurse (LPN)-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy; LPN-D called therapy and stated to NA-A, R175 required two assist with a gait belt and a walker. NA-A wheeled R175 into her room, NA-D followed into the room. NA-A put a gait belt around R175, NA-A and NA-B attempted to assist R175 to a standing position, however, R175 was not able to stand up and was not cooperative with the NAs. At 12:38 p.m. LPN-D entered the room to try and assist NAs with transferring R175 to bed. NA-A and LPN-D attempted to assist R175 to a standing position and again R175 was not able to stand up and LPN-D stated he was going to go get a physical therapist to assist. At 12:49 p.m. NA-A pushed in a full body mechanical lift into R175's room, PT-A entered the room. PT attempted to stand R175 up with NA-A and NA-B however, R175 was not	F 657	individual care plans are revised as necessary. 4.Audits will be completed to ensure any significant changes are addressed in the care plan to ensure individual care plans are revised as necessary by Nursing Management or designee daily x 10, then weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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F 657	Continued From page 14 able to stand, PT-A then instructed to use the mechanical lift. PT-A and NAs then transferred R175 into bed using the full body mechanical lift. During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) reviewed R175's record, DON indicated R175's mobility had changed within the last month. DON verified the care plan was inconsistent with the significant change MDS and should have been revised. Facility policy Care plans, Comprehensive Person Centered policy dated 12/2016, included, The care plan interventions are derived from a thorough analysis of the information gathered as part of a thorough comprehensive assessment. The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Incorporate identified problem areas reflect treatment goals, timetables and objectives in measurable outcomes. The comprehensive, person centered care plan is developed within seven days of the completion of the required MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 677	1.It is policy of Pine Haven Community to	10/29/21

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F 677	Continued From page 15 review the facility failed to follow the care plan for 1 of 2 residents (R175) reviewed for bowel and bladder. In addition, the facility failed to ensure grooming assistance was provided to 2 of 2 residents (R64, R49) who were dependent on staff for shaving. R175 toileting R175's face sheet dated 9/16/21, included diagnosis of dementia with behavioral disturbance and muscle 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. R175's toileting care plan dated 9/1/20, directed staff to toilet R175 upon rising, after breakfast, before and [after] all other meals, at bedtime, on night rounds, and as needed. During an observation on 9/13/21, at 7:40 p.m. R175 laid on her back in bed. R175's room smelled of urine. RN-H and unidentified nursing assistant were at bedside encouraging R175 to roll over to allow them to change her saturated incontinent garment. R175's mattress protectors were observed to also be urine soaked. During an observation on 9/14/21, at 7:00 a.m. R175 sat in her wheelchair in a hospital gown. At 7:50 a.m. licensed practical nurse (LPN)-D stated R175 had been in the wheelchair all night because she had been restless, stated an unawareness of the last time R175 had been	F 677	ensure that all residents□ ADL care is provided for Dependent residents. R175 bowel and bladder was reviewed to ensure it was meeting resident□s needs. Resident R49 and R64 grooming assistance were reviewed to ensure we were meeting the resident□s needs by 10/22/2021. 2.This has the potential to affect all 69 residents. All residents were reviewed to ensure we were meeting residents needs in regard to bowel and bladder and to ensure grooming assistance was being met as well. 3.Staff re-education will be completed with nursing staff to ensure toileting plans are being followed and grooming assistance on 10/21/2021 and 10/25/2021. 4.Audits will be performed by Nursing Management or designee to ensure toileting plans are being followed and grooming assistance daily x 10 days, then weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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toileted or changed.

During an observation on 9/14/21, at 8:50 a.m. R175 was given her breakfast tray. At 9:27 a.m. R175 continued sit in her wheelchair by the nursing station with her breakfast in front of her.

During an observation on 9/14/21, at 12:20 p.m. R175 remained by the nursing station. At 12:32 NA-A asked LPN-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy. NA-A was asked when R175 had last been toileted, NA-A stated the last time was between 6:00 a.m. and 7:00 a.m. when she assisted the night shift aide. At 12:49 p.m. R175 was transferred via full body mechanical lift to her bed by NA-A and NA-B. When NA's exposed R175's incontinent garment it was observed to be heavily saturated with urine. NA-A stated R175 had not been toileted since 6-7:00 a.m. that morning.

During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) stated the expectation was residents were toileted in accordance with their care plan. DON stated if residents refused, the expectation was the nurse be notified, and ultimately the physician if necessary for further medical intervention.

R64 Shaving

R64's admission MDS dated 8/19/21, indicated R64's cognition was intact. R64 required extensive physical assistance from staff for all activities of daily living (ADLs), including personal hygiene.

R64's face sheet printed 9/16/21, indicated R64's diagnoses included degenerative disease of the nervous system, type 2 diabetes mellitus, and

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F 677	Continued From page 17	F 677		

chronic kidney disease.

R64's care plan, last review date 8/12/21, indicated R64 required assist of one staff with personal hygiene which included shaving facial hair.

Record reviewed for 8/16/21 through 9/14/21, of R64's Point-of-Care (POC) Tasks documentation for section labeled, "Personal Hygiene: Self Performance - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands", indicated resident needed extensive assist of one staff.

On 9/13/21, at 5:11 p.m. R64 was observed in the hallway as she was escorted in her wheelchair by staff. R64 had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip.

During observation and interview on 9/14/21, at 8:31 a.m. R64 was sitting in her bed in her room. R64 acknowledged that she had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip, and they were due to her hormone levels. R64 stated that she had always shaved them every other day and she wanted staff to assist her.

On 9/15/21, at 7:48 a.m. R64 was sitting in her bed in her room and acknowledged she had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip.

On 9/16/21, at 1:03 p.m. nursing assistant (NA)-B stated if she had seen too many whiskers on a

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resident, she would have shaved the resident. NA-B further stated she had not assisted R64 very much and had not noticed any whiskers on R64.

On 9/16/21, at 1:35 p.m. NA-I stated shaving is considered a part of daily grooming care. NA-I further stated if a female resident had a lot of whiskers, assistance shaving should have been provided.

R49 Shaving

R49's significant change MDS completed 8/6/21, indicated R49's cognition was severely impaired. R49 was dependent on physical assistance from staff for all activities of daily living (ADLs) including personal hygiene.

R49's care plan last review date 6/25/21, indicated R49 required total assistance with personal hygiene which included shaving facial hair.

R49's face sheet printed on 9/15/21, indicated R49's diagnoses included depression, dementia, and Alzheimer's.

On 9/13/21, at 12:25 p.m. R49 was observed seated in her wheelchair in her room. R49 had greater than 30, coarse, white hairs that were 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.

On 9/15/21, at 7:31 a.m. nursing assistant (NA)-D

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and registered nurse (RN)-H were observed assisting R49 with morning cares. R49 was assisted out of bed, into her wheelchair. RN-H washed R49's face and dried it. NA-D combed R49's hair then pushed R49 to the dining room. Neither NA-D nor RN-H offered to assist R49 with shaving her facial hair.

On 9/15/21, at 7:43 a.m. NA-D stated R49 required full physical assistance from staff for personal hygiene and grooming which included shaving facial hair. NA-D stated he had never assisted a female resident with facial hair but would do it if it was needed. NA-D confirmed he did not check R49's face with morning cares and that R49 did have a shaver in her room. NA-D observed R49 in the dining room then confirmed R49 had long, coarse, white hairs on her chin and upper lip, "Yeah, there's a lot there."

On 9/15/21, at 8:56 a.m. RN-H confirmed R49 had several coarse, long, white hairs on her chin and upper lip. RN-H expected female residents who require physical assist with shaving facial hair, received the assistance as needed. RN-H stated she noticed R49's facial hair when she assisted with morning cares and R49 had a shaver in her room, "it was right in front of my eyes."

On 9/15/21, at 10:29 a.m. director of nursing (DON) stated she expected facial hair was taken care of bath days and as needed in between.

Facility policy, "Shaving a Resident" revised 2/2018 provided direction for how to assist a resident with shaving but did not address the frequency. According to the policy, the purpose of the procedure was to promote cleanliness and to

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F 677	Continued From page 20 provide skin care.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate assessment, monitoring and physician notification were completed for 3 of 3 residents (R48, R36, R44). This resulted in actual harm when R48 required re-hospitalization with fluid overload resulting in respiratory failure and acute on chronic congestive heart failure. Findings include: R48's facility face sheet identified R48 was admitted to the facility on 7/30/21, with diagnoses of heart failure, chronic obstructive pulmonary disease, and hypercapnic respiratory failure. R48's physician visit dated 7/30/21, included R48 had leg swelling and his weight was 333.8 lbs. (pounds). Plan was to continue Lasix 40 milligrams [mg], will adjust if needed, nursing to monitor weight, Check daily weight notify provider if gain 2 lbs. in a day or 5 lb. in a week.	F 684	1.It is policy of Pine Haven Community to ensure that all residents ensure appropriate assessment, monitoring and physician notification for fluid overload resulting in respiratory failure and acute or chronic congestive heart failure. Resident 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 being followed for respiratory failure and for chronic congestive heart failure. 2.This has the potential to affect all 69 residents and all residents with the diagnosis of CHF were reviewed to ensure compliance with our policy 3.Staff re-education will be completed with licensed nursing staff to ensure that orders for residents with fluid imbalance and ensure they are clear and understandable and to ensure compliance of proper daily weights, edema monitoring, documentation of fluid intake	10/29/21

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F 684	Continued From page 21 R48's physician orders reviewed, included the following -Daily weights, notify physician for weight gain over 2 lbs. (pounds) in a day OR 5 lbs. in a week (start date 8/2/21) -Lasix 40 mg (milligrams) one time a day for congestive heart failure (start date 7/31/21) -Occupational therapy wrap bilateral lower extremities Monday through Friday (start date 8/6/21) 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. R48's admission Minimum Data Set (MDS) dated 8/6/2021, identified R48 did not have cognitive impairment, required extensive assistance of two or more staff members for activities of daily living that involved mobility and extensive assist of one staff for personal hygiene and dressing. The MDS indicated R48 was administered diuretic medications. R48's care plan dated 8/6/21, indicated R48 had a diagnoses of congestive heart failure with corresponding interventions, compression stockings on in the morning off and night, physician to assess medication program periodically, medications as ordered, staff to observe for signs and symptoms of increased edema, significant weight changes, increase shortness of breath/new shortness of breath, and notify physician as needed, and weight at least weekly, or as ordered by physician, notify physician of significant weight gain. R48's record indicated on 8/6/21, physician	F 684	and proper reporting on 10/21/2021 and 10/25/2021 to include fluid balance issues, edema monitoring and documentation. 4.All residents with the diagnosis of CHF will have orders and care plan audited by Nursing Management to ensure orders for residents with fluid imbalance and ensure they are clear and understandable and to ensure compliance of proper daily weights, edema monitoring, documentation of fluid intake and proper reporting daily x 10, then weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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ordered a chest X-ray to rule out tuberculosis. R48's chest X-ray results on 8/11/21, indicated R48 had patching opacification (air in lungs replaced with other material such as fluid or bacteria) in the right lower lobe, and small pleural effusion (water on the lungs). The report also included " Patchy right lower lobe infiltrate is seen, follow up exam recommended)."

R48's weight record identified over 2 lb. weight gain in a day without evidence of physician notification per physician order.
-On 8/3/21, weight was 330.4 lbs.
-on 8/4/21, weight was 334.2 lbs.
-On 8/5/21, weight was 339.0 lbs.
-On 8/7/21, weight was 343.0 lbs.
-On 8/9/21, weight was 343.0 lbs.
R48's record lacked evidence of daily weights on 8/10/21, 8/11/21, 8/12/21, and 8/13/21.

R48's progress note dated 8/13/21, at 7:39 a.m. included, "Resident had a sudden onset of shortness of breath around 4:00 a.m. Resident appeared pale/cyanotic. Resident initially had head of bed elevated, and oxygen increased to 3 liters per minute (LPM). Lung sounds clear/diminished. Vital signs: blood pressure 146/85, Pulse of 90, respirations 28, and oxygen saturations 80%. Resident requested to be placed in a tripod position, fellow nurse assisted to position, and one on one supervision initiated. Resident refused ambulance services. Symptoms resolved approximately 30 minutes after onset. Resident requested to be put back to bed with head of bed elevated. Every one-hour checks initiated, morning staff notified of incident and sent physician notification."

R48's progress note dated 8/13/21, at 10:30 a.m.

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indicated R48 was transferred to the hospital via ambulance related to shortness of breath and low oxygen saturations.

R48's discharge summary dated 8/25/21, indicated primary diagnosis for admission was hypercarbic (increase in carbon dioxide in the bloodstream)respiratory failure and acute on chronic congestive heart failure. The summary indicated between hospital discharge on 7/25/21 and hospital admission on 8/13/21, R48 had an 8.8 lb. weight gain. The summary indicated 1.5 liters of fluid was removed from R48's lungs. The discharge summary included new orders to change diuretic from Lasix to Torsemide and add 2-liter fluid restriction.

R48's physician orders between 8/25/21 to 9/13/21 included:
-Daily weights, notify physician for weight gain over 2 lbs. in a day OR 5 lbs. in a week (start date 8/25/21)
-Fluid Restriction: 2 Liter-Document in progress note with total 24-hour fluids consumed (Start Date 8/25/21)
-Torsemide 60 mg one time a day related to heart failure (start date 8/25/21)
-Compression Stockings: Donn in a.m. prior to getting out of bed. Remove in evening once in bed (start date 8/25/21)

R48's weight record was reviewed from 8/25/21 to 9/13/21; record lacked physician notification in accordance with physician orders until 9/7/21.
-On 8/25/21, weight was 303.0 lbs.
-On 8/26/21, weight was 308 lbs.
-On 8/28/21, weight was 307.2 lbs.
-On 9/2/21, weight was 310.0 lbs.
-On 9/3/21, weight was 312.6 lbs.

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F 684	Continued From page 24 -no weight was recorded on 9/4/21 according to physician's orders -On 9/5/21, weight was 315.0 lbs. -On 9/7/21, weight was 315.0 lbs. R48's physician notification dated 9/7/21, indicated R48 had a 13 lb. weight increase since 8/31/21 with no other symptoms. The note indicated R48 had +2 pitting edema to both lower extremities. The note also included, He does have some complaints of shortness of breath with exertion but is able to catch his breath when at rest. Lungs are clear bilaterally anterior and posterior. R48's fluid intake record was reviewed along with nursing progress notes for the 24-hour fluid intake evaluation. Fluid intake was not consistently documented every shift; with the lack of documented intake on the 24-hour fluid intake it could not be calculated/reviewed in accordance to the fluid restriction. R48's record identified between 9 different shift when R48's fluid was not monitored or documented from 8/25/21 to 9/13/21. During an observation and interview on 9/13/21, at 1:43 p.m. R48 sat up in his wheelchair. R48 stated he was in the hospital a couple of weeks ago for fluid overload and they had removed 24 liters of fluid. R48 stated when he got back from the hospital, he weighed 303 lbs. but was back up again to 315 lbs. R48 stated before he went to the hospital, he had been around 330 to 335 lbs. R48 stated he had felt so much better after all the fluid was removed, and thought it had steadily progressing over time, and indicated he would have to pay closer attention to his weight gains.	F 684		

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During an interview on 9/15/21, at 8:24 a.m. medical director stated there were clear expectations nursing notify the physician when there was a weight gain in accordance with physician order. Medical director indicated the most objective measurement for fluid volume monitoring is weight gain. Medical director stated nursing needed to be monitoring/evaluating edema for the effectiveness of the treatments and medications.

During an interview on 9/15/21, director of nursing (DON) stated she expected the physician be notified of weight gain in accordance with physician orders. DON stated the expectation of monitoring edema daily and findings documented accurately. DON stated if there was a weight gain, an evaluation needed to be done to determine if the weight gain was related to fluid, the evaluation should include a complete respiratory assessment, resident interview, and assessing for edema in extremities, hips, and abdomen. DON indicated if there was a change the physician needed to be notified. DON stated the episode of shortness of breath should have been documented in its entirety with a complete assessment and passed along in shift report for continual monitoring.

R36

R36's face sheet indicated R36 was admitted to the facility on 7/20/21, with diagnoses of congestive heart failure, chronic kidney disease stage 4, and hyperkalemia.

R36's hospital discharge summary dated 7/20/21, indicated R36 was admitted in part related to fluid

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overload with a primary diagnosis of hyperkalemia (high potassium) and had a history of hospitalization for heart failure exacerbation with the last visit in May 2021. The discharge summary included, "would recommend short term rehab to allow for closer monitoring of his weights/fluid status to determine appropriate dosing of diuretic in the outpatient setting." The summary indicated R36's dry weight of 303.6 lbs. The discharge summary also included an order for daily weights with close monitoring.

R36's physician orders included:
-Daily weights notify physician for weight gain of over 2 lbs. in a day or over 5 lbs. in a week (start date 7/23/21).
-Lasix (diuretic medication) 10 mg (milligrams) in the morning for fluid retention's (start date 7/23/21).

R36's care plan dated 7/25/21, identified R36's diagnosis of congestive heart failure. Associated interventions included, elevate feet when sitting up in chair to help prevent dependent edema, monitor for signs and symptoms of hypovolemia/hypervolemia [medical condition when you have too little/too much fluid in your body], monitor/document/report to MD as needed the following signs/symptoms: Edema; weight gain of over 2 lbs. a day; neck vein distention; difficulty breathing; increased heart rate; elevated blood pressure; skin temperatures; monitor breath sounds for crackles.

R36's physician visit dated 8/27/21, indicated R36's weight was stable on low dose of Lasix; weight was 299.6 lbs. and on admit on 7/20/21 was 298 lbs.

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R36's weight record reviewed between 8/27/21 and 9/13/21, identified an increase in weight over 2 lbs. in a day or over 5 lbs in a week; record lacked evidence of physician notification.
R36's weights included:
-On 8/28/21, weight was 302.2 lbs.
-On 8/30/21, weight was 302.8 lbs.
-On 8/31/21, weight was 304.2 lbs.
-On 9/3/21, weight was 306.6 lbs.
-On 9/4/21, weight was 308.0 lbs.
-On 9/6/21, weight was 308.4 lbs.
-On 9/7/21, weight was 310.0 lbs.
-On 9/9/21, weight was 313.4 lbs.
-On 9/11/21, weight was 315.0 lbs.
-On 9/12/21, weight was 315.4 lbs.
-On 9/13/21, weight was 314.2 lbs.

During an observation on 9/13/21, at 3:21 p.m. R36 sat in his wheelchair with his feet down on the floor. R36 was wearing regular cotton socks and was observed to have edema from ankle to just below the knee. R36 stated he had a history of congestive heart failure and had been in the hospital for it.

During an observation and interview on 9/14/21, at 8:13 a.m. R36 sat in his recliner with his feet elevated. R36 was observed to have edema in both legs from ankle to just below the knee. R36 stated that he had not slept very well last night, he woke up short of breath and indicated he called for staff to assist him to his recliner. R36 stated the shortness of breath resolved once he was sitting up. R36 stated, "according to my doctor the fluid in my legs is making it hard for me to breath."

R36's progress note dated 9/14/21, at 3:56 a.m. did not address R36's episode of shortness of

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breath and indicated R36 did not have edema present. R36's documented oxygen saturations were 90% on room air, which was below R36's average of 93-98%.

During an interview on 9/14/21, at 12:05 p.m. licensed practical nurse (LPN)-D was asked, how often do you measure edema, LPN-D stated he had never measured edema while working at this facility, stated he would only measure the edema if the resident had ace wraps or if physical therapy had reported concerns of edema.

During an observation and interview on 9/14/21, at 12:11 p.m. LPN-D entered R36's room, R36 was sitting in his wheelchair with his feet down on the floor. LPN-D requested permission to evaluate edema; R36 consented. LPN-D stated R36 had 2+ pitting edema around both right and left ankles and 3+ to 4+ edema from lower shin to just below the knee on both legs. Although, R36's progress note dated 9/14/21, at 12:32 p.m. entered by LPN-D, reflected R36 had "No edema present" even though LPN-D had evaluated the edema at 12:11 p.m. in the presence of the surveyor.

R44

According to R44's electronic health record (EHR) admission record/face sheet included diagnosis of chronic congestive heart failure, cardiomyopathy (damaged heart muscle), high blood pressure, chronic obstructive pulmonary disease, shortness of breath, a dependence on supplemental oxygen and a history of pleural effusion (fluid in lungs).

R44's quarterly Minimum Data Set (MDS) assessment dated 7/30/2021, R44's primary medical condition was considered to be a

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F 684	Continued From page 29 "medically complex condition." R44's physician orders instructed nursing staff to monitor and evaluate R44 for fluid overload and reduce the risk of fluid overload. The following orders included: 2 L (liters) fluid restriction-document total consumed each shift. NOC (night shift) will total every day shift, Document progress note with total 24 hour fluids consumed; Daily weights-->notify provider if >189 lbs in the morning; Document progress note on edema location, pitting edema noted, skin intact (fluid weeping) lung sounds, weight, CNP [certified nurse practitioner] followed up on 8/13/21 and increased torsemide [diuretic]. Edema to BLE [bilateral lower extremities]. Every evening shift until resolved, Wrap legs daily with ACE bandages on in am and off at HS [bedtime]. R44's orders also included medications to control heart, blood pressure and to relieve edema: Metoprolol succinate capsule ER 24 hour sprinkle 25 mg, give 12.5 by mouth in the morning, Spironolactone tablet, give 50 mg by mouth one time a day, Torsemide tablet 20 mg, give 40 mg by mouth two times a day. R44's Torsemide dose had increased on 8/13/21 from 20 mg to 40 mg and increased again on 8/16/21 to be taken twice a day instead of once per day. . A review of R44's daily weight was not recorded on 9/3, 9/5, 9/10 or 9/11. On 9/12, 9/13 and 9/14 his weight exceeded 189 pounds.	F 684		

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A physician order dated 8/14/21 included instructions for a progress note to be written daily on R44's edema location, pitting edema noted, skin intact (fluid weeping), lung sounds and weight. A review of R44's record for September identified missing progress notes for
9/9/21-9/11/21 no note related to edema, weight, or lung sounds
9/12/21-"weight was taken after lunch. Will reweight [sic] tomorrow and reassess. Resident is asymptomatic." No additional information related to edema or lung sounds.
9/13/21-no note related to edema, weight, or lung sounds
9/14/21 at 3:42 p.m. "assessment conducted: resident is alert and oriented x3, oxygen levels 92-93% on 1 L, wheezing auscultated bilaterally, 4+ edema of R and L extremities. Weight for today 190.2 lb. Nurse manger notified of change in weight, ACE wrap applied, resident left building for scheduled appointment."

On 9/14/21, at 8:19 a.m. R44 was observed lying in bed in his room, resting. His facial appearance and limbs was red and flushed. A one liter jug of ice water was noted to be sitting at his bedside. An oxygen concentrator was beside the bed and was running, but R44 did not have a nasal cannula in his nose.

On 9/14/21, at 8:43 a.m. R44 was observed sitting on the side of his bed. His legs were bare and swollen from the knees down. R44 had difficulty speaking, but was able to communicate through short phrases, gestures, some writing and answering yes, no questions. He indicated he had noticed his legs were swollen and gestured to show they were getting bigger. He also tapped on his abdomen. He indicated his legs should be

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wrapped. His hands were slightly swollen and he held them up to be seen.

On 9/14/21, 12:03 p.m. R44 was observed to be lying in bed with his legs bare. Registered nurse (RN)-C entered the room with two elastic compression wraps and informed R44 he should have his legs wrapped before going out for the day. RN-C started wrapping R44's right leg at the toes and performed a figure eight wrap. He asked, "do you like it tight? No, just a little loose?" After reaching R44's knee, there was a considerable amount of wrap still on the roll, so RN-C proceeded to wrap the leg back down to the ankle. Following the right leg, RN-C wrapped the left leg in the same manner. RN-C stated the wraps were too long, and that he should have gone to find different wraps; however, RN-C did not go find any other wrap.

At 9/14/21, 12:15 p.m. R44 indicated he had not been weighed. RN-C stated R44 was to be weighed every day. RN-C called to a passing nursing assistant (NA-F) who said R44 had not been weighed. Another nursing assistant, NA-C stated daily weights were to be done every morning as soon as possible, before eating and confirmed that R44 had not yet been weighed for unknown reasons. NA-C weighed R44 and reported a weight of 195 lbs.

During an interview on 9/14/21 at 12:17p.m. RN-C confirmed that R44 had an order to monitor edema. He stated the best way to assess edema was to "squeeze the feet and watch how much indent would occur" and confirmed he had not done this but would do it later. RN-C noted R44's weight should be re-checked because it was more than the day before. RN-C confirmed he

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had been working the day before and had documented a weight of 191.6, but had not called the medical provider, stating he had not seen the order to call the provider for a weight greater than 189 lbs. RN-C stated an increase in weight and edema indicated a possible fluid overload.

According to an interview 9/14/21, 12:42 p.m. the nurse manager for the unit, RN-D, said a daily weight was to be done before breakfast, and edema monitoring and compression wraps should also be done early in the morning. Edema monitoring, RN-D confirmed, should be accomplished prior to the application of the compression wraps. RN-D stated a nurse should find a shorter set of compression wraps if the ones they had were too long. RN-D said a nurse should notify medical providers when a resident has a change in condition or when an order was left for notifications to be done. The expectation for notification method would be to write out an "SBAR" (situation, baseline, assessment, result/request) form and send it to the provider immediately, but any nurse should also be able to call a provider with a report. RN-D was not aware of any guidelines saying it must be the nurse manger to call. RN-D confirmed that R44 had an order for a daily weight to be done, but upon review of his EHR stated, "it has not been done daily." RN-D stated an expectation of nurses to document on R44's condition in a daily progress note as outlined in his orders with lung sounds, edema, changes in weight, but confirmed that this information was not done daily, saying, "it looks like there is no documentation since the 12th."

According to an interview 9/14/21, 12:57 p.m. with the director of nursing (DON) the DON stated an expectation that daily weights be done at the

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same time each day, preferably right away upon rising before breakfast. DON also stated an expectation for compression wraps to be applied before getting up for the day. In relation to monitoring edema, DON stated some physicians like to have edema checked later in the day, such as in the afternoon, to see if the condition progresses when the resident is up, but in general, edema monitoring should be done in the morning prior to the application of the compression wraps. DON said that when monitoring a resident for problems with fluid excess it was expected that nurses would do daily weights, monitor lung sounds, vital signs and sometimes abdominal girth if ordered. DON stated any orders should be initialed as being completed in the treatment administration record (TAR), but a progress note should be written as well.

During an interview 9/15/21, 8:46 a.m. with the facility medical director (MD-A), he stated he was watching R44's condition closely as he had a "perplexing presentation," their interventions had not been fully successful and R44's "clinical trajectory continues to decline." MD-A stated unchecked fluid intake would be problematic, although he was currently stable. The primary concern for R44, according to MD-A was an exacerbation of his heart failure.

A request was made of the facility for a policy on fluid/edema management and monitoring, but this was not provided.

The Heart Failure-Clinical Protocol policy revised November 2018 covered only expectations of physicians and did not address nursing care.

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F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, facility failed to ensure that 1 of 1 resident (R24) was offered regular vision appointments with a specialist for her failing eyesight. Findings include: According to the electronic health record (EHR) Admission Sheet/face sheet, R24 had a diagnosis of macular degeneration (loss of central vision). According to a physician's note dated 4/25/2019, R24 had severe glaucoma in both eyes and macular degeneration in both eyes. An annual minimum data set (MDS) assessment 7/9/2021 indicated R24 was cognitively intact with no memory problems. A facility "Long Term Care Evaluation" dated 6/30/21 done to inform the MDS did not include	F 685	1.It is policy of Pine Haven Community to ensure that all residents ensure all resident be offered regular vision appointment with a specialist. Resident R24 was added to the list to be seen by the contracted facility optometrist. 2.This has the potential to affect all 69 residents. All residents were reviewed and/or offered vision services 3.Staff re-education will be completed with nursing staff on 10/21/2021 and 10/25/2021 to ensure all residents are offered hearing and vision services as needed. 4.Audits will be completed to ensure compliance for hearing services being offered to all residents daily x 10 days, then weekly x 6 and monthly x 1 Results will be reviewed by our Quality committee for further recommendation.	10/29/21

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any information about R24's current visual status.

According to R24's care plan, a focus problem area (not dated) indicated R24 was at risk for further decreased/impaired vision related to macular degeneration, glaucoma, generalized aging. Sees shadows and shapes with current glasses. An associated intervention (not dated) indicated an "offer is made periodically and PRN to set up an eye exam consultation for resident to ensure appropriate meds and compensatory mechanisms are provided."

During an interview 9/13/21, 3:12 p.m. R24 stated she had major vision issues and was mostly blind. She stated she could barely make out the red and white checked blanket on her walker approximately two feet away, and all she could see beyond that was what she thought might be a curtain, but she was not sure. To her left, about four feet away was a bare wall and she stated she thought it was just "blank bricks" or maybe there was a curtain, but she could not tell. She was unable to see the wall to her left which was about 8 feet away. R24 said she was concerned that she had not been to see the eye specialist for some time, and although she knew her vision could not be improved, she felt it was important to have her medications reviewed so as to maintain what little vision she had. R24 stated she had four children but was concerned that her family was unable to assist with making any appointment or assisting her to an appointment. She did not recall being offered any vision appointments.

According to an interview on 9/15/21, 10:37 a.m. a registered nurse (RN-D) managing the unit stated the facility had recently had in-house ophthalmology services for the residents, but

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RN-D was unable to find record that services had been offered to R24 and confirmed she had not been seen. RN-D stated such services should be offered at quarterly care conferences but was unable to find record that such services had been offered to or declined by R24.

According to an interview 9/15/21, 11:46 a.m. the licensed social worker (LSW) stated the facility should offer any medical follow-up visits as needed. LSW also said R24 was known to be concerned about her family and their ability to provide assistance to her, as she had always been the caregiver of their family. Because of this, LSW said, R24 would not ask her family for any help with appointments. LSW did not know if R24 had regular appointments set up to evaluate her vision problems but stated this should be offered at quarterly care conferences. LSW was unable to find documentation indicating any such services had been offered to or declined by R24. LSW stated that given R24's significant vision loss she should see a vision specialist.

On 9/16/21, 8:30 a.m. the director of nursing (DON) confirmed that the EHR did not contain recent documentation by nursing staff of R24's current visual status. DON stated she was unable to find any documentation that R24 was offered an appointment with the eye doctor. DON stated an expectation that vision, hearing and dental visits be offered at every care conference and as needed, and stated this offer and the resident response should be documented. DON stated if the information was not documented, one could not assume that it had been done.

A request was made for a facility policy related to arranging medical appointments for residents.

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F 685	Continued From page 37 The facility provided a policy related to transporting to residents, but the information did not apply.	F 685		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This 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. Findings include R175's face sheet dated 9/16/21, included	F 686	1.It is policy of Pine Haven Community to ensure that all residents ensure to comprehensively assess risk for pressure ulcers and develop implement interventions and follow physician orders to prevent pressure ulcer injuries. Resident R175 will be assessed, interventions implemented to help treat and prevent pressure ulcers by 10/22/2021. Resident R61 was discharged on 10/04/2021. 2.This has the potential to affect all 69 residents. All residents were reviewed and assessed to ensure any pressure ulcers had interventions and physician orders were being followed.	10/29/21

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F 686	Continued From page 38 diagnoses of dementia with behavioral disturbance and congestive heart failure. R175's significant change minimum data set (MDS) assessment dated 8/23/21, indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS indicated R175 was occasionally incontinent of urine and bowel. The MDS identified R175 was at risk for pressure ulcers and did not have pressure ulcers or moisture associated skin damage at the time of the assessment. The MDS indicated pressure reducing device for chair was not used for chair however a pressure reducing device was used for bed and identified R175 did not have a turning and repositioning program. R175's record lacked a comprehensive assessment for risk of skin breakdown after R175 became dependent on staff for mobility. R175's care plan did not identify the level of assistance in accordance with the MDS. R175's toileting care plan dated 9/1/20, directed staff to toilet R175 upon rising, after breakfast, before and [after] all other meals, at bedtime, on night rounds, and as needed. R175's skin care plan dated 10/17/2019, indicated R175 "has the potential for pressure ulcer development r/t [related to] immobility. [R175] has thin, fragile skin prone to bruising, skin tears, and age related petechiae (pinpoint, round spots that appear on the skin as a result of bleeding)." Associated interventions included follow facility policies/protocols for the prevention of skin breakdown	F 686	3.Staff re-education will be completed for licensed nursing staff on 10/21/2021 and 10/25/2021 to ensure completion and accuracy of Braden assessments, skin audits, interventions and physician orders. 4.Audits will be completed for compliance by Nursing management or designee on Skin only audits, care plan, and Braden assessments will be monitored daily for 10 days, then weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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R175's Skin Only Evaluation dated 9/10/21, at 11:44 p.m. indicated skin warm and dry, normal color, turgor normal, and had a skin tag on right upper abdomen.

During an observation on 9/13/21, at 7:40 p.m. R175 laid on her back in bed. R175's room smelled of urine. RN-H and nursing assistant (NA)-H were at bedside encouraging R175 to roll over to allow them to change her saturated incontinent garment. R175's mattress protectors was observed to also be urine soaked.

R175's behavior progress note dated 9/13/21, at 10:41 p.m. included tonight nurse and nursing assistant got R175 out of bed. Pain medication was offered at the beginning of the process, she did not understand. It was attempted to roll R175 she yelled out in pain and started hitting. The morphine was given and more communication about the process was provided. After several attempts to motivate the patient we rolled her on her side, washed and laid new pads down.

During an observation on 9/14/21, at 7:00 a.m. R175 sat in her wheelchair in a hospital gown. At 7:50 a.m. licensed practical nurse (LPN)-D stated R175 had been in the wheelchair all night because she had been restless, stated an unawareness of the last time R175 had been toileted or changed.

During an observation on 9/14/21, at 8:50 a.m. R175 was given her breakfast tray. At 9:27 a.m. R175 continued to sit in her wheelchair by the nursing station with her breakfast in front of her.

During an observation and interview on 9/14/21, at 12:04 p.m. R175 continued to sit in her

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wheelchair by the nursing station. Licensed practical nurse (LPN)-D stated R175 had been sitting there since he got there this morning, and stated he was not aware if NAs had checked her incontinent brief or repositioned her. LPN-D stated R175 had "nodded off for an hour maybe two" in her chair.

During an observation on 9/14/21, at 12:20 p.m. R175 remained by the nursing station. At 12:32 NA-A asked LPN-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy. NA-A was asked when R175 had last been toileted, NA-A stated the last time was between 6:00 a.m. and 7:00 a.m. when she assisted the night shift aide. At 12:49 p.m. R175 was transferred via full body mechanical lift to her bed by NA-A and NA-B. When NAs removed R175's incontinent garment, it was observed to be heavily saturated with urine. When R175 rolled onto her right side, a dark purple/blue area with a small wound that was bleeding was observed on her lower left buttock and small reddened area was observed on her right lower buttock. NA-A exited the room to get registered nurse (RN)-D. RN-D entered the room, RN-D observed the impaired skin integrity, and indicated R175 had a stage 1 pressure ulcer to the right buttock and the left buttock wound was a stage 2 and would have to do further evaluation if the wound was a deep tissue injury. RN-D stated the left buttock had more redness than the right and appeared irritated. R175 was very cooperative with RN-D during the assessment and with application of new brief.

During an interview on 9/14/21, at 3:38 p.m. RN-D stated the wound on her left buttock was a deep tissue injury, with an open stage 2 pressure

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injury. RN-D stated she had conversed with family member who thought that R175 had a history of a pressure ulcer to the same area. RN-D stated within the last several weeks R175 had an increased need to for assistance; she used to be independent with bed mobility and positioning herself. RN-D reviewed R175's care plan and verified the care plan was not consistent with the level of care R175 required and the MDS assessment. RN-D confirmed the care plan did not identify how often R175 needed to be turned and repositioned and an assessment to determine tissue response to pressure over time had not been completed after R175's change in condition. RN-D stated the nurse should have questioned/prompted or directed NAs to reposition R175 if there was a question of how long R175 was sitting in her chair next to the nursing desk. RN-D stated if R175 was refusing care then, it was expected the NA's reattempt or get someone else to attempt, report to the nurse on the floor, nurse should then attempt and notify the charge nurse of continued refusals. RN-D indicated, if necessary, the physician should be contacted for further medical management if interventions were unsuccessful. RN-D stated the refusals with interventions and the effectiveness of the interventions needed to be documented.

R175's progress note dated 9/14/21, 9:24 p.m. identified R175 had left buttock stage 2 deep tissue injury 2 centimeters (cm) x 0.9 cm. Injury is purple/blue in color, small tear which had fresh red blood around the edges, less than 0.5 cm in diameter of fresh red blood in center of injury. The evaluation indicated dietary would be consulted, and care plan revised to include repositioning schedule and behavior plan for increased need in cares including barrier cream

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and hydrating lotion for dry skin for comfort.

During an interview on 9/15/21, at 8:24 a.m. medical director stated a familiarity with R175 and indicated R175 had worsening heart failure and advancing dementia; goals of care were conservative. Medical director indicated an awareness of R175's behaviors of rejection/refusals of medications and compression management for edema, however, was not aware of rejection/refusals for repositioning/toileting. Medical director indicated an expectation of routine skin assessments and a repositioning plan be in place for the prevention of pressure ulcers. Medical director stated if a resident demonstrated self-neglecting behaviors the physician (or hospice) needed to be notified; residents can't sit in their own urine, it would need further evaluation. When asked if the duration of time R175 sat in her wheelchair without positioning or changing incontinent brief contributed to the pressure ulcers, medical director stated "Yes, that would be the definition of a pressure ulcer."

During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) indicated R175 should have been assessed for a turning and repositioning program after her mobility declined. DON stated the expectation residents were toileted in accordance with their care plan. DON stated if residents refused, the expectation was the nurse be notified, and ultimately the physician if necessary for further medical intervention.

R61

R61's hospital discharge summary dated 8/11/21, indicated R61 had a left buttock stage 2 pressure

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ulcer that had been identified on 7/16/21; plan for treatment included cleanse skin with wound cleanser, pat dry, and cover with foam boarder dressing, change dressing daily and as needed. The discharge summary also identified an unstageable pressure ulcer on a leg with orders for wound care.

R61's Admission skin assessment dated 8/11/21, did not identify presence of pressure ulcers. The note indicated resident refused with no further information or interventions for refusal.

R61's physician order dated 8/11/21, identified the left buttock pressure ulcer as outlined by the hospital discharge summary, however had a stop date of 9/2/21.

R61's physician order dated 8/11/21 included: Leg Pressure Injury Treatment: Cleanse affected area 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).

R61's physician order dated 8/14/21 included: Daily skin monitoring. If changes, document in skin alterations and wounds progress note. Wound: pressure injury to left lower extremity-unstageable, left buttock pressure stage 2.

R61's record identified the left lower extremity pressure ulcer was not comprehensively assessed until 8/16/21, even though there were physician orders upon admission. In addition, the record lacked evidence R61's left buttock pressure ulcer had not been comprehensively assessed after facility admission, even though

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there was a physician ordered treatment for the wound upon admission and an order that directed both pressure ulcers be monitored daily.

R61's skin evaluation dated 8/16/21, indicated R61 had an unstageable pressure ulcer on the left lower extremity (location on extremity was not identified) that measured 1.5 cm (centimeters) x 0.9 cm. The skin evaluation did not identify the presence of a stage 2 pressure ulcer.

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 skin evaluation dated 8/23/21 and 8/31/21, did not identify the stage 2 pressure ulcer.

R61's record did not indicate why the physician ordered treatment to the left buttock was discontinued on 9/2/21.

R61's skin evaluations dated 9/7/21 and 9/8/21, did not identify the left buttock pressure ulcer.

R61's physician order dated 9/13/21, included, "Leg Buttocks Pressure Injury Treatment": Cleanse affected area daily with normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover with mepilex border (sacral or large size).

During an interview on 9/14/21, at 9:15 a.m. licensed practical nurse (LPN)-D indicated R61 only had one wound treatment to complete; the unstageable ulcer on the left calf.

During an observation on 9/14/21, at 9:21 a.m.

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licensed 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 gloves, and washed hands.

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 observation on 9/15/21, at 1:16 p.m. RN-B explained to R61 he was going to change the dressings on his left calf and left buttock; R61 gave consent. RN-B washed his hands and donned gloves, RN-B then removed R61's wound dressing from the left calf and through the dressings on the floor. RN-B then removed the cap from the saline bottle, put the ointments for the wound in the cap, opened a tongue depressor, and stirred the ointments together. RN-B then removed scissors from his left pocket and cut the non-stick dressing to the size of the wound. RN-B then used a Q-tip to spread the mixture of ointments onto the wound and applied the cover dressings. RN-B had the same gloves on throughout the procedure, in addition RN-B had not disinfected the scissors prior to or after the completion of the dressing change. RN-B then picked up the soiled dressings from the floor, took off gloves, and sanitized his hands. RN-B then informed R61 of the next dressing change on his left buttock. RN-B donned gloves and undid R61's incontinent brief, R61 was incontinent of stool, RN-B performed incontinent

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care (a dressing was not observed on R61's left buttock where there was a nickel sized superficial wound that was reddened), used an incontinent wipe to clean his gloves, walked to the bathroom and donned another pair of gloves (without disinfecting) over the gloves he already had on and applied the left buttock dressing per physician order.

During an interview on 9/15/21, at 2:13 p.m. RN-B confirmed there was not a dressing to the buttock wound and there should have been, RN-B stated if the wound had been resolved it's not anymore. RN-B stated he should have changed his gloves and performed hand hygiene after taking off the old dressing. RN-B stated an unawareness if double gloving was appropriate for the procedure.

During an interview on 9/16/21, at 11:44 p.m. director of nursing (DON) stated an expectation that pressure ulcers were comprehensively assessed upon admission, weekly thereafter and as need, should be monitored for improvement or worsening daily with dressing changes. DON stated the expectation dressings were applied according to physician order. DON indicated appropriate hand hygiene was expected during dressing changes, gloves should be removed after dressing and removal and cleansing the wound, hand hygiene should be performed after each glove change. DON stated soiled dressings need to go into a garbage can and not on the floor, and scissors should be disinfected prior to using on a clean dressing.

Facility policy Pressure Injury Risk Assessment dated 3/2020, included 1) The purpose of pressure injury risk assessment is to identify all

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F 686	Continued From page 47 risk factors and then determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. 2) Risk factors that increase a resident's susceptibility to develop or to not heal PU's include b) impaired/decreased mobility and decreased functional ability, the presence of previously healed PU, exposure to urinary and fecal incontinence or other source of moisture, altered skin status over pressure points, and cognitive impairment 6) once the assessment is conducted and risk factors are identified and characterized, a resident centered care plan can be created to address the modifiable risks for pressure injuries. Facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 4/2018, did not identify frequency of monitoring or completing comprehensive wound assessments. The protocol indicated a skin examine would be completed upon admission	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		10/29/21

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F 690	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 (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 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. R61 laid in bed, R61 was observed to have a	F 690	1.It is policy of Pine Haven Community to ensure appropriate management and services of an indwelling catheter that including obtain physician order for size and type of indwelling urinary catheter, to consistently document urinary output, to evaluate urinary output for potential complications, and to ensure documentation of routine catheter care for all residents with indwelling catheters. Resident R61 discharged on 10/4/2021. 2.This has the potential to affect all residents with indwelling catheters. All residents with indwelling catheters were reviewed to ensure policy is being followed.	

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F 690	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 change catheter bag and catheter per physician order. R61's current physician orders did not identify an order for an indwelling catheter. The physician order dated 8/15/21, directed staff to change R61's catheter every 30 days. R61's physician	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 obtain physician order for size and type of indwelling urinary catheter, to consistently document urinary output, to evaluate 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 obtain physician order for size and type of indwelling urinary catheter, to consistently document urinary output, to evaluatee urinary output for potential complications, and to ensure documentation of routine catheter care by Nursing Management or designee daily for 10 days, then weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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order dated 8/11/21, indicated Flush foley catheter for decrease urine output, suspected obstruction as needed.

R61's treatment administration record indicated R61's catheter was changed on 8/30/21.

R61's progress note dated 8/30/21, identified the wrong type of catheter was inserted according to the hospital discharge summary. Progress note on 8/30/21, at 2:15 p.m. included "Resident had monthly foley catheter change. 16F catheter inserted with 10cc [cubic centimeter] of sterile fluid for balloon. Resident tolerated catheter change with no c/o [complaints] of pain"

R61's recorded output documentation was reviewed between 8/24/21 through 9/14/21 in conjunction with nursing progress notes; the record identified urine output was not recorded every shift and/or recorded values were lower than R61's average the record lacked evaluation for catheter associated complications such as obstruction or symptoms of acute renal failure.
-R61's record identified 10 instances or shifts where urine output was not recorded: on 8/24/21, 8/28/21, 8/29/21, 8/31/21, 9/1/21, 9/2/21, 9/6/21, 9/9/21, 9/11/21, and 9/13/21.
-R61'2 record identified average overnight urinary output was 497 milliliters (ml), R61's record indicated decreased urine output: on 9/5/21 for night shift 100 ml, on 9/7/21 night shift 150 ml, and on 9/14/21 output was 100 ml for night shift.

R61's record lacked evidence catheter care was provided in accordance with the care plan and facility policy.

During an interview on 9/15/21, at 7:05 a.m.

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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 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 (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. 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 type.

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 catheter in place. LPN-A stated she would not have changed the catheter without a physician order, stated she would also document in a

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progress note the catheter had been changed and if there were any complications, and how the resident tolerated the procedure. LPN-A stated that if there was a decrease in urine output, she would go check the catheter to make sure it was draining appropriately, if resident had decreased intake, would look for signs and symptoms of infection or acute renal failure. LPN-A stated she would document she completed an evaluation on the decrease and what she had done for interventions. LPN-A stated nursing assistants should be doing catheter care twice a day, morning, and evening cares. LPN-A reviewed R61's record and stated the record does not have documentation catheter cares have been completed.

During an interview on 9/16/21, at 11:44 a.m. director of nursing (DON) stated a catheter required a physician's order that identified the size and type of catheter and balloon size and there should have been an order obtained prior to changing the catheter. DON indicated the catheter should not have been changed without of physician order. DON stated urinary output needed to be documented every shift and amounts evaluated for possible issues related to the catheter, and the evaluation should be documented. DON stated catheter care should be completed at least twice per day and incontinent episodes. DON stated the catheter should be monitored to make sure urine is patent and draining. DON verified the lack of physician order for catheter, evidence of catheter care was provided, lack of every shift recorded output and evaluation when there was a decreased output.

Facility policy Foley Catheter Insertion, Male Resident included 1) Verify there is a physician's

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F 690	Continued From page 53 order for this procedure. A facility policy/protocol was requested for indwelling catheter care and management and was not provided.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, facility failed to ensure that respiratory equipment was maintained in a sanitary manner for 3 of 4 residents (R6, R54 and R64) reviewed for aerosolized medications and oxygen use and failed to ensure clear and accurate orders for oxygen administration for 1 of 3 residents (R44) also reviewed for oxygen use. Findings include: According to the electronic health record (EHR) Admission Record/face sheet, R6 had diagnoses of shortness of breath, acute on chronic diastolic (congestive) heart failure, chronic combined systolic (congestive) and diastolic heart failure, acute and chronic respiratory failure with hypoxia and with hypercapnia, as well as a diagnosis of chronic obstructive pulmonary disease and	F 695	1.It is policy of Pine Haven Community to ensure that respiratory equipment was maintained in a sanitary manner and that oxygen orders are clear and accurate. Resident R6, R54 and R64 respiratory equipment were cleaned by 10/22/2021. Resident R44 oxygen orders were clarified by 10/22/2021 2.This has the potential to affect all 69 residents. All residents with respiratory equipment were cleaned according to manufacture instructions. All residents with oxygen orders were reviewed and clarified. 3.Staff re-education will be completed with nursing staff on the facility□s policy on respiratory equipment is maintained in a sanitary manner on 10/21/2021 and 10/25/2021. All licensed nursing staff were	10/29/21

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F 695	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 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 treatment. No nurse was present in the room when R6 poured the solution into the cup and started the machine. On 9/15/21, 8:40 a.m. R6's nebulizer medication cup with mouthpiece attached were observed to	F 695	re-educated on the facility policy on oxygen orders on 10/21/2021 and 10/25/2021. 4.Audits will be completed on respiratory equipment were cleaned according to manufacture instructions and oxygen orders are clear and followed by Nursing Management or designee for compliance daily x 10 days, then weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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be laying inside R6's bedside stand drawer on top of various personal items such as old letters, lotion bottles, etc. The cup was attached to tubing that extended up out of the drawer and was attached to the nebulization machine. R6 said she had not used the equipment since the evening before and stated she had not observed anyone coming into her room to clean the equipment. She confirmed that she had placed the cup inside her drawer after using it so it would not fall on the floor.

R54
According to R54's EHR Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure and heart failure.

According to a 5/11/2020 physician order, R54 could self-administer nebulized medications and meter dose inhalers once set up by the nurse.

R54's care plan in the EHR had a focus problem area (not dated) that indicated R54 could self-administer medications; however, the care plan failed to indicate who was responsible for keeping the equipment clean.

On 9/13/21, 4:51 p.m. R54's medication cup for aerosolization of medication was observed to remain connected to the face mask for administration and connected to the nebulization machine by tubing. The cup and mask were laying on the counter beside the machine. R54 was not sure if staff cleaned the equipment and could not confirm it had been cleaned that day. The mask looked visually soiled with many specks and smudges on the inner portion of the mask, the cup had moisture droplets.

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On 9/14/21, 2:20 p.m. R54's medication cup for aerosolization of medication was observed to remain connected to a face mask that appeared soiled, and to tubing connected to R54's nebulization machine. An empty medication vial was sitting next to and behind the nebulizer. The cup and mask were laying on their side on the counter. R54 stated she was able to self-administer medications and she had last used the machine around noon. R54 confirmed the medication cup and mask had not been cleaned. 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. R54 confirmed she did not need the medication at that time.

According to an interview 9/14/21, 2:27 p.m. a registered nurse (RN-C) stated that when a resident was done with a nebulization treatment the nurse should return and clean the medication cub and the mouthpiece or facemask. RN-C confirmed he had not returned to R54's room to clean the equipment. A review of R54's medication administration record (MAR) indicated RN-C had provided R54 her last dose of aerosolized solution at noon.

During an interview 9/14/21, 3:48 p.m. a licensed practical nurse (LPN-C) stated a nurse is responsible to keep the nebulization equipment clean even if a resident self-administers medication. LPN-C said the cup and mouthpiece, or facemask should be detached from the tubing and then washed. LPN-C said the med cup and mouthpiece/mask should then be left to dry on a fresh towel after every use.

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On 9/15/21, 8:35 a.m. R54's nebulizing machine remained on the counter at her side with the tubing connected to a medication cup and face mask which were laying on their side. A small white crusty area of dried solution was observed directly under the medication cup, on the counter. A review of R54's MAR at that time indicated no nebulization treatment had yet been given that morning. This was confirmed by R54. The last documented dose of any medication that would be given using the nebulizing equipment was at 10:00 p.m. on 9/14/21.

According to an interview 9/15/21, 10:28 a.m. RN-D, unit manager said the mouthpiece or face mask and medication cup should be detached from the nebulizer after treatment, rinsed off and then set out to dry. This was to be done as soon as nebulization was complete. RN-D said a resident could turn on the call-light to let the nurse know they had finished their treatment, or the nurse should return to the room as soon as possible after the treatment was likely to be completed.

R44
According to the EHR R44's admission record/face sheet, R44 had been admitted to the facility with a primary diagnosis of chronic combined systolic (congestive) and diastolic (congestive) heart failure in which the heart is no longer able to sufficiently circulate blood to meet the bodies need, and with a component of fluid overload. R44 also had significant pulmonary dysfunction with a diagnosis of chronic obstructive pulmonary disease, shortness of breath, a dependence on supplemental oxygen and a history of pleural effusion (fluid in lungs)

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among many other co-morbidities.

According to a quaterly Minimum Data Set (MDS) assessment dated 7/30/2021, R44's primary medical condition was considered to be a "medically complex condition."

R44 had a physician's order dated 7/29/21 indicating "supplemental oxygen to maintain oxygen saturations >90%; document in progress note: LPM (liters per minute) and O2 saturations with and without every shift."

A review of R44's treatment administration record (TAR) for 9/01/21 through 9/14/21 showed nurses had signed each shift acknowledging the order, but not further documentation of oxygen saturations or rate of oxygen flow was seen in the TAR. A review of R44's progress notes from 9/01/21 through 9/14/21 failed to show daily shift nurse documentation on this same information, and in fact, contained such notes only on 9/4/21 12:56 p.m. and on 9/14/21, 3:42 p.m.

On 9/14/21, 8:55 a.m. R44 was observed resting in his bed and had oxygen running at 1.5 lpm via nasal cannula. R44 shrugged when asked about his oxygen, but then wrote a note indicating he thought his O2 order was for 1.1 LPM (the oxygen concentrator did not have increments to allow 1.1 LPM)

According to an interview 9/14/21, 3:50 p.m. LPN-C stated R44 does not use his oxygen all the time. LPN-C stated she did not remember R44 having an oxygen saturation lower than 90% when she was working but stated she had seen him using his oxygen. LPN-C said they should document his oxygen saturation and the amount

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of oxygen he was using each shift. LPN-C confirmed the order did not say how many liters of oxygen per minute to apply, but thought 2 LPM was "pretty normal, but it doesn't stay that in the order." LPN-C thought the facility had a standing order to start residents on 2 LPM if they needed oxygen but was unable to find this order. LPN-C stated that if R44 had an oxygen saturation level less than 90% she would start oxygen at 2 LPM and then titrate it down until he was stable and maintained his saturations greater than 90%. LPN-C also indicated they should keep the equipment clean but confirmed there was no order to change R44's tubing. LPN-C did not know when R44's oxygen tubing or nasal canula had been changed.

According to an interview 9/15/21, 10:33 a.m. RN-D stated it was the expectation to check a resident's oxygen saturation levels each shift if they required oxygen use. RN-D said if a physician's order said to keep a resident's saturations above a certain percent, the nurse should use between 1 LPM and 5 LPM using a nasal cannula. RN-D said the 1-5 LPM recommendation "it's in my brain somehow, let me check on that for the procedure." RN-D stated she thought an LPN could make the decision on what level of oxygen to start a resident on, but they should alert an RN to do an assessment as well. RN-D said if a resident's oxygen order was not clear, a nurse should call the provider to get a new order.

According to an interview 9/15/21, 11:05 a.m. the director of nursing (DON) stated an expectation for nurses to clean the medication nebulization equipment after a dose was provided. DON said the medication cup could contain residual

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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:
"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 ..."

The Oxygen Administration policy revised October 2010, indicated a nurse should first verify there is a physician's order for oxygen administration. The document included the

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following directions, "turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liter per minute." Required documentation listed: date and time, rate of oxygen flow, route and rationale, frequency, and duration of the treatment. Documentation was also to include reason for the administration, any assessment data obtained before, during and after the procedure. The policy did not provide information about care of the oxygen equipment for those who require the on-going use of such equipment.

R64 Oxygen Use
R64's admission MDS dated 8/19/21, indicated R64's cognition was intact. R64 required extensive physical assistance from staff for all activities of daily living (ADLs) and received oxygen therapy.

R64's face sheet printed 9/16/21, indicated R64's diagnoses included obstructive sleep apnea, degenerative disease of the nervous system, type 2 diabetes mellitus, and chronic kidney disease.

R64's physician orders indicated an order dated 8/12/21, for Oxygen 1 liter every evening and night shift. On HS (bedtime) and off in AM for sleep apnea.

R64's care plan, printed 9/16/21, did not indicate interventions related to oxygen. Additionally, R64's care plan did not indicate interventions related to sleep apnea.

R64's September 2021, Electronic Treatment Administration Record (ETAR) printed 9/16/21, indicated R64's oxygen had been placed on every

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HS (bedtime) and off every AM from 9/1/21 through 9/15/21. Additionally, R64's ETAR indicated a start date of 9/20/21, to change and date oxygen tubing every Monday evening. The record lacked documentation indicating the oxygen tubing had been changed prior to 9/16/21.

On 9/14/21, at 8:31 a.m. R64's oxygen tubing with nasal cannula was observed on the floor, under a chair in R64's room.

On 9/15/21, at 7:48 a.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room.

On 9/15/21, at 12:55 p.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room.

On 9/15/21, at 3:25 p.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room.

During an interview on 9/15/21, at 3:42 p.m. licensed practical nurse (LPN)-F confirmed R64's oxygen tubing with nasal cannula was on the floor, under a chair in R64's room. LPN-F stated, "That's not good, that should not be on the floor." LPN-F picked up the tubing, removed it from the oxygen concentrator and stated that he would replace it with a new nasal cannula and new tubing. When LPN-F was asked why the nasal cannula should not be on the floor, LPN-F stated, "because of infection control". When LPN-F was asked what should have been done with the tubing when not in use, he stated the tubing should have been placed on the hook located above the oxygen concentrator, not on the floor.

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F 695	Continued From page 63 During an interview on 9/16/21, at 2:07 p.m. the Infection Preventionist (LPN)-E stated when oxygen was not in use, the tubing should have been wrapped up and placed on the oxygen concentrator, not on the floor or bed. Additionally, LPN-E stated that if the nasal cannula had been used after it had been on the floor, "it could cause infection, staph, MRSA, E-coli, a lot of bad things". Facility policy, Oxygen Administration revised 10/10, did not address placement of the oxygen tubing when not in use. Additionally, the policy did not address any changing of oxygen tubing.	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725		10/29/21

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F 725	Continued From page 64 limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement staff to answer call lights in a timely manner to meet resident physical needs and a psychosocial sense of security which had the potential to affect any of the residents residing in the facility who use a call-light independently or with assist from visitor. Findings include: According to R19's electronic health record (EHR) Admission Record (face sheet), R19 had diagnoses of muscle weakness, difficulty walking, history of falls and history of a broken hip. R19's EHR care plan included a focus problem area (not dated) that indicated she was at risk for falls and a corresponding intervention indicated staff should ensure the call-light was within reach and educate R19 to use it to call for assistance. According to R51's EHR Admission Record, R51 had paralysis of the right side, his dominant side. R51's EHR care plan included a focus problem area (not dated) that indicated he was at risk for falls related to gait and balance problems. A corresponding intervention indicated staff should encourage R51 to use his call-light to request assistance. Another focus problem area (not dated) indicated R51 had the potential for bladder	F 725	1.It is policy of Pine Haven Community to ensure that all call lights are answered timely. 2.This has the potential to affect all 69 residents 3.Staff re-education on answering call lights will be completed with nursing staff on 10/21/2021 and 10/25/2021. 4.Audits will be completed for compliance on answering call lights timely daily x 10, weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation	

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incontinence and assistance to toileting should be offered upon rising, before and after meals, at bedtime and during the night.

According to R51's MDS, 8/11/21, indicated R51 required extensive assistance of one person with toileting.

According to an interview on 9/13/21, 12:51 p.m. R19 stated she had turned her call light on during the night a few days before, and staff did not arrive for over an hour. R19 said she has generally been able to transfer herself, but she had pain in her flank, and she was not feeling well. She said she ended up voiding in her bed and was "wet from head to toe" and "I peed all over everything." When a staff person arrived, R19 said she talked to him about the extended wait, and he apologized to her but did not say why it took so long. R19 was unable to identify the staff person. She said that problems with call light wait time tended to occur during the night shift.

According to an interview on 9/13/21, 2:48 p.m. R51 said he required assistance to get to the bathroom, but on the past weekend, a few days prior, he had turned on his call-light for assistance, but after waiting for a long time with no response, he managed to get up on his own, get into his wheelchair, go to the bathroom, use the toilet, and then go back to bed. R51 said about an hour and a half later a man came in to turn off his call-light and asked what he needed. It had been so long that R51 had fallen back to sleep. R51 told the staff person that he had already taken himself to the bathroom and no excuse was offered for the wait time. R51 indicated frustration and anger about this

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instance.

A sample record of call-light times was requested for R19 and R51's unit dated 9/4/21 through 9/14/21. This report confirmed that on 9/12/21 it took staff one hour and sixteen minutes to respond to R19's call light at 3:25 a.m. and one hour and 19 minutes to R51's call light at 3:20 a.m.

According to an interview 9/16/21, 10:03 a.m. a registered nurse (RN-H) stated she had worked during the night on the past weekend but was not on the same unit as R19 and R51. RN-H was unaware of any reported significant events in the building that night which would have interfered with staff answering a call light for an extended period of time.

According to an interview 9/16/21, 11:06 a.m. the facility administrator stated there had been concerns about lengthy call-light response in the past and said he had had one other resident complain about call light times in the past few days but was not aware of R19 or R51's concerns. Administrator stated it was the facility expectation for staff to check on a resident when a call-light comes on, and if they are not able to immediately attend to the resident concerns, they are to let them know when they would be back to assist. The Administrator said "typically, it is our rule of thumb, if a light is on for 20 minutes or longer, we need to ask, what is the reasoning behind that?" The Administrator had no knowledge of any events in the facility over the last week that might have caused a slow response but did say an incident of a staff person sleeping had been reported but was unsure if there was any correlation.

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F 725	Continued From page 67 On 9/16/21, 11:55 a.m. during an interview, nursing assistant (NA- C) said she had worked Sunday night (9/12 to 9/13/21) and had heard that call-light response time had been extended the previous night but had not heard if there was a reason or event that would have caused this. NA-C said she understood the nurse who worked on the day shift was going to write up a concern form to report it to leadership. The Answering the Call Light policy revised March 2021 indicated staff should "indicate the approximate time it will take for you to respond, if the resident's request requires another staff member, notify the individual. If the resident's request is something you can fulfill, complete the task within five minutes if possible. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance." Additionally, the procedure indicates that staff should document any complaints made by resident and the request or complaint was addressed.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		10/29/21

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F 758	Continued From page 68 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 758	1.It is policy of Pine Haven Community to	

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F 758	Continued From page 69 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 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 record 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 of non-pharmacological interventions attempted or offered prior to administration. The record identified Ativan was administered on 9/8/21, at 9:04 p.m., 9/9/21 at 8:20 p.m., 9/10/21, at 1:47 p.m. and 9/11/21, at 7:40 p.m. R171's Ativan order dated 9/8/21, was changed on 9/11/21; the order dated 9/11/21, indicated Ativan 1 mg by mouth every 12 hours as needed for anxiety and/or vomiting for 14 days. The record did not identify why "withdrawal" symptom was removed as justification for administration. R171's psychotropic Evaluation tool dated 9/11/21, had a checked box in response to the	F 758	ensure to offer/attempt non pharmacological interventions prior to administration of as needed (PRN) psychotropic medications. Resident R171 discharged from the facility on 09/20/2021. 2.This has the potential to affect all 69 residents. all residents who have a (PRN) psychotropic medication will be reviewed to ensure we offer/attempt nonpharmacological interventions prior to use 3.Staff re-education will be completed with licensed nursing staff on 10/21/2021 and 10/25/2021 to ensure compliance with non-pharmacological interventions prior to use of prn psychotropic medications. 4.Nursing Management or designee will conduct audits to ensure care plans and orders include necessary components of psychotropic medication prn medications have appropriate non-pharmacological interventions in place for use prior to administration of prn medication. Daily x 10, weekly x 6 and then monthly x 1 for compliance. Results will be reviewed by our Quality committee for further recommendation	

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question, Does the resident have anxiety or nervousness that impairs his/her quality of life or limits participation in activities. The Note Section included "currently has rx [prescription] for Ativan.". The evaluation indicated the mediation 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 did not identify diagnoses of anxiety with goals of care and non-pharmacological interventions.

R171's record on 9/12/21, identified target behaviors for use of Ativan as 1. Nervousness 2. Withdrawal/refusal of care 3 nausea/vomiting.

R171's progress notes and medication administration record reviewed between 9/12/21 through 9/14/21 identified R171 was administered Ativan, the record did not identify reason for administration, however indicated the medication was effective and did not include documentation of non-pharmacological interventions attempted or offered prior to administration. The record identified Ativan administered on 9/12/21 at 8:07 p.m., 9/13/21 at 9:25 p.m., and 9/14/21 at 8:33 p.m.

During an interview on 9/15/21, at 10:02 a.m. nursing assistant (NA)-G stated he had not noticed any behaviors and R171 did not display anxiety that he had 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

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F 758	Continued From page 71 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. During an interview on 9/16/21, director of nursing (DON) reviewed R171's record and stated the target behaviors does not identify what the behaviors really are, and everybody displayed anxiety differently. DON stated as needed medications should be given for what they are specifically prescribed for and staff should offer and attempt non-pharmacological intervention first, documentation should identify which interventions were used and if which ones were effective, and if the resident refused then the refusals need to be documented.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		10/29/21

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F 761	Continued From page 72 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure that medications were properly labeled and secured for 1 of 2 residents (R54) observed for self-administration of nebulized/aerosolized medications. Findings include: According to R54's electronic health record (EHR) Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure and heart failure. According to a 5/11/2020 physician order, R54 could self-administer nebulized medications and meter dose inhalers once set up by the nurse. No order was found for R54 to keep medications at bedside. R54's care plan in the EHR had a focus problem area (not dated) that indicated R54 could self-administer medications; however, the care plan did not indicate R54 could keep medications at bedside. On 9/14/21, 2:20 p.m. R54 stated she was able	F 761	1.It is policy of Pine Haven Community to ensure medications were properly labeled and secured. Resident R54 discharged from the facility on 10/18/2021. 2.This has the potential to affect all 69 residents. All residents who self-administer medications were reviewed to ensure compliance. 3.Staff re-education will be completed with licensed nursing staff on 10/21/2021 and 10/25/2021 to ensure respiratory medications are managed according to policy and not left in resident rooms for resident self-administration. 4.Nursing Management or designee will conduct audits for compliance with oxygen and respiratory policy to ensure respiratory medications are managed according to policy and not left in resident rooms for resident self-administration daily x 10, weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation	

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F 761	Continued From page 73	F 761		

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.

According to an interview 9/14/21, 2:27 p.m. a registered nurse (RN-C) confirmed he had left the medication vial in R54's room even though she did not need an as needed (PRN) dose at that time. RN-C stated he was able to leave it there because R54 "knows how to use it."

During an interview 9/15/21, 10:28 a.m. RN-D, the unit manager stated a nurse was not to leave medications at a resident's bed side. According to RN-D, if a resident can self-administer a medication, the nurse must bring the medication in at the time it is ordered or if the order is for PRN the nurse must bring it in when needed and not before. RN-D said, leaving a medication at bedside could result in the dose not being taken at the proper time. Another nurse could potentially provide the next PRN or scheduled dose too soon, or "back-to-back doses." RN-D stated the nurse should bring the medication in when needed, and then document the time the PRN dose was taken.

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F 761	Continued From page 74 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. According to an interview 9/15/21, 11:05 a.m. the director of nursing (DON) stated residents could self-administer medications if they had a physician's order and had been assessed as being able to do so. DON said medications were not to be left at bedside unless there was an order, and the facility had provided them a safe place to store the medications. DON indicated medications must be appropriately labeled with the resident's name and a pharmacy label if kept locked at bedside. The Storage of Medications policy revised November 2020 indicated "drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications ...Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling." .	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791		10/29/21

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F 791	Continued From page 75 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		

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F 791	Continued From page 76 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, facility failed to ensure 2 of 2 residents (R24 and R3) were offered regular dental appointments to maintain oral comfort and reduce the risk of infection. Findings include: According to the electronic health record (EHR) Admission Sheet/face sheet, R24 had a diagnosis of dysphagia (difficulty swallowing) of the oropharyngeal phase (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. According to R24's care plan in the EHR, a focus problem area (not dated) indicated R24 was at risk for alteration in oral hygiene, and health related to being edentulous (no teeth), has upper and lower dentures. The focus problem indicated the dentures had been re-lined but did not indicate when that had occurred. The goal for this problem area was dated as having been initiated 6/01/2016. A corresponding intervention included: "periodic offer is made to resident/family to set up dental appointments and PRN (as needed). During an interview 9/13/21, 3:12 p.m. R24 stated she was fitted with her current dentures prior to	F 791	1.It is policy of Pine Haven Community to ensure residents are offered regular dental appointments to maintain comfort and reduce risk of infection. Residents R3 and R24 were offered dental appointments. 2.This has a potential to affect all 69 residents. All residents were reviewed to ensure they were offered routine dental services. 3.Staff re-education will be completed with licensed nursing staff on 10/21/2021 and 10/25/2021 to ensure accuracy and completion of routine oral assessments and follow through. 4.Nursing Management or designee will perform audits for accuracy and completion of routine oral assessments and follow daily x 10, weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation	

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her admission to the facility some six years ago. She said the dentures had to be re-lined twice but have not been adjusted in recent years. She stated she frequently had to take them out of her mouth in-between meals because the dentures had started to irritate her gums. She stated she had four children but was concerned that her family was unable to assist with making any appointment or assisting her to an appointment. She did not recall being offered any dental appointments.

According to an interview on 9/15/21, 10:37 a.m. a registered nurse (RN-D) managing the unit stated the facility was able to provide R24 with dental visits but was unable to record on the last time R24 had received any dental assessment. RN-D stated such services should be offered at quarterly care conferences but was unable to find record that such services had been offered to or declined by R24.

According to an interview 9/15/21, 11:46 a.m. the licensed social worker (LSW) stated the facility should offer dental visits as needed. LSW did not know if R24 had had any dental visit but stated this should be offered at quarterly care conferences. LSW was unable to find documentation indicating any such services had been offered to or declined by R24.

According to an interview 9/15/21, 12:14 p.m. a nursing assistant (NA-C) stated R24 puts her dentures in to eat her meals but will take them out in between because "there is a little spot that irritates her." NA-C stated nurses were supposed to evaluate resident oral status and set up dental appointments if they see a problem.

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On 9/16/21, 8:30 a.m. the director of nursing (DON) confirmed that the EHR did not contain recent documentation by nursing staff of R24's current oral status. DON stated she was unable to find any documentation that R24 was offered a dental appointment. DON stated an expectation that vision, hearing and dental visits be offered at every care conference and as needed, and stated this offer and the resident response should be documented. DON stated if the information was not documented, one could not assume that it had been done.

The Dental Services policy revised December 2016 indicated that selected dentists must be available to provide follow up care, and social services will assist residents with appointments and transportation arrangements. The policy also indicates that all dental services should be recorded in the resident'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

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failure and seizure disorder.

R3's care plan dated 9/15/21, provided direction to offer resident or family to periodically offer dental appointments as needed.

R3's Clinical Admission Evaluation dated 5/3/21 indicated R3 had obvious or likely cavity or broken natural teeth. This assessment did not indicate the provider should be notified of R3's dental status to obtain dental consult.

R3's progress notes dated 5/27/20 thru 9/14/21, failed to address R3's dental needs and if a dental appointment was offered.

On 9/13/21, at 1:21 p.m. R3 stated he was not offered to see in a dentist but would like to see a dentist due to several missing and broken teeth.

On 9/15/21, at 10:26 a.m. registered nurse (RN)-I stated if a resident wanted a dental appointment, staff would make her aware and she would let medical records know to make the appointment. She could also be notified through the assessment process. The nurse completing the assessment should let RN-I know about the resident's need to see a dentist. RN-I confirmed R3's assessment dated 5/3/21, indicated R3 likely had cavities or broken teeth. RN-I stated she was not notified of R3's dental needs.

On 9/15/21, at 2:42 p.m. director of nursing (DON) stated she expected dental services were offered if any issues came up. She would expect the nurse completing the assessment would update the resident's provider if concerns such as possible cavities or broken teeth were noted. Offering dental services were important as

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F 791	Continued From page 80 cavities can cause pain, increases the resident's risk for infection including sepsis (an infection of the blood stream).	F 791		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 849		10/29/21

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(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal

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illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in

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the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both

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F 849	Continued From page 84 the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to provide a system of coordination of care with their contracted hospice provider for 1 of 1 resident (R54) reviewed for hospice care. Findings include: According to R54's electronic health record (HER) Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure, heart failure and anxiety among other co-morbidities. A focus problem area was noted in R54's care plan as follows: "I have a terminal prognosis related to COPD and chronic diastolic heart failure. I began hospice care on 7/2/2021." The intervention list included the following, "work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met," but failed to indicate any specific delineation of what responsibilities were those of hospice and which were responsibilities of the facility. A review of uploaded documents in R54's EHR failed to show a hospice care plan but did include an August-September 2021 schedule. A review of the schedule showed that the schedule was incomplete and did not include the name of a nurse manager, visit nurse or hospice aide or	F 849	1.It is policy of Pine Haven Community to ensure the facility coordinates care with the contracted Hospice agency. Resident R54 was discharged from the facility on 10/18/2021. 2.This has the potential to affect all 69 residents. All residents on Hospice were reviewed to ensure Hospice schedule is available for residents and responsible parties including the names of the Nurse Manager, visit nurse, and hospice aid, as well as Hospice contact information as well as notification if hospice schedule changes. Hospice agencies will be notified and educated on the aforementioned process. 3.Staff re-education will be completed with nursing staff on 10/21/2021 and 10/25/2021 to ensure Hospice schedule is available for residents and responsible parties including the names of the Nurse Manager, visit nurse, and hospice aid, as well as Hospice contact information as well as notification if hospice schedule changes for the next 60 days. 4.Nursing Management or designee will conduct audits for new hospice resident and existing hospice residents to ensure Hospice schedule is available for residents and responsible parties including the names of the Nurse Manager, visit nurse, and hospice aid, as	

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F 849	Continued From page 85 clear schedule. According to an interview on 9/13/21, 4:34 p.m. R54 confirmed that she was receiving hospice services, but stated, "I don't know what we pay them for." R54 indicated she felt very anxious and said she had hoped having hospice services would help her, but said it seemed to make things more confusing. She reported communication issues between the facility and hospice and stated, "Peter doesn't know what Paul has done." On 9/13/21 she was particularly concerned about wraps on her legs (Unna boots- a layered compression wrap that contains a gauze zinc dressing, covered by a dry dressing, covered by a compression wrap that can be left on for up to a week, but is often changed two to three times weekly if there are open wounds) stating she understood hospice was in-charge of applying them, but no-one from hospice had arrived and she didn't know if anyone would wrap her legs. She said there had been a massage therapist from hospice in to visit, but he didn't care for her leg wraps, and he wasn't able to tell her when there would be someone from hospice in to provide those cares. R54 said she had not received any schedule or calendar from the hospice service. No such document could be observed in her room. A basket with roller gauze and compression wraps was in the room without any instruction and without any indication of a zinc wrap. R54's legs were not wrapped at that time. According to an interview on 9/14/21, 2:26 p.m. R54 was upset, stating her wraps were taken off her legs so she could have a bath, but no one had come to replace them. She again said she understood hospice was supposed to apply the	F 849	well as Hospice contact information as well as notification if hospice schedule changes daily x 10, weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation	

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	245359	A. BUILDING _____ B. WING _____	C 09/16/2021

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PINE HAVEN CARE CENTER INC	**210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 86	F 849		

wraps, but she did not know when they would come. R54's legs were observed to be swollen. She was wearing non-slip socks, but no wraps.

According to an interview 9/14/21, 2:29 p.m. a registered nurse (RN-D), the unit manager stated the hospice should fax the facility a schedule and then the facility would upload that schedule into the EHR. RN-D did not believe the resident would receive a copy of that schedule and did not know if the hospice agency would provide them one when they visited. RN-D was unsure of the hospice schedule for R54, stating she thought a nurse was scheduled twice a week, but did not think they knew a specific date as hospice often changed days of visits if something else would come up. RN-D did not think R54 had a hospice nurse manager, and various nurses came to visit. RN-D thought a hospice aide was supposed to come twice weekly and she thought it would be on Mondays and Thursdays, but she was unsure if anyone had been there the day before. RN-D said it was expected for the hospice nurse to communicate with the facility staff, but said they usually talked to the nurse responsible for the hall where the resident lives rather than coming to the unit manager. RN-D confirmed that a hospice care plan had not been uploaded into the HER.

On 9/14/21, 2:46 p.m. a telephone call was made to the hospice agency to reach out to R54's nurse manager or someone who could provide information. The person who took the phone call stated the nurse manager was not on duty and there was not another person who could take the call. Unknown individual stated the nurse manager was scheduled to visit the facility twice a week and would visit R54 on 9/15 and 9/16/21 (Wednesday and Thursday) this week, and then

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F 849	Continued From page 87	F 849		

the next week on 9/21 and 9/23/21 (Tuesday and Thursday), but stated they do change the schedule if they need to send a nurse elsewhere.

According to an interview 9/15/21, 1:42 p.m. a hospice nurse manager, RN-F stated a resident would know when she was coming because she would tell them. She stated she had not received any training to provide a written schedule to the resident, merely to provide a frequency of visits which she did verbally. She stated she liked to have a little leeway as they sometimes had to change their schedule. RN-F stated they did the same with hospice aid visits, but currently their aid had been sick for some time and now had resigned so she, RN-F, would do the aid work when she came to visit R54. RN-F said she would talk with the nurse who was on duty, and other nurses would be able to gather information by looking for any new orders or by looking for documentation in the EHR. RN-F confirmed there should be a care plan from the hospice agency but stated there was someone at the main office who was supposed to send the facility the care plan and any other documentation for the facility chart, and she did not know if anything had been sent. RN-F also stated the hospice nurse should make a note in the facility EHR after visiting but said she had lost her password so had not been doing so recently. RN-F said she did not regularly meet with the facility unit manager. As to R54's concerns regarding her leg wraps, RN-F stated the order said to change them as needed, and that hospice would change them when they were there for a visit.

According to R54's physician orders, the facility was provided the following order on 9/10/21: "Una boot to LLE (lower left extremity). Hospice to

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F 849	Continued From page 88	F 849		

change on visits. Change when needed." Contradictory orders were found in the physician's orders stating: "remove ace wraps and apply Aveeno cream and tubi strips [grips] (a compression garment cut to length) at bedtime for edema" 9/3/21.

According to an interview 9/15/21, 2:12 p.m. the facility licensed social worker (LSW) stated that social service is the point person for hospice but for clinical aspects of care, the point person for communication would be the facility unit manager.

According to interview 9/16/21, 8:17 a.m. the director of nursing (DON) stated a hospice agency should provide the facility with a schedule letting them know when the nurse and hospice aide or other team members would be visiting. DON was unsure if the residents were provided with the schedule but said they should be. DON stated the point person for communication in the facility was the unit clinical manager, "that's part of their job responsibility." DON stated the facility manager should be aware of the hospice schedule and know how to access the information. Additionally, DON stated the unit manager should be familiar with, and communicate with the hospice nurse manager and familiar with the hospice plan of care. DON confirmed that the facility should have a copy of the hospice plan of care and the hospice provider and facility should clearly know who was doing what. DON stated the facility care plan should also provide this information and should include information about the agency but confirmed this was not included in the facility care plan. DON confirmed R54's EHR did not contain a care plan from the hospice agency, nor did it contain a clear

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F 849	Continued From page 89 and complete schedule of hospice visits. A request was made for a policy related to coordination of care with hospice, but facility did not provide one.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		10/29/21

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F 880	Continued From page 90 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to perform hand hygiene when performing wound treatments to reduce the risk and/or prevent skin infections for 1 of 2	F 880	1.It is policy of Pine Haven Community to ensure that all staff perform proper hand hygiene. Resident R61 discharged from the facility on 10/4/2021.	

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F 880	Continued From page 91 residents (R61) whose treatments were observed for pressure ulcers. Findings include R61'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. 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. licensed 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 gloves, and washed hands.	F 880	2.This has a potential to affect all 69 residents. The facility□s Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, and Governing Body oversight must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. Information regarding RCAs is available in the Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs). 3.The Infection Preventionist, Director of Nursing or designee must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competent. 4.The Director of Nursing, the Infection Preventionist and/or other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met. The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.	

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F 880	Continued From page 92	F 880		

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 observation on 9/15/21, at 1:16 p.m. RN-B explained to R61 he was going to change the dressings on his left calf and left buttock; R61 gave consent. RN-B washed his hands and donned gloves, RN-B then removed R61's wound dressing from the left calf and through the dressings on the floor. RN-B then removed the cap from the saline bottle, put the ointments for the wound in the cap, opened a tongue depressor, and stirred the ointments together. RN-B then removed scissors from his left pocket and cut the non-stick dressing to the size of the wound. RN-B then used a Q-tip to spread the mixture of ointments onto the wound and applied the cover dressings. RN-B had the same gloves on throughout the procedure, in addition RN-B had not disinfected the scissors prior to or after the completion of the dressing change. RN-B then picked up the soiled dressings from the floor, took off gloves, and sanitized his hands. RN-B then informed R61 of the next dressing change on his left buttock. RN-B donned gloves and undid R61's incontinent brief, R61 was incontinent of stool, RN-B performed incontinent care, used an incontinent wipe to clean his gloves, walked to the bathroom and donned another pair of gloves (without disinfecting) over the gloves he already had on and applied the left buttock dressing per physician order.

During an interview on 9/15/21, at 2:13 p.m. RN-B stated he should have changed his gloves and performed hand hygiene after taking off the old dressing. RN-B stated an unawareness if

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F 880	Continued From page 93 double gloving was appropriate for the procedure. During an interview on 9/16/21, at 11:44 p.m. director of nursing (DON) stated appropriate hand hygiene was expected during dressing changes, gloves should be removed after dressing and removal and cleansing the wound, hand hygiene should be performed after each glove change. DON stated soiled dressings need to go into a garbage can and not on the floor, and scissors should be disinfected prior to using on a clean dressing. Facility policy Dressing, Dry/Clean dated 9/2013, included Steps in the Procedure: 5) Wash and dry your hands thoroughly 6) Put on clean gloves. Loosen tape and remove soiled dressing 7) Pull glove over dressing and discard into plastic or biohazard bag 8) Wash and dry your hands thoroughly. 9) Open dry, clean dressings. 10) Labe tape or dressing with date, time, and initials. 11) Wash and dry your hands thoroughly. 12) Put on clean gloves 15) Cleans the wound 17) Apply the ordered dressing 23) Wash and dry hands thoroughly	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		10/29/21

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receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:

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F 883	Continued From page 95 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 5 residents (R43) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R43's quarterly Minimum Data Set (MDS) dated 7/30/21, R43 had severe cognitive impairment. R43's medical record failed to address R43's vaccination status for pneumococcal and if these vaccinations were offered to R43. On 9/14/21, at 12:59 p.m. licensed practical nurse (LPN)-E confirmed documentation that would indicate R43 received the option for the pneumococcal vaccinations were offered at time of admission. On 9/15/21, at 9:59 a.m. family member (FM)-A confirmed she was R43's guardian. FM-A stated when R43 was admitted to this facility, she was not given the option for R43 to receive the pneumococcal vaccinations while in the facility. On 9/15/21, at 10:33 a.m. directory of nursing (DON) stated she expected unvaccinated	F 883	1.It is policy of Pine Haven Community to ensure all residents are offered or receive pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Resident R43 was offered the pneumococcal vaccination and will receive the vaccination by 10/31/2021. 2.This has the potential to affect all 69 residents. All residents were reviewed and any resident needing the pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations were offered the vaccination. 3.Staff re-education will be completed with licensed nursing staff to ensure all residents are offered or have received Influenza and Pneumococcal immunizations on 10/21/2021 and 10/25/2021. 4.Nursing Management or designee will conduct audits new admissions and residents who have scheduled assessments/MDSs to ensure Influenza and Pneumococcal immunizations are offered to residents daily x 10, weekly x 6 and monthly x 1. Results will be reviewed by our Quality committee for further recommendation	

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F 883	Continued From page 96 residents were offered vaccines which included the pneumococcal vaccinations. If a vaccination was refused, then the resident and their family would receive education which include risk factors to an educated decision could be made. Facility policy, Influenza and Pneumococcal Immunizations, review date 2/2020, noted pneumococcal immunization status of all residents will be determined on admission. Vaccination will be offered.	F 883		

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	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/14/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/14/2021. At the time of this survey, PINE HAVEN CARE CENTER - BUILDING 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/14/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	**210 NORTHWEST 3RD STREET** **PINE ISLAND, MN 55963**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 THE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. PINE HAVEN CARE CENTER - BUILDING 01 was constructed at three different times. A one-story building with a partial basement was constructed in 1964 and determined to be Type II (111). In 1970, an addition to the North Wing was constructed and determined to be Type II (111). In 1991, an addition was added to the West Wing and determined to be Type II (111). Because the original building and additions are compatible construction types allowed for existing	K 000		

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	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/14/2021**

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K 000	Continued From page 2 buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to PINE HAVEN CARE CENTER - BUILDING 02, which was determined to be of Type V (111) construction. There is a 2-hour fire-rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 70 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324		10/30/21

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K 324	Continued From page 3 or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide clear visual and unobstructed access to the Ansul type fire extinguishing equipment in accordance with the Life Safety Code NFPA 101 - 2012, sections 19.3.2.5, 9.2.3, 19.3.2.5.3(5)(b), and the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, NFPA 96-2011, section 10.5, 10.5.1. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during the walk-through of the facility Kitchen that the manual pull-station for the Ansul type fire suppression system was visually obscured by vertical storage of boxes, and physical access was obstructed by items placed to close on either side the device. This deficient condition was confirmed by the	K 324	1. The boxes were moved on 09/15/2021. 2. Staff were educated on 09/15/2021 3.Dietary and Maintenance Director will monitor for compliance monthly x 3.	

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K 324	Continued From page 4 Maintenance Director at the time of discovery.	K 324		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 19.3.7.8, and 8.5.4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during the walk-through of the facility that upon testing, the 200 and 300 Wing smoke barrier doors exhibited door-to-door gapping greater than a one-eighth inch which would not resist the passage of smoke. This deficient condition was confirmed by the	K 374	1. New brush seal meeting stile astragals were installed on the door on 09/21/2021. 2.Door will be check annually during Fire door annual inspection 3. Maintenance Director or designee will monitor for compliance	10/30/21

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K 374	Continued From page 5 Maintenance Director at the time of discovery.	K 374		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 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. Findings include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during documentation review that the smoke dampers were past due to the required 4-year inspection frequency. Dampers were last tested on 01/24/2017.	K 521	1. Harris Company conducted damper testing on 10/04/2021. 2. Administrator and maintenance director will monitor for compliance to ensure contractor on month 10 is scheduled to preform 4 year inspection.	10/30/21

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K 521	Continued From page 6 This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 521		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		11/24/21

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K 918	Continued From page 7 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, a review of the available documents, and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3.7, 8.3.8, 8.4.2.3, and 8.4.7. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during visual inspection of the emergency power supply systems and during document review that the installation date of the batteries for the emergency power supply system which services Building 01 (210 generator) could not be determined. 2. On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during documentation review and staff interview that there was no annual inspection and testing documentation for the facility emergency power supply systems which service Building 01 (210, Kato generators). These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 918	1.contract signed with Ziegler on 10/07/2021 to preform these tasks. 2. Administrator and maintenance director will monitor for compliance. 3. contractor was 6 weeks out to come perform these task on 10/7/2021	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		11/24/21

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K 920	Continued From page 8 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement the usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during the facility walk-through of	K 920	Electricians called to come out and add outlets. we are waiting on quotes to completes this task. most electricians are a couple months out of completing this work. 2.Administrator and maintenance director will monitor for compliance	

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K 920	Continued From page 9 the facility the use of daisy-chained power-strips in the basement on Telephone Communications wall-panel. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		10/30/21

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K 923	Continued From page 10 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store medical gas equipment per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.3.4, 11.6.2.3, and 11.6.5. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed the walk-through of the facility that Room 100L - Med Gas Storage had mixed storage of cylinders of empties with full cylinders and was missing signage physically separating empties from full cylinders. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 923	1. The Med Gas storage room was separated for full and empty cylinders to be in separate storage spaces. 2. Staff were re-educated on 10/21/2021 and 10/25/2021 on the facility policy to ensure Med gas tanks are separated. 3. The Director of Nursing or designee will monitor for compliance daily x 10, weekly x 6 and monthly x1.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/14/2021. At the time of this survey, PINE HAVEN CARE CENTER - BUILDING 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/21/2021

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 6. A detailed description of the corrective action taken or planned to correct the deficiency. 7. Address the measures that will be put in place to ensure the deficiency does not reoccur. 8. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 9. Identify who is responsible for the corrective actions and monitoring of compliance. 10. The actual or proposed date for completion of the remedy. PINE HAVEN CARE CENTER - BUILDING 02 was constructed at one time. A one-story building with no basement was constructed in 2016 and determined to be Type V (111). Because of the date of construction, the building was surveyed per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.	K 000		

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K 000	Continued From page 2 The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to PINE HAVEN CARE CENTER - BUILDING 01, which was determined to be of Type II (111) construction. There is a 2-hour fire-rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 70 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		10/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**09/14/2021**

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PINE HAVEN CARE CENTER INC	**210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963**

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K 353	Continued From page 3 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2. NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during the walk-through of the facility that items were stacked too high, less than 18 inches, from sprinkler heads in the closets of Room 537 and Room 646. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	1. These items were removed on 09/15/2021 for compliance 2. Staff were educated on 09/15/2021 3. Dietary and maintenance director will monitor for compliance monthly x 3	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		10/30/21

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	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**09/14/2021**

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K 521	Continued From page 4 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. Findings include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during documentation review that the smoke dampers were past due to the required 4-year inspection frequency. Dampers were last tested on 01/24/2017. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 521	1. Harris Company conducted damper testing on 10/04/2021. 2. Administrator and maintenance director will monitor for compliance to ensure contractor on month 10 is scheduled to preform 4 year inspection.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		11/24/21

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K 918	Continued From page 5 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, a review of the available documents, and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3.7, 8.3.8, 8.4.2.3, and 8.4.7. These deficient conditions could have a	K 918	1.contract signed with Ziegler on 10/07/2021 to preform these tasks. 2. Administrator and maintenance director will monitor for compliance. 3. contractor was 6 weeks out to come perform these task on 10/7/2021	

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K 918	Continued From page 6 widespread impact on the residents within the facility. Findings include: 1. On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during visual inspection of the emergency power supply systems and during document review that the installation date of the batteries for the emergency power supply system which services Building 02 (510 generator) could not be determined. 2. On 09/14/2021 between 108:30 AM to 01:30 PM, it was revealed during documentation review and staff interview that there was no annual inspection and testing documentation for the facility emergency power supply system which services Building 02 (510 generator). This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920		11/24/21

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K 920	Continued From page 7 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement the usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These deficient conditions could have an isolated impact on the residents within the facility. Findings include: 1. On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during facility walk-through of the facility the use of daisy-chained power-strips in Room 534. 2. On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during facility walk-through of the facility the use of a 2 to 6 plug-in electrical outlet adapter in Room 643. These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 920	1. Power strip removed from 534 on 9/15/2021. the multiple plug was removed on 9/14/2021. Electricians called to come out and add outlets. we are waiting on quotes to completes this task. most electricians are a couple months out of completing this work. 2.Administrator and maintenance director will monitor for compliance	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		10/30/21

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K 923	Continued From page 8 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

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K 923	Continued From page 9 Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.3.4, 11.6.2.3 and 11.6.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/14/2021 between 08:30 AM to 01:30 PM, it was revealed during the walk-through of the facility that Room 541 - Med Gas Storage had mixed storage of cylinders of empties with full cylinders and was missing signage physically separating empties from full cylinders. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 923	1. The Med Gas storage room was separated for full and empty cylinders to be in separate storage spaces. 2. Staff were re-educated on 10/21/2021 and 10/25/2021 on the facility policy to ensure Med gas tanks are separated. 3. The Director of Nursing or designee will monitor for compliance daily x 10, weekly x 6 and monthly x1.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	C 09/16/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 09/13/2021 through 09/16/2021, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, complaint surveys were also completed. Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please	2 000		

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5359065C (MN67309) with a deficiency cited at F725 H5359071C (MN48800) with no current deficiencies cited due to actions implementd by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5359064C, (MN73478) H5359066C (MN71083), H5359067C (MN59840), H5359068C (MN68715), H5359069C (MN63604), H5359070C (MN63692), 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing	2 000		

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2 000	Continued From page 2 orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, facility failed to ensure that respiratory equipment was maintained in a sanitary manner for 3 of 4 residents (R6, R54 and R64) reviewed for aerosolized medications and oxygen use and failed to ensure clear and accurate orders for oxygen administration for 1 of 3 residents (R44) also reviewed for oxygen use. Findings include:	2 270	Corrected	10/29/21

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2 270	Continued From page 3 According to the electronic health record (EHR) Admission Record/face sheet, R6 had diagnoses of shortness of breath, acute on chronic diastolic (congestive) heart failure, chronic combined systolic (congestive) and diastolic heart failure, acute and chronic respiratory failure with hypoxia and with hypercapnia, as well as a diagnosis of chronic obstructive pulmonary disease and 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 any aerosolized medication. The nurse was not in the room. R6 confirmed that she	2 270		

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had not cleaned the cup and did not know if any staff had cleaned the equipment since she had last had her treatment. No nurse was present in the room when R6 poured the solution into the cup and started the machine.

On 9/15/21, 8:40 a.m. R6's nebulizer medication cup with mouthpiece attached were observed to be laying inside R6's bedside stand drawer on top of various personal items such as old letters, lotion bottles, etc. The cup was attached to tubing that extended up out of the drawer and was attached to the nebulization machine. R6 said she had not used the equipment since the evening before and stated she had not observed anyone coming into her room to clean the equipment. She confirmed that she had placed the cup inside her drawer after using it so it would not fall on the floor.

R54
According to R54's EHR Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure and heart failure.

According to a 5/11/2020 physician order, R54 could self-administer nebulized medications and meter dose inhalers once set up by the nurse.

R54's care plan in the EHR had a focus problem area (not dated) that indicated R54 could self-administer medications; however, the care plan failed to indicate who was responsible for keeping the equipment clean.

On 9/13/21, 4:51 p.m. R54's medication cup for aerosolization of medication was observed to remain connected to the face mask for administration and connected to the nebulization machine by tubing. The cup and mask were

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laying on the counter beside the machine. R54 was not sure if staff cleaned the equipment and could not confirm it had been cleaned that day. The mask looked visually soiled with many specks and smudges on the inner portion of the mask, the cup had moisture droplets.

On 9/14/21, 2:20 p.m. R54's medication cup for aerosolization of medication was observed to remain connected to a face mask that appeared soiled, and to tubing connected to R54's nebulization machine. An empty medication vial was sitting next to and behind the nebulizer. The cup and mask were laying on their side on the counter. R54 stated she was able to self-administer medications and she had last used the machine around noon. R54 confirmed the medication cup and mask had not been cleaned. 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. R54 confirmed she did not need the medication at that time.

According to an interview 9/14/21, 2:27 p.m. a registered nurse (RN-C) stated that when a resident was done with a nebulization treatment the nurse should return and clean the medication cub and the mouthpiece or facemask. RN-C confirmed he had not returned to R54's room to clean the equipment. A review of R54's medication administration record (MAR) indicated RN-C had provided R54 her last dose of aerosolized solution at noon.

During an interview 9/14/21, 3:48 p.m. a licensed practical nurse (LPN-C) stated a nurse is responsible to keep the nebulization equipment

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clean even if a resident self-administers medication. LPN-C said the cup and mouthpiece, or facemask should be detached from the tubing and then washed. LPN-C said the med cup and mouthpiece/mask should then be left to dry on a fresh towel after every use.

On 9/15/21, 8:35 a.m. R54's nebulizing machine remained on the counter at her side with the tubing connected to a medication cup and face mask which were laying on their side. A small white crusty area of dried solution was observed directly under the medication cup, on the counter. A review of R54's MAR at that time indicated no nebulization treatment had yet been given that morning. This was confirmed by R54. The last documented dose of any medication that would be given using the nebulizing equipment was at 10:00 p.m. on 9/14/21.

According to an interview 9/15/21, 10:28 a.m. RN-D, unit manager said the mouthpiece or face mask and medication cup should be detached from the nebulizer after treatment, rinsed off and then set out to dry. This was to be done as soon as nebulization was complete. RN-D said a resident could turn on the call-light to let the nurse know they had finished their treatment, or the nurse should return to the room as soon as possible after the treatment was likely to be completed.

R44
According to the EHR R44's admission record/face sheet, R44 had been admitted to the facility with a primary diagnosis of chronic combined systolic (congestive) and diastolic (congestive) heart failure in which the heart is no longer able to sufficiently circulate blood to meet the bodies need, and with a component of fluid

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overload. R44 also had significant pulmonary dysfunction with a diagnosis of chronic obstructive pulmonary disease, shortness of breath, a dependence on supplemental oxygen and a history of pleural effusion (fluid in lungs) among many other co-morbidities.

According to a quaterly Minimum Data Set (MDS) assessment dated 7/30/2021, R44's primary medical condition was considered to be a "medically complex condition."

R44 had a physician's order dated 7/29/21 indicating "supplemental oxygen to maintain oxygen saturations >90%; document in progress note: LPM (liters per minute) and O2 saturations with and without every shift."

A review of R44's treatment administration record (TAR) for 9/01/21 through 9/14/21 showed nurses had signed each shift acknowledging the order, but not further documentation of oxygen saturations or rate of oxygen flow was seen in the TAR. A review of R44's progress notes from 9/01/21 through 9/14/21 failed to show daily shift nurse documentation on this same information, and in fact, contained such notes only on 9/4/21 12:56 p.m. and on 9/14/21, 3:42 p.m.

On 9/14/21, 8:55 a.m. R44 was observed resting in his bed and had oxygen running at 1.5 lpm via nasal cannula. R44 shrugged when asked about his oxygen, but then wrote a note indicating he thought his O2 order was for 1.1 LPM (the oxygen concentrator did not have increments to allow 1.1 LPM)

According to an interview 9/14/21, 3:50 p.m. LPN-C stated R44 does not use his oxygen all the time. LPN-C stated she did not remember R44

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having an oxygen saturation lower than 90% when she was working but stated she had seen him using his oxygen. LPN-C said they should document his oxygen saturation and the amount of oxygen he was using each shift. LPN-C confirmed the order did not say how many liters of oxygen per minute to apply, but thought 2 LPM was "pretty normal, but it doesn't stay that in the order." LPN-C thought the facility had a standing order to start residents on 2 LPM if they needed oxygen but was unable to find this order. LPN-C stated that if R44 had an oxygen saturation level less than 90% she would start oxygen at 2 LPM and then titrate it down until he was stable and maintained his saturations greater than 90%. LPN-C also indicated they should keep the equipment clean but confirmed there was no order to change R44's tubing. LPN-C did not know when R44's oxygen tubing or nasal canula had been changed.

According to an interview 9/15/21, 10:33 a.m. RN-D stated it was the expectation to check a resident's oxygen saturation levels each shift if they required oxygen use. RN-D said if a physician's order said to keep a resident's saturations above a certain percent, the nurse should use between 1 LPM and 5 LPM using a nasal cannula. RN-D said the 1-5 LPM recommendation "it's in my brain somehow, let me check on that for the procedure." RN-D stated she thought an LPN could make the decision on what level of oxygen to start a resident on, but they should alert an RN to do an assessment as well. RN-D said if a resident's oxygen order was not clear, a nurse should call the provider to get a new order.

According to an interview 9/15/21, 11:05 a.m. the director of nursing (DON) stated an expectation

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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'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 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 ..."

The Oxygen Administration policy revised October 2010, indicated a nurse should first verify

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there is a physician's order for oxygen administration. The document included the following directions, "turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liter per minute." Required documentation listed: date and time, rate of oxygen flow, route and rationale, frequency, and duration of the treatment. Documentation was also to include reason for the administration, any assessment data obtained before, during and after the procedure. The policy did not provide information about care of the oxygen equipment for those who require the on-going use of such equipment.

R64 Oxygen Use
R64's admission MDS dated 8/19/21, indicated R64's cognition was intact. R64 required extensive physical assistance from staff for all activities of daily living (ADLs) and received oxygen therapy.

R64's face sheet printed 9/16/21, indicated R64's diagnoses included obstructive sleep apnea, degenerative disease of the nervous system, type 2 diabetes mellitus, and chronic kidney disease.

R64's physician orders indicated an order dated 8/12/21, for Oxygen 1 liter every evening and night shift. On HS (bedtime) and off in AM for sleep apnea.

R64's care plan, printed 9/16/21, did not indicate interventions related to oxygen. Additionally, R64's care plan did not indicate interventions related to sleep apnea.

R64's September 2021, Electronic Treatment Administration Record (ETAR) printed 9/16/21, indicated R64's oxygen had been placed on every

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2 270	Continued From page 11 HS (bedtime) and off every AM from 9/1/21 through 9/15/21. Additionally, R64's ETAR indicated a start date of 9/20/21, to change and date oxygen tubing every Monday evening. The record lacked documentation indicating the oxygen tubing had been changed prior to 9/16/21. On 9/14/21, at 8:31 a.m. R64's oxygen tubing with nasal cannula was observed on the floor, under a chair in R64's room. On 9/15/21, at 7:48 a.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room. On 9/15/21, at 12:55 p.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room. On 9/15/21, at 3:25 p.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room. During an interview on 9/15/21, at 3:42 p.m. licensed practical nurse (LPN)-F confirmed R64's oxygen tubing with nasal cannula was on the floor, under a chair in R64's room. LPN-F stated, "That's not good, that should not be on the floor." LPN-F picked up the tubing, removed it from the oxygen concentrator and stated that he would replace it with a new nasal cannula and new tubing. When LPN-F was asked why the nasal cannula should not be on the floor, LPN-F stated, "because of infection control". When LPN-F was asked what should have been done with the tubing when not in use, he stated the tubing should have been placed on the hook located above the oxygen concentrator, not on the floor. During an interview on 9/16/21, at 2:07 p.m. the	2 270		

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2 270	Continued From page 12 Infection Preventionist (LPN)-E stated when oxygen was not in use, the tubing should have been wrapped up and placed on the oxygen concentrator, not on the floor or bed. Additionally, LPN-E stated that if the nasal cannula had been used after it had been on the floor, "it could cause infection, staph, MRSA, E-coli, a lot of bad things". Facility policy, Oxygen Administration revised 10/10, did not address placement of the oxygen tubing when not in use. Additionally, the policy did not address any changing of oxygen tubing. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' oxygen equipment is managed. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 270		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		10/29/21

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2 302	Continued From page 13 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to ensure that 1 of 8 staff persons finished Alzheimer's/dementia training as required. Findings include: A request was made for the training records of 5 front line staff, and 3 supervisors and reviewed for having completed Alzheimer's/dementia training. One registered nurse (RN-E) hired on 10/20/20, completed one of four required training areas on 11/20/20 and a second on 12/2/20, but the facility did not have record the remainder were completed. According to an interview on 9/16/21, 2:10 p.m. the director of nursing (DON) stated an	2 302	Corrected	

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2 302	Continued From page 14 expectation for all nursing staff to complete a comprehensive Alzheimer's/dementia training prior to starting their work with the residents. DON stated all staff must complete a basic training prior to starting to work. DON confirmed that facility did not have record of RN-E's completion of the training. SUGGESTED METHOD OF CORRECTION: The DON or designee could monitor for compliance/completion of planned education within the facility. The DON could assure that new employees do not begin working with residents until a certificate of dementia training is completed and in the employee's file.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a comprehensive care plan was developed for urinary indwelling catheter for 1 of 1 resident (R61) reviewed for catheters. Findings include:	2 560	Corrected	10/29/21

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2 560	Continued From page 15 During an observation on 9/13/21, at 2:55 p.m. R61 laid in bed, R61 was observed to have a 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, also did not identify the size and type of catheter R61 required. R61's current physician orders did not identify an order for an indwelling catheter. The physician order dated 8/15/21, directed staff to change R61's catheter every 30 days. R61's treatment administration record indicated R61's catheter was changed on 8/30/21. R61's record did not identify what size or type of catheter was inserted, nor the size of the balloon.	2 560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 16 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 the type. 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 catheter in place. During an interview on 9/16/21, at 11:44 a.m. director of nursing (DON) stated a catheter required a physician's order that identified the size and type of catheter and balloon size and there should have been an order obtained prior to changing the catheter. Facility policy Care plans, Comprehensive Person Centered policy dated 12/2016, included, The care plan interventions are derived from a	2 560		

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2 560	Continued From page 17 thorough analysis of the information gathered as part of a thorough comprehensive assessment. The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Iincorporate identified problem areas, reflect treatment goals, timetables, and objectives in measurable outcomes. The comprehensive, person centered care plan is developed within seven days of the completion of the required MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to plan of care. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are comprehensively developed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	2 570		10/29/21

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2 570	Continued From page 18 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure revision of the care plan for activities of daily living (ADLs) after the completion of significant change Minimum Data Set (MDS) was completed for 1 of 2 (R175) residents reviewed for bowel and bladder. Findings include: R175's Restorative Nursing Screener dated 7/14/21, indicated R175 was independent with bed mobility and required supervision or touching assistance for transfers. R175's care plan for mobility/positioning/locomotion dated 5/11/20, included "Transfers/ambulation with FWW [front wheeled walker] and gait belt. Use wheelchair for longer distances outside of room." R175's care plan for transfers dated 5/11/20, indicated R175 required assist of one for use with FWW. R175's dressing care plan dated 4/2/21, indicated assist of one. R175's significant change MDS dated 8/23/21, indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R175's care plan did not identify the level of	2 570	Corrected	

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2 570	Continued From page 19 assistance in accordance with the MDS. During an observation on 9/14/21, at 12:32 p.m. R175 sat in her wheelchair in front of the nursing station. Nursing assistant (NA)-A asked licensed practical nurse (LPN)-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy; LPN-D called therapy and stated to NA-A, R175 required two assist with a gait belt and a walker. NA-A wheeled R175 into her room, NA-D followed into the room. NA-A put a gait belt around R175, NA-A and NA-B attempted to assist R175 to a standing position, however, R175 was not able to stand up and was not cooperative with the NAs. At 12:38 p.m. LPN-D entered the room to try and assist NAs with transferring R175 to bed. NA-A and LPN-D attempted to assist R175 to a standing position and again R175 was not able to stand up and LPN-D stated he was going to go get a physical therapist to assist. At 12:49 p.m. NA-A pushed in a full body mechanical lift into R175's room, PT-A entered the room. PT attempted to stand R175 up with NA-A and NA-B however, R175 was not able to stand, PT-A then instructed to use the mechanical lift. PT-A and NAs then transferred R175 into bed using the full body mechanical lift. During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) reviewed R175's record, DON indicated R175's mobility had changed within the last month. DON verified the care plan was inconsistent with the significant change MDS and should have been revised. Facility policy Care plans, Comprehensive Person Centered policy dated 12/2016, included, The care plan interventions are derived from a thorough analysis of the information gathered as part of a thorough comprehensive assessment.	2 570		

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2 570	Continued From page 20 The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Incorporate identified problem areas reflect treatment goals, timetables and objectives in measurable outcomes. The comprehensive, person centered care plan is developed within seven days of the completion of the required MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830		10/29/21

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2 830	Continued From page 21 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate assessment, monitoring and physician notification were completed for 3 of 3 residents (R48, R36, R44). This resulted in actual harm when R48 required re-hospitalization with fluid overload resulting in respiratory failure and acute on chronic congestive heart failure. Findings include: R48's facility face sheet identified R48 was admitted to the facility on 7/30/21, with diagnoses of heart failure, chronic obstructive pulmonary disease, and hypercapnic respiratory failure. R48's physician visit dated 7/30/21, included R48 had leg swelling and his weight was 333.8 lbs. (pounds). Plan was to continue Lasix 40 milligrams [mg], will adjust if needed, nursing to monitor weight, Check daily weight notify provider if gain 2 lbs. in a day or 5 lb. in a week. R48's physician orders reviewed, included the following -Daily weights, notify physician for weight gain over 2 lbs. (pounds) in a day OR 5 lbs. in a week (start date 8/2/21) -Lasix 40 mg (milligrams) one time a day for congestive heart failure (start date 7/31/21) -Occupational therapy wrap bilateral lower extremities Monday through Friday (start date 8/6/21)	2 830	Corrected	

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2 830	Continued From page 22 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. R48's admission Minimum Data Set (MDS) dated 8/6/2021, identified R48 did not have cognitive impairment, required extensive assistance of two or more staff members for activities of daily living that involved mobility and extensive assist of one staff for personal hygiene and dressing. The MDS indicated R48 was administered diuretic medications. R48's care plan dated 8/6/21, indicated R48 had a diagnoses of congestive heart failure with corresponding interventions, compression stockings on in the morning off and night, physician to assess medication program periodically, medications as ordered, staff to observe for signs and symptoms of increased edema, significant weight changes, increase shortness of breath/new shortness of breath, and notify physician as needed, and weight at least weekly, or as ordered by physician, notify physician of significant weight gain. R48's record indicated on 8/6/21, physician ordered a chest X-ray to rule out tuberculosis. R48's chest X-ray results on 8/11/21, indicated R48 had patching opacification (air in lungs replaced with other material such as fluid or bacteria) in the right lower lobe, and small pleural effusion (water on the lungs). The report also included " Patchy right lower lobe infiltrate is seen, follow up exam recommended)." R48's weight record identified over 2 lb. weight gain in a day without evidence of physician	2 830		

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2 830	Continued From page 23	2 830		

notification per physician order.
-On 8/3/21, weight was 330.4 lbs.
-on 8/4/21, weight was 334.2 lbs.
-On 8/5/21, weight was 339.0 lbs.
-On 8/7/21, weight was 343.0 lbs.
-On 8/9/21, weight was 343.0 lbs.
R48's record lacked evidence of daily weights on 8/10/21, 8/11/21, 8/12/21, and 8/13/21.

R48's progress note dated 8/13/21, at 7:39 a.m. included, "Resident had a sudden onset of shortness of breath around 4:00 a.m. Resident appeared pale/cyanotic. Resident initially had head of bed elevated, and oxygen increased to 3 liters per minute (LPM). Lung sounds clear/diminished. Vital signs: blood pressure 146/85, Pulse of 90, respirations 28, and oxygen saturations 80%. Resident requested to be placed in a tripod position, fellow nurse assisted to position, and one on one supervision initiated. Resident refused ambulance services. Symptoms resolved approximately 30 minutes after onset. Resident requested to be put back to bed with head of bed elevated. Every one-hour checks initiated, morning staff notified of incident and sent physician notification."

R48's progress note dated 8/13/21, at 10:30 a.m. indicated R48 was transferred to the hospital via ambulance related to shortness of breath and low oxygen saturations.

R48's discharge summary dated 8/25/21, indicated primary diagnosis for admission was hypercarbic (increase in carbon dioxide in the bloodstream)respiratory failure and acute on chronic congestive heart failure. The summary indicated between hospital discharge on 7/25/21 and hospital admission on 8/13/21, R48 had an 8.8 lb. weight gain. The summary indicated 1.5

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2 830	Continued From page 24 liters of fluid was removed from R48's lungs. The discharge summary included new orders to change diuretic from Lasix to Torsemide and add 2-liter fluid restriction. R48's physician orders between 8/25/21 to 9/13/21 included: -Daily weights, notify physician for weight gain over 2 lbs. in a day OR 5 lbs. in a week (start date 8/25/21) -Fluid Restriction: 2 Liter-Document in progress note with total 24-hour fluids consumed (Start Date 8/25/21) -Torsemide 60 mg one time a day related to heart failure (start date 8/25/21) -Compression Stockings: Donn in a.m. prior to getting out of bed. Remove in evening once in bed (start date 8/25/21) R48's weight record was reviewed from 8/25/21 to 9/13/21; record lacked physician notification in accordance with physician orders until 9/7/21. -On 8/25/21, weight was 303.0 lbs. -On 8/26/21, weight was 308 lbs. -On 8/28/21, weight was 307.2 lbs. -On 9/2/21, weight was 310.0 lbs. -On 9/3/21, weight was 312.6 lbs. -no weight was recorded on 9/4/21 according to physician's orders -On 9/5/21, weight was 315.0 lbs. -On 9/7/21, weight was 315.0 lbs. R48's physician notification dated 9/7/21, indicated R48 had a 13 lb. weight increase since 8/31/21 with no other symptoms. The note indicated R48 had +2 pitting edema to both lower extremities. The note also included, He does have some complaints of shortness of breath with exertion but is able to catch his breath when at rest. Lungs are clear bilaterally anterior and	2 830		

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2 830	Continued From page 25 posterior. R48's fluid intake record was reviewed along with nursing progress notes for the 24-hour fluid intake evaluation. Fluid intake was not consistently documented every shift; with the lack of documented intake on the 24-hour fluid intake it could not be calculated/reviewed in accordance to the fluid restriction. R48's record identified between 9 different shift when R48's fluid was not monitored or documented from 8/25/21 to 9/13/21. During an observation and interview on 9/13/21, at 1:43 p.m. R48 sat up in his wheelchair. R48 stated he was in the hospital a couple of weeks ago for fluid overload and they had removed 24 liters of fluid. R48 stated when he got back from the hospital, he weighed 303 lbs. but was back up again to 315 lbs. R48 stated before he went to the hospital, he had been around 330 to 335 lbs. R48 stated he had felt so much better after all the fluid was removed, and thought it had steadily progressing over time, and indicated he would have to pay closer attention to his weight gains. During an interview on 9/15/21, at 8:24 a.m. medical director stated there were clear expectations nursing notify the physician when there was a weight gain in accordance with physician order. Medical director indicated the most objective measurement for fluid volume monitoring is weight gain. Medical director stated nursing needed to be monitoring/evaluating edema for the effectiveness of the treatments and medications. During an interview on 9/15/21, director of nursing (DON) stated she expected the physician	2 830		

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2 830	Continued From page 26	2 830		

be notified of weight gain in accordance with physician orders. DON stated the expectation of monitoring edema daily and findings documented accurately. DON stated if there was a weight gain, an evaluation needed to be done to determine if the weight gain was related to fluid, the evaluation should include a complete respiratory assessment, resident interview, and assessing for edema in extremities, hips, and abdomen. DON indicated if there was a change the physician needed to be notified. DON stated the episode of shortness of breath should have been documented in its entirety with a complete assessment and passed along in shift report for continual monitoring.

R36

R36's face sheet indicated R36 was admitted to the facility on 7/20/21, with diagnoses of congestive heart failure, chronic kidney disease stage 4, and hyperkalemia.

R36's hospital discharge summary dated 7/20/21, indicated R36 was admitted in part related to fluid overload with a primary diagnosis of hyperkalemia (high potassium) and had a history of hospitalization for heart failure exacerbation with the last visit in May 2021. The discharge summary included, "would recommend short term rehab to allow for closer monitoring of his weights/fluid status to determine appropriate dosing of diuretic in the outpatient setting." The summary indicated R36's dry weight of 303.6 lbs. The discharge summary also included an order for daily weights with close monitoring.

R36's physician orders included:
-Daily weights notify physician for weight gain of over 2 lbs. in a day or over 5 lbs. in a week (start

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2 830	Continued From page 27 date 7/23/21). -Lasix (diuretic medication) 10 mg (milligrams) in the morning for fluid retention's (start date 7/23/21). R36's care plan dated 7/25/21, identified R36's diagnosis of congestive heart failure. Associated interventions included, elevate feet when sitting up in chair to help prevent dependent edema, monitor for signs and symptoms of hypovolemia/hypervolemia [medical condition when you have too little/too much fluid in your body], monitor/document/report to MD as needed the following signs/symptoms: Edema; weight gain of over 2 lbs. a day; neck vein distention; difficulty breathing; increased heart rate; elevated blood pressure; skin temperatures; monitor breath sounds for crackles. R36's physician visit dated 8/27/21, indicated R36's weight was stable on low dose of Lasix; weight was 299.6 lbs. and on admit on 7/20/21 was 298 lbs. R36's weight record reviewed between 8/27/21 and 9/13/21, identified an increase in weight over 2 lbs. in a day or over 5 lbs in a week; record lacked evidence of physician notification. R36's weights included: -On 8/28/21, weight was 302.2 lbs. -On 8/30/21, weight was 302.8 lbs. -On 8/31/21, weight was 304.2 lbs. -On 9/3/21, weight was 306.6 lbs. -On 9/4/21, weight was 308.0 lbs. -On 9/6/21, weight was 308.4 lbs. -On 9/7/21, weight was 310.0 lbs. -On 9/9/21, weight was 313.4 lbs. -On 9/11/21, weight was 315.0 lbs. -On 9/12/21, weight was 315.4 lbs. -On 9/13/21, weight was 314.2 lbs.	2 830		

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2 830	Continued From page 28 During an observation on 9/13/21, at 3:21 p.m. R36 sat in his wheelchair with his feet down on the floor. R36 was wearing regular cotton socks and was observed to have edema from ankle to just below the knee. R36 stated he had a history of congestive heart failure and had been in the hospital for it. During an observation and interview on 9/14/21, at 8:13 a.m. R36 sat in his recliner with his feet elevated. R36 was observed to have edema in both legs from ankle to just below the knee. R36 stated that he had not slept very well last night, he woke up short of breath and indicated he called for staff to assist him to his recliner. R36 stated the shortness of breath resolved once he was sitting up. R36 stated, "according to my doctor the fluid in my legs is making it hard for me to breath." R36's progress note dated 9/14/21, at 3:56 a.m. did not address R36's episode of shortness of breath and indicated R36 did not have edema present. R36's documented oxygen saturations were 90% on room air, which was below R36's average of 93-98%. During an interview on 9/14/21, at 12:05 p.m. licensed practical nurse (LPN)-D was asked, how often do you measure edema, LPN-D stated he had never measured edema while working at this facility, stated he would only measure the edema if the resident had ace wraps or if physical therapy had reported concerns of edema. During an observation and interview on 9/14/21, at 12:11 p.m. LPN-D entered R36's room, R36 was sitting in his wheelchair with his feet down on the floor. LPN-D requested permission to	2 830		

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2 830	Continued From page 29	2 830		

evaluate edema; R36 consented. LPN-D stated R36 had 2+ pitting edema around both right and left ankles and 3+ to 4+ edema from lower shin to just below the knee on both legs. Although, R36's progress note dated 9/14/21, at 12:32 p.m. entered by LPN-D, reflected R36 had "No edema present" even though LPN-D had evaluated the edema at 12:11 p.m. in the presence of the surveyor.

R44

According to R44's electronic health record (EHR) admission record/face sheet included diagnosis of chronic congestive heart failure, cardiomyopathy (damaged heart muscle), high blood pressure, chronic obstructive pulmonary disease, shortness of breath, a dependence on supplemental oxygen and a history of pleural effusion (fluid in lungs).

R44's quarterly Minimum Data Set (MDS) assessment dated 7/30/2021, R44's primary medical condition was considered to be a "medically complex condition."

R44's physician orders instructed nursing staff to monitor and evaluate R44 for fluid overload and reduce the risk of fluid overload. The following orders included:
2 L (liters) fluid restriction-document total consumed each shift. NOC (night shift) will total every day shift,
Document progress note with total 24 hour fluids consumed;
Daily weights-->notify provider if >189 lbs in the morning;
Document progress note on edema location, pitting edema noted, skin intact (fluid weeping) lung sounds, weight, CNP [certified nurse practitioner] followed up on 8/13/21 and increased torsemide [diuretic]. Edema to BLE

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2 830	Continued From page 30 [bilateral lower extremities]. Every evening shift until resolved, Wrap legs daily with ACE bandages on in am and off at HS [bedtime]. R44's orders also included medications to control heart, blood pressure and to relieve edema: Metoprolol succinate capsule ER 24 hour sprinkle 25 mg, give 12.5 by mouth in the morning, Spironolactone tablet, give 50 mg by mouth one time a day, Torsemide tablet 20 mg, give 40 mg by mouth two times a day. R44's Torsemide dose had increased on 8/13/21 from 20 mg to 40 mg and increased again on 8/16/21 to be taken twice a day instead of once per day. . A review of R44's daily weight was not recorded on 9/3, 9/5, 9/10 or 9/11. On 9/12, 9/13 and 9/14 his weight exceeded 189 pounds. A physician order dated 8/14/21 included instructions for a progress note to be written daily on R44's edema location, pitting edema noted, skin intact (fluid weeping), lung sounds and weight. A review of R44's record for September identified missing progress notes for 9/9/21-9/11/21 no note related to edema, weight, or lung sounds 9/12/21-"weight was taken after lunch. Will reweight [sic] tomorrow and reassess. Resident is asymptomatic." No additional information related to edema or lung sounds. 9/13/21-no note related to edema, weight, or lung sounds 9/14/21 at 3:42 p.m. "assessment conducted: resident is alert and oriented x3, oxygen levels 92-93% on 1 L, wheezing auscultated bilaterally, 4+ edema of R and L extremities. Weight for today 190.2 lb. Nurse manger notified of change	2 830		

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2 830	Continued From page 31 in weight, ACE wrap applied, resident left building for scheduled appointment." On 9/14/21, at 8:19 a.m. R44 was observed lying in bed in his room, resting. His facial appearance and limbs was red and flushed. A one liter jug of ice water was noted to be sitting at his bedside. An oxygen concentrator was beside the bed and was running, but R44 did not have a nasal cannula in his nose. On 9/14/21, at 8:43 a.m. R44 was observed sitting on the side of his bed. His legs were bare and swollen from the knees down. R44 had difficulty speaking, but was able to communicate through short phrases, gestures, some writing and answering yes, no questions. He indicated he had noticed his legs were swollen and gestured to show they were getting bigger. He also tapped on his abdomen. He indicated his legs should be wrapped. His hands were slightly swollen and he held them up to be seen. On 9/14/21, 12:03 p.m. R44 was observed to be lying in bed with his legs bare. Registered nurse (RN)-C entered the room with two elastic compression wraps and informed R44 he should have his legs wrapped before going out for the day. RN-C started wrapping R44's right leg at the toes and performed a figure eight wrap. He asked, "do you like it tight? No, just a little loose?" After reaching R44's knee, there was a considerable amount of wrap still on the roll, so RN-C proceeded to wrap the leg back down to the ankle. Following the right leg, RN-C wrapped the left leg in the same manner. RN-C stated the wraps were too long, and that he should have gone to find different wraps; however, RN-C did not go find any other wrap.	2 830		

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2 830	Continued From page 32 At 9/14/21, 12:15 p.m. R44 indicated he had not been weighed. RN-C stated R44 was to be weighed every day. RN-C called to a passing nursing assistant (NA-F) who said R44 had not been weighed. Another nursing assistant, NA-C stated daily weights were to be done every morning as soon as possible, before eating and confirmed that R44 had not yet been weighed for unknown reasons. NA-C weighed R44 and reported a weight of 195 lbs. During an interview on 9/14/21 at 12:17p.m. RN-C confirmed that R44 had an order to monitor edema. He stated the best way to assess edema was to "squeeze the feet and watch how much indent would occur" and confirmed he had not done this but would do it later. RN-C noted R44's weight should be re-checked because it was more than the day before. RN-C confirmed he had been working the day before and had documented a weight of 191.6, but had not called the medical provider, stating he had not seen the order to call the provider for a weight greater than 189 lbs. RN-C stated an increase in weight and edema indicated a possible fluid overload. According to an interview 9/14/21, 12:42 p.m. the nurse manager for the unit, RN-D, said a daily weight was to be done before breakfast, and edema monitoring and compression wraps should also be done early in the morning. Edema monitoring, RN-D confirmed, should be accomplished prior to the application of the compression wraps. RN-D stated a nurse should find a shorter set of compression wraps if the ones they had were too long. RN-D said a nurse should notify medical providers when a resident has a change in condition or when an order was left for notifications to be done. The expectation for notification method would be to write out an	2 830		

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2 830	Continued From page 33 "SBAR" (situation, baseline, assessment, result/request) form and send it to the provider immediately, but any nurse should also be able to call a provider with a report. RN-D was not aware of any guidelines saying it must be the nurse manger to call. RN-D confirmed that R44 had an order for a daily weight to be done, but upon review of his EHR stated, "it has not been done daily." RN-D stated an expectation of nurses to document on R44's condition in a daily progress note as outlined in his orders with lung sounds, edema, changes in weight, but confirmed that this information was not done daily, saying, "it looks like there is no documentation since the 12th." According to an interview 9/14/21, 12:57 p.m. with the director of nursing (DON) the DON stated an expectation that daily weights be done at the same time each day, preferably right away upon rising before breakfast. DON also stated an expectation for compression wraps to be applied before getting up for the day. In relation to monitoring edema, DON stated some physicians like to have edema checked later in the day, such as in the afternoon, to see if the condition progresses when the resident is up, but in general, edema monitoring should be done in the morning prior to the application of the compression wraps. DON said that when monitoring a resident for problems with fluid excess it was expected that nurses would do daily weights, monitor lung sounds, vital signs and sometimes abdominal girth if ordered. DON stated any orders should be initialed as being completed in the treatment administration record (TAR), but a progress note should be written as well. During an interview 9/15/21, 8:46 a.m. with the facility medical director (MD-A), he stated he was	2 830		

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2 830	Continued From page 34 watching R44's condition closely as he had a "perplexing presentation," their interventions had not been fully successful and R44's "clinical trajectory continues to decline." MD-A stated unchecked fluid intake would be problematic, although he was currently stable. The primary concern for R44, according to MD-A was an exacerbation of his heart failure. A request was made of the facility for a policy on fluid/edema management and monitoring, but this was not provided. The Heart Failure-Clinical Protocol policy revised November 2018 covered only expectations of physicians and did not address nursing care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit orders for residents with fluid imbalance and ensure they are clear and understandable. DON or designee could ensure all nursing staff receive education on fluid balance issues, edema monitoring and documentation. Audits could be done to ensure compliance of proper daily weights, edema monitoring, documentation of fluid intake and proper reporting. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean	2 850		10/29/21

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2 850	Continued From page 35 and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal care assistance to promote dignity for 1 of 2 female residents (R49) who depended on staff for assistance with shaving facial hair. R49's significant change Minimum Date Set (MDS) completed 8/6/21, indicated R49's cognition was severely impaired. R49 was dependent on physical assistance from staff for all activities of daily living (ADLs) including personal hygiene and grooming. R49's face sheet printed on 9/15/21, indicated R49's diagnoses included depression, dementia, and Alzheimer's. R49's care plan last review date 6/25/21, indicated R49 required total assistance with personal hygiene which included shaving facial hair. On 9/13/21, at 12:25 p.m. R49 was observed seated in her wheelchair in her room. R49 had greater than 30, coarse, white hairs that were 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, white hairs that were approximately 1/4 inch in length on her chin and upper lip. On 9/15/21, at 7:31 a.m. nursing assistant (NA)-D	2 850	Corrected	

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and registered nurse (RN)-H were observed assisting R49 with morning cares. R49 was assisted out of bed, into her wheelchair. RN-H washed R49's face and dried it. NA-D combed R49's hair then brought R49 to the dining room. Neither NA-D nor RN-H offered to assist R49 with shaving her facial hair.

On 9/15/21, at 7:43 a.m. NA-D stated R49 required full physical assistance from staff for personal hygiene and grooming which included shaving facial hair. NA-D stated he had never assisted a female resident with facial hair but would do it if it was needed. NA-D confirmed he did not check R49's face with morning cares and that R49 did have a shaver in her room. NA-D observed R49 in the dining room then confirmed R49 had long, coarse, white hairs on her chin and upper lip, "Yeah, there's a lot there."

On 9/15/21, at 8:18 a.m. RN-J confirmed R49 had several coarse, long, white hairs on her chin and upper lip. RN-J stated she expected residents were assisted with shaving facial hair as needed. RN-J stated, "There are a lot who have long chin hairs, we aren't doing it and staff are in a hurry." RN-J indicated she would feel embarrassed and uncomfortable if she was around other residents and had long facial hair.

On 9/15/21, at 8:56 a.m. RN-H stated if R49 was able to speak for herself, she would be bothered having long facial hair when around other residents and visitors.

On 9/15/21, at 10:29 a.m. director of nursing (DON) stated she expected facial hair was taken care of on bath days and as needed in between. DON expected female residents received assistance with shaving facial hair for dignity, "I

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2 850	Continued From page 37 would anticipate if they were to see themselves in the mirror, the whiskers would not be acceptable to them." DON compared it to herself walking out of the house without her hair being combed. Facility policy, "Dignity" revision date 2/2021, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction in life, and feelings of self-worth and self-esteem. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a system to educate staff and develop a monitoring system to ensure dependent resident receive assistance with shaving as indicated on the care plan. The DON or designee could develop and implement system to audit grooming services, including shaving and provide education as needed when concerns are noted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		10/29/21

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2 900	Continued From page 38 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. Findings include R175's face sheet dated 9/16/21, included diagnoses of dementia with behavioral disturbance and congestive heart failure. R175's significant change minimum data set (MDS) assessment dated 8/23/21, indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS indicated R175 was occasionally incontinent of urine and bowel. The MDS identified R175 was at risk for pressure ulcers and did not have pressure ulcers or moisture associated skin damage at the time of the assessment. The MDS indicated pressure reducing device for chair was	2 900	Corrected	

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not used for chair however a pressure reducing device was used for bed and identified R175 did not have a turning and repositioning program.

R175's record lacked a comprehensive assessment for risk of skin breakdown after R175 became dependent on staff for mobility.

R175's care plan did not identify the level of assistance in accordance with the MDS. R175's toileting care plan dated 9/1/20, directed staff to toilet R175 upon rising, after breakfast, before and [after] all other meals, at bedtime, on night rounds, and as needed. R175's skin care plan dated 10/17/2019, indicated R175 "has the potential for pressure ulcer development r/t [related to] immobility. [R175] has thin, fragile skin prone to bruising, skin tears, and age related petechiae (pinpoint, round spots that appear on the skin as a result of bleeding)." Associated interventions included follow facility policies/protocols for the prevention of skin breakdown

R175's Skin Only Evaluation dated 9/10/21, at 11:44 p.m. indicated skin warm and dry, normal color, turgor normal, and had a skin tag on right upper abdomen.

During an observation on 9/13/21, at 7:40 p.m. R175 laid on her back in bed. R175's room smelled of urine. RN-H and nursing assistant (NA)-H were at bedside encouraging R175 to roll over to allow them to change her saturated incontinent garment. R175's mattress protectors was observed to also be urine soaked.

R175's behavior progress note dated 9/13/21, at 10:41 p.m. included tonight nurse and nursing assistant got R175 out of bed. Pain medication

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was offered at the beginning of the process, she did not understand. It was attempted to roll R175 she yelled out in pain and started hitting. The morphine was given and more communication about the process was provided. After several attempts to motivate the patient we rolled her on her side, washed and laid new pads down.

During an observation on 9/14/21, at 7:00 a.m. R175 sat in her wheelchair in a hospital gown. At 7:50 a.m. licensed practical nurse (LPN)-D stated R175 had been in the wheelchair all night because she had been restless, stated an unawareness of the last time R175 had been toileted or changed.

During an observation on 9/14/21, at 8:50 a.m. R175 was given her breakfast tray. At 9:27 a.m. R175 continued to sit in her wheelchair by the nursing station with her breakfast in front of her.

During an observation and interview on 9/14/21, at 12:04 p.m. R175 continued to sit in her wheelchair by the nursing station. Licensed practical nurse (LPN)-D stated R175 had been sitting there since he got there this morning, and stated he was not aware if NAs had checked her incontinent brief or repositioned her. LPN-D stated R175 had "nodded off for an hour maybe two" in her chair.

During an observation on 9/14/21, at 12:20 p.m. R175 remained by the nursing station. At 12:32 NA-A asked LPN-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy. NA-A was asked when R175 had last been toileted, NA-A stated the last time was between 6:00 a.m. and 7:00 a.m. when she assisted the night shift aide. At 12:49 p.m. R175 was transferred via full body mechanical lift to her

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bed by NA-A and NA-B. When NAs removed R175's incontinent garment, it was observed to be heavily saturated with urine. When R175 rolled onto her right side, a dark purple/blue area with a small wound that was bleeding was observed on her lower left buttock and small reddened area was observed on her right lower buttock. NA-A exited the room to get registered nurse (RN)-D. RN-D entered the room, RN-D observed the impaired skin integrity, and indicated R175 had a stage 1 pressure ulcer to the right buttock and the left buttock wound was a stage 2 and would have to do further evaluation if the wound was a deep tissue injury. RN-D stated the left buttock had more redness than the right and appeared irritated. R175 was very cooperative with RN-D during the assessment and with application of new brief.

During an interview on 9/14/21, at 3:38 p.m. RN-D stated the wound on her left buttock was a deep tissue injury, with an open stage 2 pressure injury. RN-D stated she had conversed with family member who thought that R175 had a history of a pressure ulcer to the same area. RN-D stated within the last several weeks R175 had an increased need to for assistance; she used to be independent with bed mobility and positioning herself. RN-D reviewed R175's care plan and verified the care plan was not consistent with the level of care R175 required and the MDS assessment. RN-D confirmed the care plan did not identify how often R175 needed to be turned and repositioned and an assessment to determine tissue response to pressure over time had not been completed after R175's change in condition. RN-D stated the nurse should have questioned/prompted or directed NAs to reposition R175 if there was a question of how long R175 was sitting in her chair next to the

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nursing desk. RN-D stated if R175 was refusing care then, it was expected the NA's reattempt or get someone else to attempt, report to the nurse on the floor, nurse should then attempt and notify the charge nurse of continued refusals. RN-D indicated, if necessary, the physician should be contacted for further medical management if interventions were unsuccessful. RN-D stated the refusals with interventions and the effectiveness of the interventions needed to be documented.

R175's progress note dated 9/14/21, 9:24 p.m. identified R175 had left buttock stage 2 deep tissue injury 2 centimeters (cm) x 0.9 cm. Injury is purple/blue in color, small tear which had fresh red blood around the edges, less than 0.5 cm in diameter of fresh red blood in center of injury. The evaluation indicated dietary would be consulted, and care plan revised to include repositioning schedule and behavior plan for increased need in cares including barrier cream and hydrating lotion for dry skin for comfort.

During an interview on 9/15/21, at 8:24 a.m. medical director stated a familiarity with R175 and indicated R175 had worsening heart failure and advancing dementia; goals of care were conservative. Medical director indicated an awareness of R175's behaviors of rejection/refusals of medications and compression management for edema, however, was not aware of rejection/refusals for repositioning/toileting. Medical director indicated an expectation of routine skin assessments and a repositioning plan be in place for the prevention of pressure ulcers. Medical director stated if a resident demonstrated self-neglecting behaviors the physician (or hospice) needed to be notified; residents can't sit in their own urine, it would need further evaluation. When asked if the duration of

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time R175 sat in her wheelchair without positioning or changing incontinent brief contributed to the pressure ulcers, medical director stated "Yes, that would be the definition of a pressure ulcer."

During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) indicated R175 should have been assessed for a turning and repositioning program after her mobility declined. DON stated the expectation residents were toileted in accordance with their care plan. DON stated if residents refused, the expectation was the nurse be notified, and ultimately the physician if necessary for further medical intervention.

R61

R61's hospital discharge summary dated 8/11/21, indicated R61 had a left buttock stage 2 pressure ulcer that had been identified on 7/16/21; plan for treatment included cleanse skin with wound cleanser, pat dry, and cover with foam boarder dressing, change dressing daily and as needed. The discharge summary also identified an unstageable pressure ulcer on a leg with orders for wound care.

R61's Admission skin assessment dated 8/11/21, did not identify presence of pressure ulcers. The note indicated resident refused with no further information or interventions for refusal.

R61's physician order dated 8/11/21, identified the left buttock pressure ulcer as outlined by the hospital discharge summary, however had a stop date of 9/2/21.

R61's physician order dated 8/11/21 included: Leg Pressure Injury Treatment: Cleanse affected area

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2 900	Continued From page 44 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). R61's physician order dated 8/14/21 included: Daily skin monitoring. If changes, document in skin alterations and wounds progress note. Wound: pressure injury to left lower extremity-unstageable, left buttock pressure stage 2. R61's record identified the left lower extremity pressure ulcer was not comprehensively assessed until 8/16/21, even though there were physician orders upon admission. In addition, the record lacked evidence R61's left buttock pressure ulcer had not been comprehensively assessed after facility admission, even though there was a physician ordered treatment for the wound upon admission and an order that directed both pressure ulcers be monitored daily. R61's skin evaluation dated 8/16/21, indicated R61 had an unstageable pressure ulcer on the left lower extremity (location on extremity was not identified) that measured 1.5 cm (centimeters) x 0.9 cm. The skin evaluation did not identify the presence of a stage 2 pressure ulcer. 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 skin evaluation dated 8/23/21 and 8/31/21, did not identify the stage 2 pressure ulcer. R61's record did not indicate why the physician ordered treatment to the left buttock was	2 900		

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2 900	Continued From page 45 discontinued on 9/2/21. R61's skin evaluations dated 9/7/21 and 9/8/21, did not identify the left buttock pressure ulcer. R61's physician order dated 9/13/21, included, "Leg Buttocks Pressure Injury Treatment": Cleanse affected area daily with normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover with mepilex border (sacral or large size). During an interview on 9/14/21, at 9:15 a.m. licensed practical nurse (LPN)-D indicated R61 only had one wound treatment to complete; the unstageable ulcer on the left calf. During an observation on 9/14/21, at 9:21 a.m. licensed 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 gloves, and washed hands. 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 observation on 9/15/21, at 1:16 p.m. RN-B explained to R61 he was going to change the dressings on his left calf and left buttock; R61 gave consent. RN-B washed his hands and donned gloves, RN-B then removed R61's wound dressing from the left calf and through the dressings on the floor. RN-B then removed the	2 900		

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cap from the saline bottle, put the ointments for the wound in the cap, opened a tongue depressor, and stirred the ointments together. RN-B then removed scissors from his left pocket and cut the non-stick dressing to the size of the wound. RN-B then used a Q-tip to spread the mixture of ointments onto the wound and applied the cover dressings. RN-B had the same gloves on throughout the procedure, in addition RN-B had not disinfected the scissors prior to or after the completion of the dressing change. RN-B then picked up the soiled dressings from the floor, took off gloves, and sanitized his hands. RN-B then informed R61 of the next dressing change on his left buttock. RN-B donned gloves and undid R61's incontinent brief, R61 was incontinent of stool, RN-B performed incontinent care (a dressing was not observed on R61's left buttock where there was a nickel sized superficial wound that was reddened), used an incontinent wipe to clean his gloves, walked to the bathroom and donned another pair of gloves (without disinfecting) over the gloves he already had on and applied the left buttock dressing per physician order.

During an interview on 9/15/21, at 2:13 p.m. RN-B confirmed there was not a dressing to the buttock wound and there should have been, RN-B stated if the wound had been resolved it's not anymore. RN-B stated he should have changed his gloves and performed hand hygiene after taking off the old dressing. RN-B stated an unawareness if double gloving was appropriate for the procedure.

During an interview on 9/16/21, at 11:44 p.m. director of nursing (DON) stated an expectation that pressure ulcers were comprehensively assessed upon admission, weekly thereafter and

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2 900	Continued From page 47 as need, should be monitored for improvement or worsening daily with dressing changes. DON stated the expectation dressings were applied according to physician order. DON indicated appropriate hand hygiene was expected during dressing changes, gloves should be removed after dressing and removal and cleansing the wound, hand hygiene should be performed after each glove change. DON stated soiled dressings need to go into a garbage can and not on the floor, and scissors should be disinfected prior to using on a clean dressing. Facility policy Pressure Injury Risk Assessment dated 3/2020, included 1) The purpose of pressure injury risk assessment is to identify all risk factors and then determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. 2) Risk factors that increase a resident's susceptibility to develop or to not heal PU's include b) impaired/decreased mobility and decreased functional ability, the presence of previously healed PU, exposure to urinary and fecal incontinence or other source of moisture, altered skin status over pressure points, and cognitive impairment 6) once the assessment is conducted and risk factors are identified and characterized, a resident centered care plan can be created to address the modifiable risks for pressure injuries. Facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 4/2018, did not identify frequency of monitoring or completing comprehensive wound assessments. The protocol indicated a skin examine would be completed upon admission	2 900		

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2 900	Continued From page 48 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the care plan for 1 of 2 residents (R175) reviewed for bowel and bladder. In addition, the facility failed to ensure grooming assistance was provided to 2 of 2 residents (R64, R49) who were dependent on staff for shaving. R175 toileting R175's face sheet dated 9/16/21, included diagnosis of dementia with behavioral	2 920	Corrected	10/29/21

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2 920	Continued From page 49 disturbance and muscle 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. R175's toileting care plan dated 9/1/20, directed staff to toilet R175 upon rising, after breakfast, before and [after] all other meals, at bedtime, on night rounds, and as needed. During an observation on 9/13/21, at 7:40 p.m. R175 laid on her back in bed. R175's room smelled of urine. RN-H and unidentified nursing assistant were at bedside encouraging R175 to roll over to allow them to change her saturated incontinent garment. R175's mattress protectors were observed to also be urine soaked. During an observation on 9/14/21, at 7:00 a.m. R175 sat in her wheelchair in a hospital gown. At 7:50 a.m. licensed practical nurse (LPN)-D stated R175 had been in the wheelchair all night because she had been restless, stated an unawareness of the last time R175 had been toileted or changed. During an observation on 9/14/21, at 8:50 a.m. R175 was given her breakfast tray. At 9:27 a.m. R175 continued sit in her wheelchair by the nursing station with her breakfast in front of her. During an observation on 9/14/21, at 12:20 p.m. R175 remained by the nursing station. At 12:32 NA-A asked LPN-D how R175 transferred. LPN-D stated an unawareness and stated he would call	2 920		

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therapy. NA-A was asked when R175 had last been toileted, NA-A stated the last time was between 6:00 a.m. and 7:00 a.m. when she assisted the night shift aide. At 12:49 p.m. R175 was transferred via full body mechanical lift to her bed by NA-A and NA-B. When NA's exposed R175's incontinent garment it was observed to be heavily saturated with urine. NA-A stated R175 had not been toileted since 6-7:00 a.m. that morning.

During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) stated the expectation was residents were toileted in accordance with their care plan. DON stated if residents refused, the expectation was the nurse be notified, and ultimately the physician if necessary for further medical intervention.

R49 Shaving
R49's significant change MDS completed 8/6/21, indicated R49's cognition was severely impaired. R49 was dependent on physical assistance from staff for all activities of daily living (ADLs) including personal hygiene.

R49's care plan last review date 6/25/21, indicated R49 required total assistance with personal hygiene which included shaving facial hair.

R49's face sheet printed on 9/15/21, indicated R49's diagnoses included depression, dementia, and Alzheimer's.

On 9/13/21, at 12:25 p.m. R49 was observed seated in her wheelchair in her room. R49 had greater than 30, coarse, white hairs that were

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2 920	Continued From page 51 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. On 9/15/21, at 7:31 a.m. nursing assistant (NA)-D and registered nurse (RN)-H were observed assisting R49 with morning cares. R49 was assisted out of bed, into her wheelchair. RN-H washed R49's face and dried it. NA-D combed R49's hair then pushed R49 to the dining room. Neither NA-D nor RN-H offered to assist R49 with shaving her facial hair. On 9/15/21, at 7:43 a.m. NA-D stated R49 required full physical assistance from staff for personal hygiene and grooming which included shaving facial hair. NA-D stated he had never assisted a female resident with facial hair but would do it if it was needed. NA-D confirmed he did not check R49's face with morning cares and that R49 did have a shaver in her room. NA-D observed R49 in the dining room then confirmed R49 had long, coarse, white hairs on her chin and upper lip, "Yeah, there's a lot there." On 9/15/21, at 8:56 a.m. RN-H confirmed R49 had several coarse, long, white hairs on her chin and upper lip. RN-H expected female residents who require physical assist with shaving facial hair, received the assistance as needed. RN-H stated she noticed R49's facial hair when she assisted with morning cares and R49 had a shaver in her room, "it was right in front of my eyes."	2 920		

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2 920	Continued From page 52 On 9/15/21, at 10:29 a.m. director of nursing (DON) stated she expected facial hair was taken care of bath days and as needed in between. R64 Shaving R64's admission MDS dated 8/19/21, indicated R64's cognition was intact. R64 required extensive physical assistance from staff for all activities of daily living (ADLs), including personal hygiene. R64's face sheet printed 9/16/21, indicated R64's diagnoses included degenerative disease of the nervous system, type 2 diabetes mellitus, and chronic kidney disease. R64's care plan, last review date 8/12/21, indicated R64 required assist of one staff with personal hygiene which included shaving facial hair. Record reviewed for 8/16/21 through 9/14/21, of R64's Point-of-Care (POC) Tasks documentation for section labeled, "Personal Hygiene: Self Performance - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands", indicated resident needed extensive assist of one staff. On 9/13/21, at 5:11 p.m. R64 was observed in the hallway as she was escorted in her wheelchair by staff. R64 had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip. During observation and interview on 9/14/21, at 8:31 a.m. R64 was sitting in her bed in her room.	2 920		

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2 920	Continued From page 53 R64 acknowledged that she had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip, and they were due to her hormone levels. R64 stated that she had always shaved them every other day and she wanted staff to assist her. On 9/15/21, at 7:48 a.m. R64 was sitting in her bed in her room and acknowledged she had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip. On 9/16/21, at 1:03 p.m. nursing assistant (NA)-B stated if she had seen too many whiskers on a resident, she would have shaved the resident. NA-B further stated she had not assisted R64 very much and had not noticed any whiskers on R64. On 9/16/21, at 1:35 p.m. NA-I stated shaving is considered a part of daily grooming care. NA-I further stated if a female resident had a lot of whiskers, assistance shaving should have been provided. Facility policy, "Shaving a Resident" revised 2/2018 provided direction for how to assist a resident with shaving but did not address the frequency. According to the policy, the purpose of the procedure was to promote cleanliness and to provide skin care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal	2 920		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 54 hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21335	MN Rule 4658.0725 Subp. 3 A&B Providing Routine & Emergency Oral Health Ser Subp. 3. Emergency dental services. A. A nursing home must provide, or obtain from an outside resource, emergency dental services to meet the needs of each resident. Emergency dental services include services needed to treat: an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; or any other problem of the oral cavity, appropriately treated by a dentist, that requires immediate attention. B. When emergency dental problems arise, a nursing home must contact a dentist within 24 hours, describe the dental problem, and document and implement the dentist's plans and orders. This MN Requirement is not met as evidenced by: Based on interviews and document review, facility failed to ensure 2 of 2 residents (R24 and R3) were offered regular dental appointments to maintain oral comfort and reduce the risk of infection. Findings include: According to the electronic health record (EHR) Admission Sheet/face sheet, R24 had a diagnosis of dysphagia (difficulty swallowing) of the	21335	Corrected	10/29/21

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	00148	A. BUILDING: _____ B. WING _____	C 09/16/2021

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oropharyngeal phase (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.

According to R24's care plan in the EHR, a focus problem area (not dated) indicated R24 was at risk for alteration in oral hygiene, and health related to being edentulous (no teeth), has upper and lower dentures. The focus problem indicated the dentures had been re-lined but did not indicate when that had occurred. The goal for this problem area was dated as having been initiated 6/01/2016. A corresponding intervention included: "periodic offer is made to resident/family to set up dental appointments and PRN (as needed).

During an interview 9/13/21, 3:12 p.m. R24 stated she was fitted with her current dentures prior to her admission to the facility some six years ago. She said the dentures had to be re-lined twice but have not been adjusted in recent years. She stated she frequently had to take them out of her mouth in-between meals because the dentures had started to irritate her gums. She stated she had four children but was concerned that her family was unable to assist with making any appointment or assisting her to an appointment. She did not recall being offered any dental appointments.

According to an interview on 9/15/21, 10:37 a.m. a registered nurse (RN-D) managing the unit stated the facility was able to provide R24 with dental visits but was unable to record on the last time R24 had received any dental assessment. RN-D stated such services should be offered at

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quarterly care conferences but was unable to find record that such services had been offered to or declined by R24.

According to an interview 9/15/21, 11:46 a.m. the licensed social worker (LSW) stated the facility should offer dental visits as needed. LSW did not know if R24 had had any dental visit but stated this should be offered at quarterly care conferences. LSW was unable to find documentation indicating any such services had been offered to or declined by R24.

According to an interview 9/15/21, 12:14 p.m. a nursing assistant (NA-C) stated R24 puts her dentures in to eat her meals but will take them out in between because "there is a little spot that irritates her." NA-C stated nurses were supposed to evaluate resident oral status and set up dental appointments if they see a problem.

On 9/16/21, 8:30 a.m. the director of nursing (DON) confirmed that the EHR did not contain recent documentation by nursing staff of R24's current oral status. DON stated she was unable to find any documentation that R24 was offered a dental appointment. DON stated an expectation that vision, hearing and dental visits be offered at every care conference and as needed, and stated this offer and the resident response should be documented. DON stated if the information was not documented, one could not assume that it had been done.

The Dental Services policy revised December 2016 indicated that selected dentists must be available to provide follow up care, and social services will assist residents with appointments and transportation arrangements. The policy also indicates that all dental services should be

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21335	Continued From page 57 recorded in the resident'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. R3's care plan dated 9/15/21, provided direction to offer resident or family to periodically offer dental appointments as needed. R3's Clinical Admission Evaluation dated 5/3/21 indicated R3 had obvious or likely cavity or broken natural teeth. This assessment did not indicate the provider should be notified of R3's dental status to obtain dental consult. R3's progress notes dated 5/27/20 thru 9/14/21, failed to address R3's dental needs and if a dental appointment was offered. On 9/13/21, at 1:21 p.m. R3 stated he was not offered to see in a dentist but would like to see a dentist due to several missing and broken teeth. On 9/15/21, at 10:26 a.m. registered nurse (RN)-I stated if a resident wanted a dental appointment, staff would make her aware and she would let	21335		

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21335	Continued From page 58 medical records know to make the appointment. She could also be notified through the assessment process. The nurse completing the assessment should let RN-I know about the resident's need to see a dentist. RN-I confirmed R3's assessment dated 5/3/21, indicated R3 likely had cavities or broken teeth. RN-I stated she was not notified of R3's dental needs. On 9/15/21, at 2:42 p.m. director of nursing (DON) stated she expected dental services were offered if any issues came up. She would expect the nurse completing the assessment would update the resident's provider if concerns such as possible cavities or broken teeth were noted. Offering dental services were important as cavities can cause pain, increases the resident's risk for infection including sepsis (an infection of the blood stream). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and social worker (SW) could review how and when appointments, either external or internal are offered and documented to residents. DON or SW could educate assigned staff, and audit the effectiveness of any developed plan. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21335		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		10/29/21

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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 must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a two step tuberculin skin test (TST) for 1 of 6 residents (R10) and failed to complete a two step TST for 1 of 6 staff. Findings include: R10's face sheet print date 9/15/21, showed R10 had an admission date of 6/8/21. Staff read the first step TST on 6/22/21. However, a 2nd step TST had not been recorded. Dietary Aide (DA)-A's personnel file, DA-A's hire date was 2/24/20. DA-A's file did not have record of DA-A receiving a two step TST. On 9/15/21, at 8:45 a.m. licensed practical nurse (LPN)-E stated R10 refused the first attempt to	21426	Corrected	

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21426	Continued From page 60 administer the TST but accepted the second attempt. A third attempt should have been attempted or R10 should have had a chest x-ray. On 9/15/21, at 10:38 a.m. director of nursing (DON) stated she expected residents received their first step, of the two step TST, upon admission. The resident should receive their second step 14 days after the first. If a resident refused the TST, then a chest x-ray needed to be completed. Staff were expected to have their first step TST upon hire with their second step happening approximately 14 days after the first. Facility policy Employee Screening for Tuberculosis dated 9/2019, indicated each newly hired employee is screened for latent and active tuberculosis after an employment offer has been made but prior to the employee's duty assignment. Facility policy Screening Residents for Tuberculosis dated 8/2019, indicated the facility shall screen all residents for tuberculosis infection and disease. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents are screened for physical signs and symptoms of active TB disease on admission. The DON or designee could educate the appropriate staff on the policies/procedures, and could develop a monitoring system by auditing residents' charts to ensure ongoing compliance.	21426		

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21426	Continued From page 61 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter	21530		10/29/21

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21530	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-pharmacological 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 record 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 of non-pharmacological interventions attempted or offered prior to administration. The record identified Ativan was administered on 9/8/21, at 9:04 p.m., 9/9/21 at 8:20 p.m., 9/10/21, at 1:47 p.m. and 9/11/21, at 7:40 p.m.	21530	Corrected	

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21530	Continued From page 63 R171's Ativan order dated 9/8/21, was changed on 9/11/21; the order dated 9/11/21, indicated Ativan 1 mg by mouth every 12 hours as needed for anxiety and/or vomiting for 14 days. The record did not identify why "withdrawal" symptom was removed as justification for administration. R171's psychotropic Evaluation tool dated 9/11/21, had a checked box in response to the question, Does the resident have anxiety or nervousness that impairs his/her quality of life or limits participation in activities. The Note Section included "currently has rx [prescription] for Ativan.". The evaluation indicated the mediation 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 did not identify diagnoses of anxiety with goals of care and non-pharmacological interventions. R171's record on 9/12/21, identified target behaviors for use of Ativan as 1. Nervousness 2. Withdrawal/refusal of care 3 nausea/vomiting. R171's progress notes and medication administration record reviewed between 9/12/21 through 9/14/21 identified R171 was administered Ativan, the record did not identify reason for administration, however indicated the medication was effective and did not include documentation of non-pharmacological interventions attempted or offered prior to administration. The record identified Ativan administered on 9/12/21 at 8:07 p.m., 9/13/21 at 9:25 p.m., and 9/14/21 at 8:33 p.m.	21530		

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21530	Continued From page 64 During an interview on 9/15/21, at 10:02 a.m. nursing assistant (NA)-G stated he had not noticed any behaviors and R171 did not display anxiety that he had 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. During an interview on 9/16/21, director of nursing (DON) reviewed R171's record and stated the target behaviors does not identify what the behaviors really are, and everybody displayed anxiety differently. DON stated as needed medications should be given for what they are specifically prescribed for and staff should offer and attempt non-pharmacological intervention first, documentation should identify which interventions were used and if which ones were effective, and if the resident refused then the refusals need to be documented. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for the managment of psychotropic medications. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure as needed psychotropic are administered appropriately.. The quality	21530		

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21530	Continued From page 65 assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure that medications were properly labeled and secured for 1 of 2 residents (R54) observed for self-administration of nebulized/aerosolized medications. Findings include: According to R54's electronic health record (EHR) Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure and heart failure. According to a 5/11/2020 physician order, R54 could self-administer nebulized medications and meter dose inhalers once set up by the nurse. No order was found for R54 to keep medications at bedside. R54's care plan in the EHR had a focus problem area (not dated) that indicated R54 could	21610	Corrected	10/29/21

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self-administer medications; however, the care plan did not indicate R54 could keep medications at bedside.

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.

According to an interview 9/14/21, 2:27 p.m. a registered nurse (RN-C) confirmed he had left the medication vial in R54's room even though she did not need an as needed (PRN) dose at that time. RN-C stated he was able to leave it there because R54 "knows how to use it."

During an interview 9/15/21, 10:28 a.m. RN-D, the unit manager stated a nurse was not to leave medications at a resident's bed side. According to RN-D, if a resident can self-administer a medication, the nurse must bring the medication in at the time it is ordered or if the order is for PRN the nurse must bring it in when needed and not before. RN-D said, leaving a medication at bedside could result in the dose not being taken at the proper time. Another nurse could potentially provide the next PRN or scheduled dose too soon, or "back-to-back doses." RN-D stated the

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nurse should bring the medication in when needed, and then document the time the PRN dose was taken.

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.

According to an interview 9/15/21, 11:05 a.m. the director of nursing (DON) stated residents could self-administer medications if they had a physician's order and had been assessed as being able to do so. DON said medications were not to be left at bedside unless there was an order, and the facility had provided them a safe place to store the medications. DON indicated medications must be appropriately labeled with the resident's name and a pharmacy label if kept locked at bedside.

The Storage of Medications policy revised November 2020 indicated "drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications ...Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling."

SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 68 train nursing staff in the facility policies for safe storage of medication, specifically storage at resident bedside. DON or designee could audit residents with self-administration orders to ensure that medications are not left with them unsupervised when not appropriate. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		