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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FOXI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245359**
2.STATE VENDOR OR MEDICAID NO.
(L2) **664240300**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/02/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 11/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245359

November 4, 2015

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

Dear Mr. Ziller:

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

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

Effective October 23, 2015 the above facility is certified for:

66 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 4, 2015

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

RE: Project Number S5359025

Dear Mr. Ziller:

On October 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 17, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 17, 2015, effective October 23, 2015 and therefore remedies outlined in our letter to you dated October 2, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245359	A. Building B. Wing	11/2/2015

Name of Facility	Street Address, City, State, Zip Code
PINE HAVEN CARE CENTER INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/23/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **10/23/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/23/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/23/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	11/04/2015	10160	11/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/17/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FOXI

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 **09/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 10/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 2, 2015

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

RE: Project Number S5359024

Dear Mr. Ziller:

On September 17, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 27, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 27, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you

identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 17, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		10/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/09/2015

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive plan of care related to sleep medications for 1 of 5 residents (R68) reviewed in the sample for unnecessary medications. Findings include: R68's physician orders revealed R68 received scheduled mirtazapine (an anti-depressant also used to treat insomnia) 7.5 milligrams (mg) by mouth at bedtime for insomnia, dated 9/10/15. In addition R68 had a physician order for melatonin (a supplement also used to treat insomnia) 1 mg by mouth at bedtime for insomnia, dated 9/8/15 the original start date for this medication was 5/27/15. The medication administration record for R68 showed the medications were given every day per the physician orders. R68's care plan, reviewed 8/3/15 did not identify the use of the two sleep medications, lacked a focus for sleep and lacked non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R68's sleep patterns and potential side effects of the medications. On 09/17/2015 at 11:23:26 a.m., the director of nursing (DON) verified there had not been a care plan developed for the use of sleep medications for R68 since her admission to the facility on 5/5/15. The DON stated R68's first order for Melatonin was 5/27/15, and stated her expectation was when a resident was on medications for sleep a care plan would be	F 279	Pine Haven Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents¿ right to refuse cares/services. The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented. Within seven days of completion of the comprehensive assessment, an interdisciplinary care plan is developed. During the October 13, 2015, mandatory meeting, the nursing staff will be 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents' care plans must be current at all times and 3) instructed that care plans must address insomnia and related interventions when a resident has problems with sleep.	

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 developed to monitor and assess sleep. A facility policy related to Care Planning was requested but not provided.	F 279	The care plan for resident number 68 has been revised to reflect the use of medications and nonpharmacological interventions to promote sleep. Direction for monitoring and evaluating the resident's sleep patterns and the potential side effects of the sleep medications are now addressed in the plan of care. To assure maximum comfort and high quality care at end-of-life, the certified nurse practitioner has ordered an evaluation for hospice services. As part of the quarterly care conference process, the interdisciplinary team reviews the care plans for completeness, accuracy, and relevancy. For the next quarter, the MDS Coordinator will conduct focused audits on the accuracy of the care plans of residents who are receiving medications to promote sleep. If noncompliance is noted, additional monitoring will be done. Compliance will be reviewed during the next quarterly Quality Assessment and Assurance Committee meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		10/23/15

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 _____	09/17/2015

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 280	Continued From page 3 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was revised as directed by the physician's orders and followed for 1 of 3 residents (R31) reviewed for restraints. Findings included: R31 was originally admitted to the facility on 1/11/2011 according the facilities admission record with diagnoses that included but was not limited to; dementia with behavior disturbances, anxiety, and Alzheimer's disease. R31's quarterly Minimum Data Set (MDS) dated 8/15/15 indicated R31 had severe cognitive impairment and required extensive assist to complete activities of daily living (ADL's). The MDS further indicated R31 used restraint daily in a chair to prevent rising. R31's physician orders dated 9/17/15 read, "Monitor velcro lap belt and release at meals, place on after meals" with a start date of 12/31/2013. During an observation on 9/16/15, at 12:37 p.m. R31 had been sitting at the dining room table in wheel chair with the velcro lap belt fastened. NA-A stated she had forgotten to	F 280	Pine Haven Care Center staff develop personalized care plans within seven days after the completion of a comprehensive assessment of the residents¿ needs and preferences. The care plans are prepared by an interdisciplinary team which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. The professional disciplines work together to plan and provide necessary services to enhance the residents¿ functional abilities and quality of life. Care plans are routinely reviewed and revised by the interdisciplinary team after each quarterly assessment and more often as necessary. The residents and their families/legal representative are encouraged to participate in the care planning process and the quarterly care conferences to the greatest extent possible. During the October 13, 2015 mandatory	

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 _____	09/17/2015

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 280	Continued From page 4 release the belt on interview following the meal. During a breakfast observation on 9/17/15, at 8:45 a.m. NA-A had been assisting R31 with eating. R31's lap belt was observed to be fastened. NA-A stated she had forgotten to release the belt during an interview following breakfast. During a lunch observation on 9/17/15, at 12:45 p.m. licensed practical nurse (LPN)-A had been assisting R31 with eating. R31's lap belt was observed to be fastened. LPN-A stated she had forgotten all about removing it again an interview following the meal. R31's care plan provided by the facility on 9/17/2015 read, "self release alarmed belt on w/c [wheelchair], staff are to reposition her q2h [every two hours]." According to the care plan this intervention was created on 5/23/13. During an interview on 9/16/15, at 11:15 a.m. nursing assistant (NA)-B explained R31's lap belt was removed during meals and then placed back on after meals. NA-B further stated the belt was removed during toileting. During an interview on 9/16/15, at 11:17 a.m. registered nurse (RN)-B explained the lap belt was to be removed at meal time and observed for a while without it on. During an interview on 9/16/15, at 11:21 a.m. RN-A stated the staff were taught to remove the belts during meals and when the resident is repositioned.	F 280	meeting, the nursing staff will be informed of 1) the regulatory requirement and the facility policy that the resident's care plans for use of safety devices be followed at all times and 2) that being aware of and following the resident's plan of care is a job performance expectation and responsibility of all nursing staff. The use of the wheel chair safety belt for resident number 31 was reassessed. Since the resident has not recently triggered staff alerting devices by attempting unsafe transfers and has had no recent falls, use of the safety belt was discontinued September 29, 2015. The resident's mobility/safety risk will continue to be monitored and appropriate interventions will be implemented to reduce the risk of injury. The care plan has been updated accordingly. To monitor compliance, the Director of Nursing/Designee will review resident safety devices currently in use. If inappropriate use is identified, additional auditing and staff training will be done. The interdisciplinary team will continue to assess for appropriate use of safety devices during the residents¿ routine quarterly care conferences and more often if necessary. Compliance will be reviewed at the quarterly Quality Assessment and Assurance Committee meeting.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		10/23/15

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing monitoring of chronic symptoms of fluid retention evident by sudden unexplained weight gain and pedal edema for 1 of 5 residents (R48) reviewed for pitting edema in lower extremities. Findings included; R48 had been observed on 9/14/15, at 4:19 p.m. R48 had been wearing shorts with no socks and had sandals on. Bilateral lower extremities were swollen from toes to mid-thigh region, the skin appeared shiny and taught below the knee. During an interview on 9/16/15, at 1:19 p.m. R48 was asked, "Are you retaining fluid?" R48 pressed down on his right leg just above the knee with his right index finger. The finger made a dent in the skin that stayed for two seconds. R48 stated, "Yes!" R48 then explained he was, "checking for fluid ...the longer the skin stays white and indented the more fluid I have." R48 stated usually the edema is limited to his feet, however this time "it goes all the way up my thigh right now." R48 further indicated awareness of the weight gain and recited last two recorded weights. R48 stated, "I like to keep my weight between 200-205 pounds."	F 309	Pine Haven Care Center staff provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. The Administrator, Director of Nursing, Clinical Manager, Social Worker, Dietary Manager, and Activity Director meet five days per week to discuss each resident's condition as reported by direct care nursing staff. The facility's policies and procedures for documenting, tracking, and communicating changes in the resident¿s condition were reviewed and found appropriate. The resident¿s attending physician is routinely notified in a timely manner of significant changes. The Situation, Background, Assessment, Recommendation (SBAR) format will	

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 According to a hospital discharge record dated 4/22/15, R48 had a diagnosis of congestive heart failure. The date of the diagnoses was 5/7/2010. R48's last admission date was on 4/22/14 according to the facility's admission record with diagnoses that included but were not limited to chronic obstructive pulmonary disorder (COPD), peripheral neuropathy, and edema. However, congestive heart failure (CHF) was not identified on the list of active diagnoses. R48's annual Minimum Data Set (MDS) dated 7/8/15 indicated moderate cognitive impairment with a Brief interview for Mental Status score of 8. The MDS further identified R48 received a diuretic medication during the assessment period. The MDS did not identify R48 had a diagnosis of congestive heart failure. R48's physician's orders provided by the facility on 9/16/15 included Lasix (diuretic) 20 milligrams twice per day for pedal edema. R48's care plan did not identify concerns with fluid retention especially pedal edema for which Lasix had been prescribed. The care plan read, "Potential for adverse side effects from medications prescribed for medical conditions ...staff to observe for adverse side effects, or outcome from medications. If sx's [signs/symptoms] suspected, refer to current drug reference book and/or speak with pharmacist, and notify MD/NP [medical doctor/nurse practitioner as needed." R48's nursing assistant care sheets did not give direction to monitor for fluid retention, weight gain and/or edema. R48's weight record indicated a 9 pound weight gain between 8/31/15 and 9/14/15: It was not evident in the medical record the reason for the weight gain or if it was reported to the physician. Weights as follows:	F 309	continue to be used to alert the physician/nurse practitioner of changes in condition. During the mandatory meeting October 13, 2015, the nurses will be instructed on 1) the regulations/requirements and facility policies for monitoring changes in the residents' condition and notifying the physician of changes, especially acute changes such rapid weight gain and edema and 2) documentation related to changes in condition. The nursing assistants will be reminded to report changes in the resident's condition promptly to the charge nurse. Resident number 48 was seen by his attending physician October 7, 2015 who noted, "For his edema, there is no documented reason why the patient has edema. There is no echocardiogram in his medical record. We will continue to use Lasix as prescribed which is 20 mg every day. He appears unchanged from an edema standpoint from nursing and on exam, if edema worsens or patient continues to gain weight we will consider getting an echo and adjusting Lasix and other CHF meds if it is in fact caused by congestive heart failure." The physician reviewed the resident's weight gain and ordered small portions at meal time. This was discussed with the resident and his wife and they were in agreement. The physician also ordered weekly weights and requested that the next two weights be faxed to the clinic	

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 8/31/15- 205 pounds (lbs.) 9/7/15- 211 lbs. 9/14/15-214 lbs. There were concerns with possible wheel chair changes and incorrect weights secondary to the wheel chair however, this had not been fully assessed and determined to be the problem vs. weight gain due to fluid retention especially with the increase in pedal and leg edema. R48's nursing progress notes were reviewed from August 2015 through time of survey September 1, 2015; it was not evident periodic pedal edema had been monitored and determined if a concern. During an interview with on 9/16/15, at 11:47 a.m. the MDS coordinator registered nurse (RN)-A was asked how R48's pedal edema or diuretic use was monitored and what the care plan instructed to do. RN-A indicated R48 did not have a diagnosis for congestive heart failure and monitoring of pedal edema had not been developed. Even though the pedal edema and weight monitoring for fluid retention has been a chronic condition. RN-A further indicated monitoring and interventions should have been in the care plan in regards to fluid retention, edema and weight gain. RN-A further explained the dietary manager was in charge of monitoring weights. During an interview on 9/16/15, at 1:19 p.m. the certified dietary manager (CDM) verified she was the one responsible for monitoring weights and verified she had not identified the weight increase for R48 in the resent past. CDM stated she had noticed the initial six pound weight gain she would have asked the resident be re-weighed. The further explained if the re-weight reflected an actual weight gain she would then talk with the nurses to find out what the interventions would be. CDM also stated, nurses watched weights for	F 309	office for review. According to the physician's discussion with the licensed nurses, the physician plans to investigate the cause of edema and the possibility of congestive heart failure. The nursing staff will continue to routinely monitor the resident's condition and the physician will be notified of significant weight increases or worsening edema. The care plan will be updated as necessary. The Director of Nurses/designee will monitor for timely and appropriate physician notification of changes in the residents¿ condition for 30 days and randomly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the next monthly Quality Assessment and Assurance Committee meetings.	

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 medication monitoring as well. During an interview on 9/16/15, at 2:00 p.m. nursing assistant (NA)-C explained trained medication assistance (TMA) monitor for edema if there is a scheduled task on the medication administration record to do so. NA-C then checked the medication administration record and verified there was no intervention for R48 to monitor for fluid retention, edema, etc. During an interview on 9/16/15, at 2:06 p.m. NA-D was not aware of fluid monitoring for R48. NA-D indicated she had not been monitoring for edema. NA-D said edema monitoring was not on the aide care sheet. NA-D indicated the NAs know if they are supposed to monitor for edema by their computer tasks, report from the nurse, or the aide care sheets. A facility policy pertaining to acute change of condition was requested and not received.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent assessment and monitoring of an area of skin	F 314	Based on the comprehensive assessment, Pine Haven Care Center staff ensure that residents who enter the	10/23/15

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 breakdown on right heel for 1 of 1 resident (R18) reviewed who had a history of pressure ulcers in this area. Findings included: R18 was observed on 9/16/15 at 7:09 a.m., while sitting up in her wheelchair. At that time nursing assistant (NA)-E was asked about skin concerns and NA-E indicated R18 had a wound on her right heel. NA-E removed R18's sock and the skin on R18's heel had been observed to have a closed whitish/gray area over it. The periphery of the whitish/gray area was reddened with small areas of flaking skin, and the heel appeared as if it might be soft or boggy. At that time, there was no dressing over the area however, NA-E stated, "They were putting a Mepilex [type of wound dressing] on it." On 9/16/15 at 9:11 a.m., the director of nursing (DON) was observed to remove R18's sock to visualize the wound. The DON stated the impaired skin integrity on the right heel was not an active pressure ulcer but appeared to be scar tissue, from a stage 2 ulcer the resident had developed back in October of 2014. The DON then stated the stage 2 pressure ulcer had resolved somewhere around August 2015, but that the area was still being monitored and the Mepilex dressing was being used for prevention of reoccurrence. During an interview on 9/16/15 at 12:13 p.m., licensed practical nurse (LPN)-B stated he had last observed the Mepilex dressing to be in place on 9/13/15, but at that time had not removed the dressing to observe the wound. LPN-B stated the last time he had seen the wound was on 9/10/15 and that at that time there had been a "pencil eraser size area that was hardened over, with some redness." LPN-B confirmed he had not documented a description of the wound from the	F 314	facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure areas from developing. Based on the comprehensive skin assessment, care plans are developed to address and minimize risks of skin breakdown. The plans focus on services that maintain skin integrity, prevent pressure sores, and provide treatment as prescribed. The policies and procedures for comprehensively assessing the residents' skin condition and risk factors were reviewed and found appropriate. An evaluation of the resident¿s skin condition, skin risk factors, and tissue tolerance will continue to be completed at the time of admission, readmission from the hospital, quarterly, and with significant changes in condition. A licensed nurse observes the residents' skin condition weekly. The physician and dietary manager are notified of open lesions and the plan of care is revised to reflect related interventions. Open lesions are monitored and measured on a routine basis and the physician is notified of worsening/nonhealing wounds. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol. During the October 13, 2015 mandatory	

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 9/10/15 observation in a progress note. During an interview on 9/16/15, at 10:26 a.m. the nurse practitioner (NP)-B stated the last time R18 had been seen by a physician/nurse practitioner pertaining to the pressure ulcer was on 7/22/15. NP-B read the exam note and stated the pressure ulcer to the right heal was healing. NP-B stated there had not been any additional correspondence from the nursing after the date of 7/22/15 pertaining to the right heel pressure ulcer status. NP-B stated he was not aware that the pressure ulcer had healed nor did he been informed of the reddened, boggy area that may have recently developed on the right heel ulcer. NP-B further explained it was the expectation of the facility to report changes of pressure ulcers including healed pressure ulcers. During a follow up interview with the DON on 9/16/15 at 12:28 p.m., the DON acknowledged the record lacked any documentation of when R18's wound had heeled. The DON provided an informal note which indicated the ulcer had resolved 8/12/15. The DON stated she'd make a late entry in the medical record to indicate the resolution of the wound. On 9/17/15 at 1:05 p.m., R18 was observed with nurse practitioner (NP)-B to be seated in her wheelchair. NP-B observed R18's heel area and stated, "the posterior aspect is a healed pressure ulcer, and the anterior aspect is an early stage 1." R18's admission record indicated the resident had been admitted to the facility on 11/19/13 with diagnoses including: senile dementia, diabetes type II, hypertension, hyperlipidemia, and chronic ischemic heart disease. R18's quarterly Minimum Data Set (MDS) dated 7/15/15 indicated R18 had severe cognitive impairment with a Brief Interview for Mental status score of 5, required extensive assist to	F 314	meeting, the nursing staff will be reinstructed on the facility's skin related policies and procedures. The need to complete weekly monitoring and documentation describing the appearance/healing/nonhealing of open lesions and the need to address/monitor skin areas at high risk of breakdown will be reinforced. The nursing assistants will be counseled to report skin changes to the charge nurse. Resident number 18 was seen by the Nurse Practitioner September 23, 2015 noting that "Patient is on hospice, has had a noted right heel ulceration which I did see patient on 9/17/15 for same. She continues on the heel protector boot as well as Mirapex. However, there is no draining or discharge from same. . . Extremities reveal a healing ulceration on the right heel, there is a 1x1 cm circular area that appears to have callus with eschar. There is no erythema, does not blanch. There is no drainage or discharge. It is nontender consistent with a healed ulceration." On September 29, 2015, the Hospice RN Case Manager noted "R heel remains intact and has heel lift boot on." The nurses will continue to routinely monitor the condition of the resident's right heel. The physician will be notified of open areas. The care plan was reviewed and revised. Compliance will be monitored by the Director of Nurses/designee through random audits of weekly skin assessment documentation for 30 days. If	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 complete activities of daily living, and had a current unhealed stage 2 pressure ulcer which had originated on 10/14/14, and was being treated at the time of the assessment. R18's current physician orders included the use of Arginaid two times a day for wound healing. Additionally, orders for wound care included: "Monitor right heel daily (AM) shift for signs and symptoms of infection, redness, drainage, increase pain one time a day every 3 day(s) Mepilex or equivalent foam dressing to the right heel every third day or before if needed." The wound care orders also directed staff to replace Mepilex dressing when needed. R18's current care plan included; "At risk for alteration in skin integrity ...10/29/14 pressure ulcer right heel." The interventions pertaining to the pressure ulcer included but were not limited to: "see TAR [treatment administration record] for care of pressure ulcer on left heel, to keep shoes off of right foot, off loading boot on right, wound nurse to monitor for healing. Notify MD/NP [medical doctor/nurse practitioner] of any concerns ..." The care plan further instructed staff to to observe and report changes of skin integrity daily, with cares, and for a licensed staff to complete a weekly skin audit per facility policy. R18's Braden Scale Pressure Score Risk Assessment dated 7/13/15, indicated the resident had a slightly limited sensory perception, moisture was often present, spent the majority of shift in bed or chair, mobility was slightly limited, received adequate nutrition, and a potential problem with friction and shear. R18's Nutritional Assessment dated 7/17/15, indicated R18 used Arginaid (a nutritional supplement to promote skin healing), a consistent carbohydrate controlled therapeutic diet, and that R18 was at moderate risk for impaired skin	F 314	noncompliance with facility policy is noted, additional auditing and staff education will be done. Compliance will be reviewed at the next quarterly Quality Assessment and Assurance Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12	F 314		

integrity related to spending a greater share of time in the chair. The nutritional assessment did not reference the right heel stage 2 pressure ulcer present at the time of the MDS assessment. An additional dietary progress note dated 9/3/15, referenced R18 having weight loss and continued use of the Arginaid however, there was still no reference to the heel ulcer. A dietary progress note dated 9/14/15, subsequently indicated R18 had been admitted to hospice, had experienced a 4.3% weight loss in 6 months, and received Arginaid for wound healing.

R18's skin/wound progress notes were reviewed from October 2014 to September 16, 2015. The notes did not reflect consistent monitoring of the resident's heel ulcer. Weekly documentation of the right heel ulcer condition was not recorded to ensure comprehensive assessment of changes, treatment and/or services to ensure promotion of healing of the pressure ulcer. According to a skin/wound note on 5/20/15 the pressure ulcer measured 1 centimeter (cm) by 1 cm this was the last recorded measurement of the wound. An entry 7/20/15 included, "Continues to have an area that is monitored to the right heel that is slow healing but does not improve in size and appearances weekly."

A late entry progress note entered on 9/16/15 with an effective date of 8/12/15 authored by the DON read, "This writer had noticed provider due to be here this AM. Wanted to place eye on healing wound. Wound is healed, continue to apply Mepilex if needed for protection. Will monitor and update if needed." This entry was added after the surveyor asked about the right heel ulcer status on 9/16/15.

A progress note dated 9/16/15 authored by the DON indicated the wound was healed and did not feel there was a concern.

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 R18's medication administration record (MAR) indicated the dressing to the right heel had been completed as ordered and had last been changed on 9/13/15. The MAR had check marks in the box that indicated monitoring for signs and symptoms of infection had been completed. Corresponding nursing notes or assessments of the evaluation of routine monitoring was not evident. R18's facility Body Audit Forms were reviewed from 4/1/15 through 9/16/15. Body audits identified the presence of impaired skin integrity to the right heel on 4/9/15, 4/16/15, 4/30/15, 5/7/15, 5/14/15, and on 8/6/15. It was not evident in the record Body Audit Forms were completed from 8/13/15 through 9/11/15. Body Audit findings were inconsistent with skin/wound weekly progress notes that identified the presence of the right heel ulcer. Facility policy Skin Ulcers last reviewed 5/4/08 read, "..residents who enter the facility without skin ulcers do not develop them, unless the clinical record demonstrates they are unavoidable." and "Skin will be observed daily during cares done by nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits on bath/shower day will be performed by the Licensed Nurse." The policy further gave directions for treatment of the pressure ulcer that included, "Initiate weekly Wound Eva [evaluation by RN [registered nurse] (RN to refer to Pressure Ulcer Stages Sheet, 2007 Pressure Ulcer Staging Guidelines) which will include: type of wound, location, date, stage, length, width and depth; wound base description wound edge description and if present: drainage, odor, undermining, tunneling, and/or pain. When a pressure ulcer is present, wound observation with treatment and/or dressing changes should include: odor, color,	F 314		

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 pain and drainage an evaluation of the status of intact dressing. Document on any changes or concerns in the nurses notes and notify the nurse manager." The policy also gave direction on when to notify the physician if there had been no improvement in 2-4 weeks.	F 314		

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 _____	**09/17/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 17, 2015. At the time of this survey, Pine Haven Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Pine Haven Care Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1970, addition was constructed to the North Wing that was determined to be of Type II(111) construction. In 1991, another addition was added to the West Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 66 beds and had a census of 48 at the time of the survey.	K 000		

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

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 _____	**09/17/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
October 2, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5359024

Dear Mr. Ziller:

The above facility was surveyed on September 14, 2015 through September 17, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 14, 15, 16 & 17, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive plan of care related to sleep medications for 1 of 5 residents (R68) reviewed in the sample for unnecessary medications. Findings include: R68's physician orders revealed R68 received scheduled mirtazapine (an anti-depressant also used to treat insomnia) 7.5 milligrams (mg) by mouth at bedtime for insomnia, dated 9/10/15. In addition R68 had a physician order for melatonin (a supplement also used to treat insomnia) 1 mg by mouth at bedtime for insomnia, dated 9/8/15 the original start date for this medication was 5/27/15. The medication administration record for R68 showed the medications were given every	2 560	Pleaser refer to response to Federal Tag F279	10/23/15

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 3 day per the physician orders. R68's care plan, reviewed 8/3/15 did not identify the use of the two sleep medications, lacked a focus for sleep and lacked non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R68's sleep patterns and potential side effects of the medications. On 09/17/2015 at 11:23:26 a.m., the director of nursing (DON) verified there had not been a care plan developed for the use of sleep medications for R68 since her admission to the facility on 5/5/15. The DON stated R68's first order for Melatonin was 5/27/15, and stated her expectation was when a resident was on medications for sleep a care plan would be developed to monitor and assess sleep. A facility policy related to Care Planning was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible to developed care plan interventions the need to develop the interventions based on current health needs identified and assessed for the resident/s. 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	2 570		10/23/15

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 4 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 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 the care plan was revised as directed by the physician's orders and followed for 1 of 3 residents (R31) reviewed for restraints. Findings included: R31 was originally admitted to the facility on 1/11/2011 according the facilities admission record with diagnoses that included but was not limited to; dementia with behavior disturbances, anxiety, and Alzheimer's disease. R31's quarterly Minimum Data Set (MDS) dated 8/15/15 indicated R31 had severe cognitive impairment and required extensive assist to complete activities of daily living (ADL's). The MDS further indicated R31 used restraint daily in a chair to prevent rising. R31's physician orders dated 9/17/15 read, "Monitor velcro lap belt and release at meals, place on after meals" with a start date of 12/31/2013. During an observation on 9/16/15, at 12:37 p.m. R31 had been sitting at the dining room table in wheel chair with the velcro lap belt fastened. NA-A stated she had forgotten to release the belt on interview following the meal. During a breakfast observation on 9/17/15, at 8:45 a.m. NA-A had been assisting R31 with	2 570	Please refer to response for Federal Tag F280.	

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 5 eating. R31's lap belt was observed to be fastened. NA-A stated she had forgotten to release the belt during an interview following breakfast. During a lunch observation on 9/17/15, at 12:45 p.m. licensed practical nurse (LPN)-A had been assisting R31 with eating. R31's lap belt was observed to be fastened. LPN-A stated she had forgotten all about removing it again an interview following the meal. R31's care plan provided by the facility on 9/17/2015 read, "self release alarmed belt on w/c [wheelchair], staff are to reposition her q2h [every two hours]." According to the care plan this intervention was created on 5/23/13. During an interview on 9/16/15, at 11:15 a.m. nursing assistant (NA)-B explained R31's lap belt was removed during meals and then placed back on after meals. NA-B further stated the belt was removed during toileting. During an interview on 9/16/15, at 11:17 a.m. registered nurse (RN)-B explained the lap belt was to be removed at meal time and observed for a while without it on. During an interview on 9/16/15, at 11:21 a.m. RN-A stated the staff were taught to remove the belts during meals and when the resident is repositioned. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 570		

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 (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 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 ongoing monitoring of chronic symptoms of fluid retention evident by sudden unexplained weight gain and pedal edema for 1 of 5 residents (R48) reviewed for pitting edema in lower extremities. Findings included; R48 had been observed on 9/14/15, at 4:19 p.m. R48 had been wearing shorts with no socks and had sandals on. Bilateral lower extremities were swollen from toes to mid-thigh region, the skin appeared shiny and taught below the knee. During an interview on 9/16/15, at 1:19 p.m. R48 was asked, "Are you retaining fluid?" R48 pressed down on his right leg just above the knee	2 830	Please refer to response to Federal Tag F309	10/23/15

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7	2 830		

with his right index finger. The finger made a dent in the skin that stayed for two seconds. R48 stated, "Yes!" R48 then explained he was, "checking for fluid ...the longer the skin stays white and indented the more fluid I have." R48 stated usually the edema is limited to his feet, however this time "it goes all the way up my thigh right now." R48 further indicated awareness of the weight gain and recited last two recorded weights. R48 stated, "I like to keep my weight between 200-205 pounds."
According to a hospital discharge record dated 4/22/15, R48 had a diagnosis of congestive heart failure. The date of the diagnoses was 5/7/2010. R48's last admission date was on 4/22/14 according to the facility's admission record with diagnoses that included but were not limited to chronic obstructive pulmonary disorder (COPD), peripheral neuropathy, and edema. However, congestive heart failure (CHF) was not identified on the list of active diagnoses.
R48's annual Minimum Data Set (MDS) dated 7/8/15 indicated moderate cognitive impairment with a Brief interview for Mental Status score of 8. The MDS further identified R48 received a diuretic medication during the assessment period. The MDS did not identify R48 had a diagnosis of congestive heart failure.
R48's physician's orders provided by the facility on 9/16/15 included Lasix (diuretic) 20 milligrams twice per day for pedal edema.
R48's care plan did not identify concerns with fluid retention especially pedal edema for which Lasix had been prescribed. The care plan read, "Potential for adverse side effects from medications prescribed for medical conditions ...staff to observe for adverse side effects, or outcome from medications. If sx's [signs/symptoms] suspected, refer to current drug reference book and/or speak with pharmacist,

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 _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 and notify MD/NP [medical doctor/nurse practitioner as needed." R48's nursing assistant care sheets did not give direction to monitor for fluid retention, weight gain and/or edema. R48's weight record indicated a 9 pound weight gain between 8/31/15 and 9/14/15: It was not evident in the medical record the reason for the weight gain or if it was reported to the physician. Weights as follows: 8/31/15- 205 pounds (lbs.) 9/7/15- 211 lbs. 9/14/15-214 lbs. There were concerns with possible wheel chair changes and incorrect weights secondary to the wheel chair however, this had not been fully assessed and determined to be the problem vs. weight gain due to fluid retention especially with the increase in pedal and leg edema. R48's nursing progress notes were reviewed from August 2015 through time of survey September 1, 2015; it was not evident periodic pedal edema had been monitored and determined if a concern. During an interview with on 9/16/15, at 11:47 a.m. the MDS coordinator registered nurse (RN)-A was asked how R48's pedal edema or diuretic use was monitored and what the care plan instructed to do. RN-A indicated R48 did not have a diagnosis for congestive heart failure and monitoring of pedal edema had not been developed. Even though the pedal edema and weight monitoring for fluid retention has been a chronic condition. RN-A further indicated monitoring and interventions should have been in the care plan in regards to fluid retention, edema and weight gain. RN-A further explained the dietary manager was in charge of monitoring weights. During an interview on 9/16/15, at 1:19 p.m. the certified dietary manager (CDM) verified she was	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 the one responsible for monitoring weights and verified she had not identified the weight increase for R48 in the resent past. CDM stated she had noticed the initial six pound weight gain she would have asked the resident be re-weighed. The further explained if the re-weight reflected an actual weight gain she would then talk with the nurses to find out what the interventions would be. CDM also stated, nurses watched weights for medication monitoring as well. During an interview on 9/16/15, at 2:00 p.m. nursing assistant (NA)-C explained trained medication assistance (TMA) monitor for edema if there is a scheduled task on the medication administration record to do so. NA-C then checked the medication administration record and verified there was no intervention for R48 to monitor for fluid retention, edema, etc. During an interview on 9/16/15, at 2:06 p.m. NA-D was not aware of fluid monitoring for R48. NA-D indicated she had not been monitoring for edema. NA-D said edema monitoring was not on the aide care sheet. NA-D indicated the NAs know if they are supposed to monitor for edema by their computer tasks, report from the nurse, or the aide care sheets. A facility policy pertaining to acute change of condition was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for providing resident cares to develop care plan interventions according to assessed needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 10	2 900		
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 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: 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	Please refer to response to Federal Tag F314.	10/23/15