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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NELY

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)

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	

8. ACCREDITATION STATUS: (L34)
0 Unaccredited 1 TJC
2 AOA 3 Other

6. DATE OF SURVEY 07/22/2013 (L10)

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

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):

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective July 16, 2013, the facility is certified for () skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 08/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/06/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5359 December 20, 2013

Mr. Steven Ziller, Administrator
Pine Haven Care Center Inc.
210 Northwest 3rd Street
Pine Island, Minnesota 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 July 16, 2013, 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

August 14, 2013

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

RE: Project Number S5359022

Dear Mr. Ziller:

On June 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 6, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 22, 2013, 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 June 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 16, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 6, 2013, effective July 16, 2013 and therefore remedies outlined in our letter to you dated June 12, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4118 Fax: (651) 281-9697

Enclosure

cc: Licensing and Certification File   5359r13.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245359	A. Building B. Wing	7/22/2013

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**07/16/2013**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	**07/16/2013**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	**07/16/2013**
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**07/16/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**07/16/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**07/16/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**07/16/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**07/16/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**07/16/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	**07/16/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**07/16/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GPN	08/14/2013	10160	07/22/2013
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/6/2013			

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NELY
Facility ID: 00148

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **06/06/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

At the time of the June 6, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. In addition, at the time of the standard survey completed on June 6, 2013, an investigation of complaiint number H5359018 was conducted and found to be unsubstantiated Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Robin Lewis, HFE NE II 06/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 08/05/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

POSTED 8/6/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2616

June 12, 2013

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

RE: Project Number S5359022, H5359018

Dear Mr. Ziller:

On June 6, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 6, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5359018 that was found to be unsubstantiated.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

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 July 16, 2013, 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 July 16, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 September 6, 2013 (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 December 6, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118   Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5359s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING ____ JUN 24 2013 B. WING ____ MN Dept of Health Rochester	06/06/2013

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5359018 had not been substantiated during this survey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156 6/25/13 [initials]	See Attachment 1	7-16-2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO/ADMINISTRATOR (X6) DATE: 6-19-2013

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 JUN 24 2013 B. WING MN Dept of Health Rochester	06/06/2013

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 156	Continued From page 1 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification	F 156		

Attachment 1

Regulation 483.10(b)(5) Tag F156
Notice of Rights and Services

JUN 24 2013
MN Dept of Health
Rochester

The goal of Pine Have Care Center is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, and as appropriate during the resident's stay. The facility routinely notifies the resident/family before Medicare benefits are discontinued and of their right to have an independent review of the decision to deny benefits.

The policies and procedures for resident/family notification of reduction or discontinuation of Medicare benefits were reviewed. Whenever required, the family/legal representative will be provided with and requested to sign 1) an Advanced Beneficiary Notice of denial of benefits explaining the reduction or discontinuation of Medicare benefits, payment liability, and the right to have a demand bill submitted and 2) a notice of the right to an expedited appeal of the decision to discontinue Medicare benefits. If the resident/legal representative is unable/unavailable to receive/sign the required notices, the notifications are sent by certified mail.

The staff member responsible for notifying residents/families of the denial of Medicare benefits is aware of the requirement for providing an Advanced Beneficiary Notice which includes an explanation of the right to submit a demand bill. A log has been implemented to track the issuance of the required Medicare (non)coverage notification letters. Duplicate copies of all related forms will be retained by the facility.

Residents number 11 (admitted 12/24/12; discharged 1/17/12) and number 38 (admitted 1/10/13; discharged 2/28/13) were admitted from the hospital for short-term rehabilitation services, met their goals, and chose to return home while they were eligible for Medicare Part A benefits. Both residents were anticipating discharge, neither resident expressed any concerns regarding the Medicare eligibility or discontinuation of Medicare benefits. Since the residents were Medicare eligible at the time of discharge and since the facility had no immediate plans to deny coverage, the intent and purpose of the notices addressing liability for payment and the right to an expedited appeal of the facility's decision to deny Medicare benefits did not apply. There is some question whether the Advance Beneficiary Notification of Noncoverage form is required in the above situations, However, until the issue is clarified and if required, residents choosing to return home while receiving a Medicare qualifying skilled service will receive the required payment liability notices regardless of Medicare eligibility and the reason for discharge.

Resident number 43 is eligible for medical assistance and traditional Medicare, therefore the resident was not obligated to personally pay for services ineligible for Medicare reimbursement. In the future, the resident will receive required payment liability notices when there is denial of Medicare benefits.

The Business Office Manager will be responsible for monitoring compliance through review of billing information and tracking logs.

Completion Date: July 16, 2013

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	245359	A. BUILDING ______ B. WING ______	06/06/2013

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F 156	Continued From page 3 The medical record indicated R43 received Medicare skilled speech therapy services until 2/15/2013. The medical record indicated the Expedited Notice (CMS form 10123) had been given to the resident on 2/3/2013. However, the traditional demand bill form was not provided to R43 or his legal representative prior to termination of coverage. R11 was not provided a traditional notice of Medicare non-coverage. The medical record indicated R11 received the expedited notice of Medicare non- coverage dated 1/17/2013 upon discharge. It identified remaining benefits for the resident. However, the traditional demand bill form was not provided to R11 or their legal representative prior to termination of coverage. R38 was not provided a traditional (Center for Medicare Services (CMS) form 10055) notice of Medicare non-coverage. The medical record indicated R38 received the expedited notice of Medicare non- coverage dated 2/28/2013 upon discharge. It identified remaining benefits for the resident. However, the traditional demand bill form was not provided to R38 or legal representative prior to termination of coverage. On 6/6/2013 at 11:15 a.m., a registered nurse (RN)-B was interviewed. She verified the traditional demand bill forms were not provided as part of the liability process.	F 156		
F 176	483.10(n) RESIDENT SELF-ADMINISTER	F 176	See Attachment 2	7-16-2013

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F 156	Continued From page 2 agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were fully informed of their rights concerning Medicare non-coverage for 3 of 3 residents (R43, R11, R38) reviewed who qualified for Medicare benefits. Findings include: R43 was not provided a traditional (Center for Medicare Services (CMS) form 10055) notice of Medicare non-coverage.	F 156		

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F 176 SS=D	Continued From page 4 DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure residents who self- administered medications were assessed prior to taking medications to determine if the resident is able to safely self- administer medications for 2 of 2 residents (R39, R30) observed during dining and medication pass. Findings include: R39 was observed sitting in the dining room with a glass of chocolate milk with red liquid in the bottom of the glass. During dining observation on 6/3/13, at 12:10 p.m. R39 was sitting in wheelchair up to the table with a glass of chocolate milk with a red liquid in the bottom of the glass with no licensed staff present. During interview on 6/3/13, at 12:25 p.m. registered nurse (RN)-D indicated the red liquid was Tylenol liquid. RN-D verified R39 was not able to self-administer medications and confirmed no licensed staff was present. During review of R39 ' s self- administration assessment dated 4/11/13, indicated staff was to	F 176		

Attachment 2

383.20(d)(2)(ii) Tag F176
Self-administration of Drugs

Pine Haven Care Center respects the residents' right to self-administer medications after the interdisciplinary care team has determined that this practice is safe.

The policies and procedures addressing self-administration of medications were reviewed and found appropriate. All residents are routinely assessed for the capability to safely self-administer medications at the time of admission. The appropriateness of self-administration of drugs is reviewed at least quarterly and more often as necessary. The care plan reflects who will be responsible for storage, documentation, and the location of drug self-administration.

During the mandatory meeting June 10, 2013, the licensed nursing staff and trained medication aides were instructed on medication self-administration regulatory requirements and facility policies/procedures. Specific instruction was provided on the assessments, physician orders, and other related documentation required before a resident can be left unattended with medications and during nebulizer treatments.

Resident number 39 - The resident's ability to self-administer medications provided by the staff was reassessed. It was determined that the resident could not safely be left unattended with medications. The resident died at the facility June 16, 2013.

Resident number 30 - The resident's ability to be left unattended during nebulizer treatments was reassessed. It was determined that the resident could not safely be left unsupervised during treatments. The care plan was updated accordingly.

The Clinical Manager and/or the Staff Development Coordinator will monitor compliance with self-administration of medication policies/regulations through observation and random record reviews of residents who are self-administering medications for one month. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the July Quality Assessment and Assurance Committee meeting.

Completion date: July 16, 2013

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F 176	Continued From page 5 administer medications due to dementia and resident often refuses. During interview on 6/5/13, at 3:23 p.m. the director of nursing indicated staff were to explain which medications were in the chocolate milk and would expect the staff to stay with the resident until the medication was fully consumed. R30 was observed in room with nebulizer treatment with medication running with no licensed staff present. During observation on 6/5/13, at 7:35 a.m. trained medication assistant (TMA)-A assisted R30 to resident's room. TMA-A placed prescribed medication into the nebulizer cup and attached the cup to the nebulizer mask and placed the mask over R30's mouth and nose with the strap around resident's head. TMA-A indicated to the resident they would be back in 10 minutes and she left the room. There was no licensed staff present in room or in hallway during the nebulizer treatment. During observation on 6/5/13, at 9:13 a.m. TMA-A assisted R30 for a second nebulizer treatment. TMA-A placed medication in nebulizer cup and attached the cup to the nebulizer mask and placed the mask over R30's mouth and nose and the strap around resident's head. TMA-A again indicated they would be back in 10 minutes to take the nebulizer off. Again there was no licensed staff present in room or in hallway during the nebulizer treatment. During review of R30 ' s self-administration assessment dated 4/11/13, R30 was not able to	F 176		

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F 176	Continued From page 6 self-administer medications due to dementia. During interview on 6/5/13, at 9:23 a.m. TMA-A confirmed R30 was not assessed to self-administer medications and not sure if resident was able to be left alone in room with nebulizer administering medication. During interview on 6/5/13, at 9:27 a.m. RN-B indicated R30 was not able to self- administer medications including nebulizer and would not be able to be left alone. During interview on 6/5/13, at 10:16 a.m. the director of nursing indicated staff noticed last week there was no order for self-administration of nebulizers and had updated the physician and the physician indicated would review on next rounds. Verified R30 was not able to self- administer nebulizers and should not have been left alone. During Self-Administration of Medication policy review dated 2/00, identified Pine Haven Care Center will provide the opportunity for alert, orientated cognitively and physically able residents to self-administer their medications. Residents, who desire to administer their own medications, will be assessed to assure that medications will be safely administered.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221	See Attachment 3	7-16-2013

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F 221	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R52) who utilized a restraint had an assessment to determine medical need for the restraint, if it was the least restrictive, and if it was safe for the resident to use. Findings include: During observation of R52 on 6/3/13 at 2:26 p.m., R52 was observed seated in her wheelchair with a Velcro lap belt secured in place across her lap. R52 also had a chair alarm attached to her shirt and wheelchair. During observation of cares on 6/5/13 at 11:35 a.m., R52 was observed seated in the dining room at the table with the lap restraint across her lap. R52 was also noted to have a chair alarm attached to her shirt and wheelchair. The self-release Velcro alarm belt had not been released during the meal time. Trained medication assistant (TMA)-A was observed to wheel R52 out of the dining room and into resident's room. TMA-A left R52 seated with the Velcro belt in place. During an interview on 6/5/13 at 3:25 p.m., registered nurse (RN)-A stated the self-release Velcro alarm belt was put into place as a falls intervention for R52. RN-A verified there had not been a safety assessment completed for the safe use of the belt prior to the use of the belt and verified education on the risks vs. benefits associated with the Velcro belt had not been reviewed with R52's daughter.	F 221		

Attachment 3

Regulation 483.13(a) Tag F221
Restraints

Pine Haven Care Center staff assure that residents are free from physical restraints that are not required to treat medical symptoms. The resident's condition and the need for safety/enabling devices are reviewed and reassessed quarterly and more often if indicated. The policies and procedures for restraint use were reviewed and found appropriate.

At the time of admission, quarterly, with changes in condition, and more often as necessary, the Interdisciplinary Care Team will continue to (re)assess all residents using enabling/safety devices to assure that 1) the least restrictive device is being used for the least amount of time 2) the benefits of the device outweigh the risks 3) devices are used only where justified to treat residents' medical symptoms and 4) the device promotes the resident's highest practicable level of function. A safety assessment tool is used to assist with this process. When indicated, referrals are made to the physical/occupational therapists to assess the resident's need for a safety/enabling device and make recommendations for the most appropriate device.

During the June 10, 2013 mandatory meeting, the nursing staff were reminded of the facility's restraint policies and the residents' right to be free of restraints not necessary to treat medical symptoms. The facility policies on restraint use, the restraint assessment process, use of the least restrictive device/intervention, tracking/documenting restraint use, and risks of associated with use of restraints were addressed. During new employee orientation, the residents' right to be free of restraints not needed to treat medical symptoms is addressed.

An assessment of the safety of the Velcro wheel chair lap belt has been completed for Resident Number 18. Use of the wheel chair belt is least restrictive device to reduce the risk of falls/injuries. The resident has removed the belt at the request of her husband, but does not routinely remove it at will or upon request of staff. The staff was instructed on the need to release the Velcro safety belt when the resident is being closely observed by staff such as meal time and during one-to-one supervision. The nurse practitioner will update the Velcro safety belt order to include the medical symptoms of lack of safety awareness, weakness, and unstable gait. The legal representative has been informed of the risks and benefits of the wheel chair safety belt; an informed consent has been sent for signature. The resident's care plan was reviewed and revised to include removal of the wheel chair belt during meal time and one-to-one supervision.

The staff nurse assigned to the dining room will routinely monitor for removal of for the wheel chair belt during mealtime. The clinical manager will review the records of residents using wheel chair belts to assure that appropriate assessments and care planning have completed for devices that meet the definition of a restraint. Compliance will be reviewed at the quarterly Quality Assessment and Assurance Committee meeting.

Completion date: July 16, 2013

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F 221	Continued From page 8	F 221		

R52's Physician Orders dated 5/23/13 read, " self release Velcro alarm belt on wheel chair." The Physician Orders did not include the medical symptoms exhibited that warranted its use or duration of use.

R52's quarterly Minimum Data Set (MDS) assessment dated 4/23/13 identified that R52 needed extensive assistance of 1 staff to transfer or ambulate.

R52's last Positioning/Physical Device Evaluation completed on 5/13/13, indicated R52 was using a wander guard, motion sensor and right-sided grab bar on bed. There was no assessment for use of the lap belt.

R52's care plan revised date of 5/23/13, identified R52 was at risk for falls characterized by history of falls/ injury, multiple risk factors related to: use of psychotropic medications, dementia. Interventions included: Motion sensor on bed use when in bed, tabs alarm in chair and w/c [wheelchair]. Self release alarmed belt on w/c, staff are to reposition her q2h [every two hours].

During an interview on 6/5/13 at 4:10 p.m. the director of nursing verified her expectation was an assessment for safety, education and documentation on risk vs. benefits and a positioning physical device evaluation would have been completed for the Velcro alarmed belt for R52.

During an observation at 4:23 p.m. on 6/5/13 the DON and RN-A both prompted R52 to release the self-release Velcro alarmed belt. R52 did not

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F 221	Continued From page 9 release the belt upon command. RN-A verified this was the first attempt made to have R52 self-release the belt. During an interview on 6/6/13 at 12:31 p.m. RN-A verified therapy had not completed an assessment for safety for the Velcro alarmed belt for R52. Physical restraint monitoring and reduction policy dated review dated 10/03, Indicated the informed choice consent for physical restraints form is given to residents and/or their legal representative on an annual basis. These forms are reviewed quarterly and renewed annually or more often if there is a change. These forms are signed and kept in the consent section of the residents' chart.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	See Attachment 4	7-16-2013

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F 225	Continued From page 10 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of an injury of unknown origin immediately to the designated state agency (Office of Health & Facility Complaints [OHFC] division of Minnesota Department of Health-MDH) for 1 of 3 residents (R56) reviewed for abuse prohibition. Findings include: R56 had an allegation of a bruise of unknown origin of the breast area on 11/26/2012. However; OHFC had not been notified until the next day on 11/27/12. On 6/5/2013 at 9:15 a.m. to 10:15 a.m., the social	F 225		

Attachment 4

483.13(c)(1, 2-4) Tag F225
Staff Treatment of Residents

Pine Haven Care Center policy requires that all alleged violations involving resident mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property be 1) reported immediately to the administrator and other appropriate officials and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process.

Pine Have Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service is investigated and reported to the appropriate registry or licensing authority.

The policies, procedures, and forms for identifying, reporting and internally investigating incidents were reviewed and updated to clearly reflect the requirement to immediately notify the Minnesota Department of Health of suspected abuse/neglect. All care plans address the resident's vulnerability to abuse and neglect as well as the risk of the resident abusing others. During the June 25, 2013 all staff mandatory meeting, the Nurse Consultant/Policy Analyst from Aging Services will provide education on the residents' right to be free from abuse/neglect and related regulations. The following will be addressed: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) timely reporting of incidents 5) the policies and procedures for communicating/documenting resident concerns/incidents and 6) internal reporting of vulnerable adult issues. The staff are educated on vulnerable adult issues at least every twelve months and vulnerable adult reporting and investigation are addressed during new employee orientation.

Resident number 56 – The resident's bruise was first observed November 26, 2012. Since the cause could not be immediately determined, a report was submitted to the Office of Health Facility Complaints (OHFC) on November 27, 2012. The facility further investigated the possible cause of the bruise and sent a subsequent report to the OHFC later in the day. The report indicated that the resident is often combative with cares, self-propels her wheelchair by pulling on the hallway handrails. She uses both her hands to grab at actual and perceived objects (visual hallucinations). The resident uses a lap tray which is removed at meal time and every two hours. It was suspected that the resident may have

bumped herself causing bruising from the lap tray and/or other contact with environmental objects. No abuse or mistreatment of neglect was suspected. The December 12, 2012 follow up response from the OHFC stated, "The information has been reviewed and it has been determined that no further action by this office is necessary at this time."

The Social Worker will monitor compliance with timely reporting of incidents to the Office of Health Facility Complaints by record review of reported incidents for one month. If noncompliance is noted, further auditing and staff education will be done. Compliance will be reviewed during the July Quality Assurance and Assessment Committee meeting and ongoing.

Completion date: July 16, 2013

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F 225	Continued From page 11 services staff (SS) was interviewed regarding the facility process for reporting abuse/neglect allegations. SS said that the nurse aides are to report bruises to their charge nurse and the charge nurse is to complete the initial assessment. After that, a report is made on the computer and e-mailed to OHFC then a copy of the report is faxed to the county social service. Then the interdisciplinary team reviews and investigates the bruise and come to conclusion within 5 working days. The nurse notifies the administrator right away after she initially assesses the situation. They then call the administrator and speak with him. If they can't reach him they are to report to SS and the administrator will call in. Staff has the right to report to the county sheriff. The nurses are responsible to notify MDH immediately. They have 2 separate policies and the second policy is a procedure that breaks down into steps what they are to do. The incident of 11/26/2012 for R56 was discussed with SS and the SS did verify it was not reported to OHFC immediately but on the next day. On 6/5/2013 at 10:30 a.m., the administrator was interviewed. He verified the staff calls him for everything in all hours of the day and night They have to make sure they call one of these three SS, director of nursing or administrator if he isn't available. The facility policy with revised date of 3/25/2013 for PINE HAVEN CARE CENTER POLICIES AND PROCEDURES " contained 2 separate policies, 1. Resident Incident, Accident and Injury Responsibilities and 2. Pine Haven Care Center Abuse Prevention Plan/Vulnerable Adult. Both	F 225		

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Rochester

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

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F 225	Continued From page 12 were reviewed and found to be somewhat confusing however, the facility staff interpret the correct reporting requirements.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff followed the facility abuse prevention plan for reporting to the state agency for 1 of 3 residents (R56) reviewed with an abuse/neglect allegation. Findings include: R56 had an allegation of an injury of unknown origin which was a bruise located on the breast area on 11/26/2012. However, the designated state agency (Office of Health and Facility Complaints-OHFC) had not been contacted immediately but the next day. The facility policy with revised date of 3/25/2013 for PINE HAVEN CARE CENTER POLICIES AND PROCEDURES " contained 2 separate policies, 1. " Resident Incident, Accident and Injury Responsibilities " and 2. " Pine Haven Care Center Abuse Prevention Plan/Vulnerable Adult ". Both were reviewed and the following read: #1 policy: Procedure II. 7. If the cause of the	F 226	See Attachment 5	7-16-2013

Attachment 5

Regulation 483.13(c) Tag F226
Staff Treatment of Residents

Pine Haven Care Center has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection and reporting/response.

Pine Haven Care Center staff recognize and respect each resident's right to be free from mistreatment and misappropriation of property and does all that is within their control to prevent such occurrences. The staff 1) identifies residents who are at risk for abuse, neglect and/or misappropriation of property as well as those at risk of abusing others 2) develops intervention strategies to prevent occurrences and 3) continually reassesses the effectiveness of the interventions.

The policies, procedures, and forms for identifying, reporting and internally investigating incidents were reviewed and updated to clearly reflect the requirement to immediately notify the Minnesota Department of Health of suspected abuse/neglect. During the June 25, 2013 all staff mandatory meeting, the Nurse Consultant/Policy Analyst from Aging Services will provide education on the residents' right to be free from abuse/neglect and related regulations. The following will be addressed: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/ misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) timely reporting of incidents 5) the policies and procedures for communicating/documenting resident concerns/incidents and 6) internal reporting of vulnerable adult issues. The staff are educated on vulnerable adult issues at least every twelve months and vulnerable adult reporting and investigation are addressed during new employee orientation.

Resident number 56 – The resident's bruise was first observed November 26, 2012. Since the cause could not be immediately determined, a report was submitted to the Office of Health Facility Complaints (OHFC) on November 27, 2012. The facility further investigated the possible cause of the bruise and sent a subsequent report to the OHFC later in the day. The report indicated that the resident is often combative with cares, self-propels her wheelchair by pulling on the hallway handrails. She uses both her hands to grab at actual and perceived objects (visual hallucinations). The resident uses a lap tray which is removed at meal time and every two hours. It was suspected that the resident may have bumped herself causing bruising from the lap tray and/or other contact with environmental objects. No abuse or mistreatment or neglect was suspected.

The December 12, 2012 follow up response from the OHFC stated, "The information has been reviewed and it has been determined that no further action by this office is necessary at this time."

Through record review and interviews, the Social Worker will monitor compliance with facility policies and regulatory mandates related to identification, investigating and reporting of resident mistreatment and misappropriation of resident property for one month. Compliance will be reviewed during the July Quality Assurance and Assessment and Committee meeting and ongoing.

Completion date: July 16, 2013

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F 226	Continued From page 13 injury has not been observed, i.e. Report of injuries of unknown cause, an investigation must be initiated by you immediately. The Administrator and Director of Nursing need to be notified immediately by leaving a message if the person does not answer directly. If no answer, initiate the on line report to the Department of Health at the Office of Health Facility Complaints via the internet reporting site. " On 6/5/2013 at 9:15 a.m. to 10:15 a.m., the social services staff (SS) was interviewed regarding the facility policy for reporting abuse/neglect allegations. The incident of 11/26/2012 for R56 was discussed with SS and the SS did verify it had not been reported to OHFC immediately.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the written care plan was followed for bathroom transfers for 1 of 3 residents (R10) reviewed for non-pressure related skin conditions. Findings include: The facility failed to follow the care plan for R10 during an EZ-stand transfer when going through the bathroom door.	F 282	See Attachment 6	7-16-2013

Attachment 6

Regulation 483.20(k)(3)(ii) Tag F282
Services by Qualified Personnel per Care Plan

Pine Haven Care Center assures that services are provided that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary.

During the mandatory training meetings June 10 and 25, 2013, the nursing staff were reminded/instructed that the plans of care must be followed and that job performance expectations include being aware of and following the resident's plan of care. The importance of safe resident transfers and reducing the risk of injuries/falls were stressed.

Resident number 10 – The resident's transfer ability was reassessed. The current plan of care for assistance of two with transport to the bathroom using the EZ stand is appropriate. The nursing assistants are aware of the mobility plan of care.

Compliance with monitored by the Director of Nurses/designee through random direct observation of residents transfers for two weeks. If noncompliance with the plan of care is noted, additional observations and staff training will be done. Compliance will be reviewed at the July quarterly Quality Assessment and Assurance Committee meeting.

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F 282	Continued From page 14 R10's diagnoses included congestive heart failure and diabetes. Review of the medical record revealed R10 had a history of fragile skin which resulted in bruising and skin tears related to bumping her elbows on the bathroom door frame during EZ-stand transfers. The quarterly Minimum Data Set (MDS) dated 2/11/13 revealed R10 had required extensive assist of two staff for transfer and toilet use. Review of R10's care plan initiated 11/20/12, identified risk for alteration in skin integrity and had included intervention of two staff assist with transfers using the EZ-stand when going through the bathroom door. During observation on 6/5/13, at 10:22 a.m. nursing assistant (NA)-A transferred R10 through the bathroom door using the EZ-stand without assist from a second person. During interview on 6/6/13, at 8:24 a.m. the director of nursing (DON) verified R10's care plan directed two staff assist with transfers through the bathroom door using the EZ-stand. The DON indicated her expectation for staff is to follow the care plan for all residents at all times.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	See Attachment 7	7-16-2013

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F 329	Continued From page 15 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were implemented and the facility failed to monitor efficacy of pain medications for 1 of 10 residents (R59) reviewed for unnecessary medication. Findings include: R59 was not offered non-pharmacological interventions prior to administration of oxycodone, and was not monitored to determine efficacy of the medication. R59 was admitted on 8/4/11, with diagnoses that included unspecified backache, dementia, and anxiety. Review of R59's medical record revealed physician's orders dated 5/14/13, included oxycodone (medication given for pain	F 329		

Attachment 7

483.25(l) Tag F329
Unnecessary Drugs

Pine Haven Care Center staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. Based on the resident's comprehensive assessment, Pine Haven Care Center staff, an effort is made to simplify medication regimens and discontinue psychotropic medications whenever possible. Guidelines/parameters are developed when two or more analgesics are prescribed or when psychotropic medications are prescribed on an as needed (PRN) basis. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during routine 30/60 day visits and more often as indicated.

At the time of the quarterly care conference and more often if needed, the resident's medications are reassessed by licensed nurses and the social worker. The medication type/dose and other related information are reviewed to assure that the record continues to reflect adequate indications for use.

During the mandatory meetings June 10 and 25, 2013 the licensed nurses will be instructed on the importance of 1) following directions on the medication administration record 2) offering nonpharmacological interventions before administration of a PRN medication when appropriate and 3) documenting the effectiveness of PRN analgesics.

Resident number 59 – The resident's pain management program was reviewed; use of PRN oxycodone will continue. The statement on the medication administration record (MAR) to attempt nonpharmacological interventions prior to administration of PRN oxycodone is a nursing reminder, not an order initiated by the physician/nurse practitioner. The MAR has been revised and the nursing interventions related to administration of PRN oxycodone are now more appropriately documented in the pain management plan of care. The staff is aware of the need to document the resident response to and the effectiveness of PRN analgesics.

The Clinical Manager/designee will monitor compliance by random reviews of records of residents receiving PRN analgesics. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the July Quality Assessment and Assurance Committee meeting.

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F 329	Continued From page 16 management) 2.5 milligram (mg) by mouth every four hours PRN (as needed) for pain, and try non-pharmacological interventions and document results before administering PRN pain medication. The care plan initiated 8/15/2011, identified potential for alteration in comfort and included intervention to give PRN medication for breakthrough pain and note the effectiveness. Review of R59's May 2013 medication administration record revealed oxycodone had been administered on 5/14/13, at 5:30 p.m., 5/15/13, at 1:05 p.m., 5/16/13, at 4:00 a.m., and again at 4:30 p.m., and 5/18/13, at 2:50 p.m. Further review of the record revealed non-pharmacological interventions had not been offered prior to administration of the medication for all dates and times listed; also the effectiveness had not been documented following administration of the medication on 5/15/13, at 1:05 p.m., or administration on 5/16/13, at 4:00 a.m., or 4:30 p.m. During interview on 6/6/13, at 11:21 a.m. the director of nursing (DON) verified the findings. The DON indicated her expectation for the staff is to follow physician orders and the care plan for all residents.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	See Attachment 8	7-16-2013

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F 371	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure sanitary conditions were maintained related to food storage, and food preparation area cleanliness. This had the potential to affect all 59 residents residing in the facility. Findings include: On 6/3/13, during tour of the kitchen with the dietary and maintenance directors at 12:25 p.m. the following was observed: The stainless steel table which held a steamer had white and brown marks which appeared as a fluid stain covering the top of the table. The maintenance manager stated "looks like we have a leak." The floor grate used for a previous brazing skillet located in front of the stove had thick layer of food particles and dirt build up covering the surface. The metal shelving unit which held canned food in the dry storage room had thick layer of light colored dust build up on upper shelves and dark sticky buildup on bottom shelf. The stainless steel storage cupboard in the dry store room had food debris and dark sticky grime around perimeter of floor beside and directly behind the cupboard. The above was verified during the tour by the dietary director and maintenance manager.	F 371		

Attachment 8

Regulation 483.35(l) Tag F371
Sanitary Food Procurement, Storage, Preparation, Serving

The goal of Pine Haven Care Center is to store, prepare, distribute, and serve food under sanitary conditions. To reduce the risk of food borne illnesses, the dietary and nursing staff are trained on safe food handling practices.

The distributor for the food steamer was contacted regarding the leak in the water supply which caused the staining on the table top. Repairs were made within 24 hours. The steamer is routinely wiped as part of the general kitchen cleaning/sanitizing procedures. The dietary staff have been instructed to promptly report equipment malfunction to the dietary manager or maintenance director.

The debris in the floor drain cavity from the previous brazing skillet was from a floor mat which was rolled for cleaning and inadvertently placed on top of the drain grate. The staff have been instructed not to place soiled rugs on the grate.

The dry food storage room shelves and floor have been thoroughly cleaned. Responsibility of checking and cleaning of the shelves and floor in the dry storage room has been assigned to the staff member who stocks the shelves.

Compliance will be monitored by the Dietary Service Manager by direct observation and ongoing monitoring of cleaning task check lists. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the July Quality Assessment and Assurance Committee meeting.

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F 371	Continued From page 18 Review of Cleaning Guidelines updated 9/12/12, directed floor maintenance (sweep and mop) was to be done each day and spills to be mopped immediately. Mopping included under and around equipment, along walls and in corners. Splash and soil marks were to be wiped from the baseboards and walls. The guidelines further directed cleaning of equipment, stainless steel and shelving, and areas behind and under equipment must be clean.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	See Attachment 9	7-16-2013

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F 431	Continued From page 19 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: During observation, interview and document review, the facility failed to remove outdated medications from 1 of 1 medication store room and failed to ensure 2 of 3 medication carts were maintained in a sanitary and clean manner. Findings include: Outdated medications were not removed from use. During tour of the medication room on 6/6/13, at 8:29 a.m. observed R18 had a tube of preparation H with an expired date of 2/13. R49 had a box of nebulizers with a label ipratropium br 0.02% inhalation solution use in nebulizer 1 vial four times a day as needed. The label on the nebulizer box indicated the medication expired 6/12, the expiration date on the medication indicated the medication expired 1/12 and was still in use. Three tubes of Vanicream sunscreen expired 5/13. R17 had a bottle of calcium chewable 650 milligrams (mg) chew one tablet by mouth four times a day as needed with an expiration date of 7/13 on the label and the bottle had expired 5/13. R65 had a box of bisacodyl suppositories with label reading 10 mg Dulcolax	F 431		

Attachment 9

Regulation 483.60(b, d, e) F431
Labeling of Drugs and Biologicals

In coordination with the consultant licensed pharmacist, Pine Haven Care Center provides for 1) safe and secure storage (including proper temperature controls, limited access, and mechanisms to minimize loss or diversion) and safe handling (including disposition) of all medications 2) accurate labeling to facilitate consideration of precautions and safe administration of medications and 3) a system of medication records that enables periodic accurate reconciliation and accounting of all controlled medications. The facility utilizes only persons authorized under state requirements to administer medications. Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standards.

All medication storage areas were checked for outdated and discontinued medications and biologicals. Medication storage areas were cleaned. The policies for storage of medications were reviewed and found appropriate. The night nurse will be assigned the responsibility for monitoring cleanliness of the medication storage areas and to remove all discontinued and outdated medications/biologicals from the medication carts and cabinets. An audit sheet has been implemented to verify completion of the tasks.

During the mandatory meeting June 10, 2013, the licensed nurses and trained medication aides were instructed on 1) the procedures for processing discontinued and outdated medications and biologicals and 2) the procedures for assuring the cleanliness of the medication carts and other medication storage areas.

Compliance with cleanliness of the the medication storage areas and disposition of outdated medications/biologicals will be monitored by the Director of Nurses/designee and consultant pharmacist. If noncompliance is noted additional monitoring and staff education will be done. Compliance will be reviewed during the July Quality Assessment and Assurance Committee meetings.

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F 431	Continued From page 20 insert one suppository rectally every 3rd day as needed with an expiration date of 5/13. Four 2 ounce tubes of hemorrhoidal ointment expired 11/12. During interview on 6/6/13, at 8:49 a.m. registered nurse (RN)-C verified all medications were expired and were available for use. RN-C removed the expired medications from availability for use. During review of the wing medication cart/refrigerator weekly audit noted on June 2, 2013 the following was initialed as completed; expiration dates were acceptable. During interview on 6/6/13, at 10:17 a.m. the director of nursing verified the night shift nurses were responsible for reviewing the medication room and carts for expired medications. Policy titled, Medications with shortened expiration dates dated 10/2/07, directed staff for all medications, if the manufacturer's expiration date or pharmacy's label expiration date occurs before the expiration date or beyond use date noted on the container, and the earlier of the two dates was to be utilized. Two of the three medication carts were soiled. During observation on 6/6/13, at 8:57 a.m. the 300 wing medication cart 3rd drawer had two bottles of robathol bath oil with sticky and smeared labels. On the bottom of the drawer was a sticky yellow substance along with the bath oil and on the bottom of the medication bottles stored in the drawer. During review of the 400 wing medication cart the 3rd drawer had a stock	F 431		

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F 431	Continued From page 21 bottle of Geri tussin DM (cough medication) with red liquid dripped down the front of the bottle and also on the sides and bottom of the of the cart drawer also the bottles stored in this drawer. During interview on 6/6/13, at 9:05 a.m. RN-C verified the medication carts were soiled and indicated the night nurses were responsible for cleaning the carts and wiping everything down. During interview on 6/6/13, at 10:17 a.m. the director of nursing each licensed nurse was responsible for the cleanliness of the cart as they are in the carts every day.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	See Attachment 10	7-16-2013

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 ______ JUN 24 2013	06/06/2013

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

MN Dept of Health Rochester

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F 441	Continued From page 22 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program to include surveillance and investigation of infections that occur in the facility, track employee infections, and maintain accurate and comprehensive records of infections. This had the potential to affect all 59 residents residing in the facility, employees and visitors. Findings include: A review of the facilities Resident Infections Log(s) from July 2, 2012, through May 13, 2013, revealed the following had not been included on the Resident Infections Log(s): Organism of infection, signs and symptoms of infection, or whether the infection was community or facility acquired. The log(s) also lacked consistent indication of the effectiveness of the treatment, and which body system had been involved.	F 441		

Attachment 10

Regulation 483.65 Tag F441
Infection Control

Pine Haven Health Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control.

The facility has comprehensive infection control policies and procedures consistent with the current state and federal infection control regulations. The policies address the surveillance and investigation of infections and include procedures for gathering data on employee infections and maintaining accurate and comprehensive records of resident infections. A registered nurse has recently been assigned the responsibility to oversee the review and implementation of the policies and procedures.

During the June 10 and 25, 2013 mandatory meetings, the licensed nurses were/will be instructed on the importance of completing the requested information on the resident and employee infection data gathering forms. The infection control nurse will review and organize the data to facilitate tracking and trending of resident and employee illnesses/infections. The infection control related forms, tracking logs, and spreadsheets will be reviewed and modified as necessary to improve efficiency and efficacy.

Compliance with facility policies and regulatory requirements will be monitored by the Director of Nurses/designee through review of the infection control related forms, logs and spreadsheets. The results of the infection control surveillance and investigation activities are reviewed monthly as part of the continuous quality improvement program. Compliance will be reviewed at the July quarterly Quality Assessment and Assurance Committee meeting and ongoing.

Completion date: July 16, 2013

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 ____	06/06/2013

NAME OF PROVIDER OR SUPPLIER: PINE HAVEN CARE CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 210 NORTHWEST 3RD STREET, PINE ISLAND, MN 55963

JUN 24 2013 MN Dept of Health Rochester

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 The facility was unable to provide documentation that they had tracked and trended employee illness. During interview on 6/5/13, at 10:07 a.m. the infection control nurse reported he/she had been responsible for resident infections only. The infection control nurse indicated the infection report forms were filled out by the nurses when an antibiotic is ordered for a resident and then placed in the infection control communication box. The infection control nurse indicted the forms are reviewed once a week and the information is entered on a spread sheet. The infection control nurse verified the above finding and was unable to provide additional information. During interview on 6/5/13, at 4:01 p.m. the director of nursing (DON) verified infection tracking forms were not completed to track and trend. The DON indicated employee tracking had been completed previously and stated, "It fell by the side in January and hasn't been done since then." The facility was unable to provide a policy reflecting current infection control standards and regulations.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	See Attachment 11	7-16-2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MN Dept of Health
Rochester

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F 465	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure sanitary conditions were maintained in the kitchen. This had the potential to affect all 59 residents residing in the facility. Findings include: On 6/3/13, during tour of the kitchen with the dietary and maintenance directors at 12:25 p.m. the following was observed: The eye wash station was observed to have dirt particles covering the base, and one half to one inch black sticky grime on the floor surrounding the base. The ice machine had white lime build up on the floor base and wall behind the machine and on the floor under the right side back leg of the machine. The above was verified during the tour by the dietary director and maintenance manager. Review of Cleaning Guidelines updated 9/12/12; the guidelines directed cleaning of equipment, stainless steel and shelving, and areas behind and under equipment must be clean.	F 465		

Attachment 11

483. 70(h) Tag F456
Safe, Sanitary, Comfortable Environment

Pine Haven Care Center staff strive to 1) maintain all essential mechanical, electrical, and patient care equipment in safe operating condition and 2) provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

The superficial soil on the floor in the eye wash station area was removed–no buildup of debris was noted. The mineral deposits on the ice machine have been removed. The dietary staff have been instructed to give special attention to the cleanliness of the floor near the eye wash station and to mineral deposits on, behind, and under the ice machine. Cleaning of these specific areas has been added to the task check list.

The dietary manager will monitor compliance through direct observation and review of the cleaning schedule check lists.

Completion Date: July 16, 2013

F5359023

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

FORM APPROVED
OMB NO. 0938-0391

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 ______	06/04/2013

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 Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Pine Haven Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 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 60 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.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2616

June 12, 2013

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 S5359022, H5359018

Dear Mr. Ziller:

The above facility was surveyed on June 3, 2013 through June 6, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numberH5359018 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. 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 at (507) 206-2731.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118   Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5359s13LicLtr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 census of 60 at the time of the survey.	K 000		