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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VFB5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 12/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/24/2014 (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
11/12/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245359

December 24, 2014

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 December 12, 2014 the above facility is certified for:

66 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health Telephone:
(651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 24, 2014

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

RE: Project Number S5359023

Dear Mr. Ziller:

On November 19, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 23, 2014. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on September 25, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on November 12, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 22, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 12, 2014, as of December 12, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 12, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of November 19, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 25, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 25, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 25, 2014, is to be rescinded.

In our letter of November 19, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 25, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 12, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded .

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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245359	PINE HAVEN CARE CENTER INC

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 19694	12-22-2014	12-22-2014	0.75	0.00	2.00	1.00	1.00	0.50
2. ~~31221~~	~~11-12-2014~~	~~11-12-2014~~	~~1.75~~	~~0.00~~	~~8.25~~	~~0.00~~	~~4.00~~	~~6.50~~
3. Team Leader 33559	11-12-2014	11-12-2014	4.00	0.00	8.25	0.00	0.50	1.75
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 2.50 ~~3.50~~

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VFB5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/12/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Josephine Hassinger, HFE NE II 12/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/16/2014 (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
11/12/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 0039

November 19, 2014

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

RE: Project Number S5359023

Dear Mr. Ziller:

On October 13, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 25, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 12, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 4, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on September 25, 2014. The deficiency(ies) not corrected is/are as follows:

F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective November 23, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 25, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 25, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 25, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Pine Haven is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 25, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW

Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 25, 2015 (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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245359	A. Building B. Wing	11/12/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **11/04/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/04/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/04/2014**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **11/18/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/04/2014**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **11/04/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/KFD	11/18/2014	33559	11/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/25/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

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 _____	R 11/12/2014

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 An on-site post certification revisit (PCR) was completed on November 12, 2014 to determine compliance with Federal deficiencies issued during a recertification survey exited on July 31, 2014. During this visit the following regulation was determined to be not corrected: F318.	{F 000}		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure range of motion (ROM) services were consistently documented to determine assessed needs are affective or new interventions are needed according to residents current history of maintaining, improving or declining in ROM services for 3 of 3 residents (R7, R34, R30) who were reviewed for ROM services. Findings Include: R7's quarterly Minimum Data Set dated 8/26/14, indicated R7 was diagnosed with congestive heart failure had moderate cognitive impairment. R7's rehabilitative (Rehab)-Nursing	{F 318}	See Attachment 1 12-5-14 GPM	12-12-2014

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

Steve Kilber | Administrator | 12-1-2014

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 _____ B. WING _____	R 11/12/2014

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 318}	Continued From page 1 Communication form from rehab services dated 1/4/14 indicated R7 was to have restorative therapy and read, "Please complete shoulder range of motion with focus on raise + [and] lower arms + [and] bringing arms across + [and] out to the side of the body-Also move neck to the left." R7's Occupational Therapy- Therapy and Therapist Progress & Discharge Summary dated 2/7/14 read, R7, "...has limited joint movement and was set up with restorative ex [exercise] program with AAROM [active assisted range of motion exercises] for R7's shoulders... Discharge Plan & Instructions: PT [patient] has HEP [home exercise program] for assisted UE [upper extremity] range with restorative." R7's personal care plan (PCP) read, " ROM-PROM [passive range of motion] to both UE [upper extremities] 1 x [time] a day." R7's progress notes were reviewed and no documentation was found related to ROM services. Documentation of monitoring for R7's ROM services was requested and none was provided. On 11/12/14 at 2:37 p.m. nursing assistant (NA)-A verified the PCP did not indicate specific therapy recommendations for the staff to complete for R7. R34's quarterly Minimum Data Set dated 9/8/14 indicated R34 was cognitively intact and was diagnosed with anxiety and depression. R34's rehabilitative (Rehab)-Nursing Communication form from rehab services dated 1-10-11 indicated R34 was to, "Ambulate 50' [feet] -150' [feet] with walker and assist q [one]	{F 318}		

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 _____	R 11/12/2014

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 318}	Continued From page 2 staff. Do PROM [passive range of motion] to bilateral knees prior to ambulation. 7-31-13 Hold ambulation because DR [doctor] order to DC [discontinue] foot brace. Continue ROM [range of motion] exercises." R34's personal care plan (PCP) read, "PROM [passive range of motion] to knees before ambulation especially RT [right] knee, apply Lt [left] foot splint 1 x [time] a day." R34's progress notes were reviewed and no documentation was found related to ROM services. Documentation of monitoring for R34's ROM services was requested and none was provided. On 11/12/14 at 2:37 p.m. when asked what ROM exercises staff was to provide to R34, NA-B stated R34 was to be ambulated daily by staff for her restorative program daily. NA-B did not state staff was to provide PROM [passive range of motion] to bilateral knees prior to ambulation. R30's quarterly Minimum Data Set dated 10/1/14 indicated R30 was diagnosed with dementia and had severe cognitive impairment. R30's personal care plan (PCP) read, "A/PROM [active/passive range of motion] to bilateral UE [upper extremities] + [plus] bilateral LE [lower extremities] 5 x [times] / [per] wk [week]. Secondary to pt. [patient] at risk for developing contractures." R30's progress notes were reviewed and no documentation was found related to ROM services. Documentation of monitoring for R30's ROM services was requested and none was	{F 318}		

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 _____	R 11/12/2014

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 318}	Continued From page 3 provided. On 11/12/14 at 2:32 p.m. NA-A stated she completed ROM to R30's legs and arms on the days she worked with her. NA-A stated the PCP did not indicate how many repetitions were to be completed and stated she usually completed four repetitions for each arm and leg. On 11/12/14 at 12:44 p.m. the director of nursing (DON) stated the nurse managers are to oversee the ROM services for the residents on their assigned wings as they are the ones that would receive the orders from therapy of any changes or recommendations to resident programs. The DON verified there was no documentation of monitoring ROM services for residents receiving the ROM services to determine if the assessed needs are affective or if new interventions are needed according to the residents' current history of maintaining, improving or declining in ROM. The DON verified nursing staff are only documenting resident refusals for ROM services. The DON verified there was no documentation of the audits completed for ROM. On 11/12/14 at 3:08 p.m. the DON verified the therapy recommendations for ROM for R7 and R34 did not match the instructions on the PCP the nursing assistants use as a guide to provide the ROM. The Range of Motion Exercises- procedure dated October 2010 read, "Documentation: You will find that the ROM to be completed is located on the PCP [personal care plan]. Please perform as instructed on the PCP [personal care plan] or by your nurse if a new order is given on that day. If a resident does not	{F 318}		

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 _____	R 11/12/2014

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 318}	Continued From page 4 perform, update your Nurse so they can document the following. 1. The date and time that the exercises were to be performed. 2. The name and title of the individual(s) who reported refusal by resident. 3. The type of ROM exercise missed (noted on PCP or chart) 4. Why the resident refused 5. Whether the exercise was active or passive 6. Whether they were offered throughout the day again. Reporting 1. Notify the supervisor if the resident refuses the exercises more than two days in a row. 2. Report other information in accordance with facility policy and professional standards of practice."	{F 318}		

Attachment 1

Tag F318 483.25(e)(2) Tag F318
Range of Motion

Pine Haven Care Center provides comprehensive care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of all residents. Pine Haven Care Center staff ensures that residents who enter the facility without limited range of motion do not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction is unavoidable.

Based on the initial comprehensive assessment and the routine reassessments, residents with limited range of motion receive appropriate treatment and services to increase range of motion to the highest possible level and/or to prevent further limitation in range of motion.

The policies and procedures for providing and documenting nursing restorative/ maintenance services including range of motion were reviewed and revised. The residents' nursing maintenance program will now be routinely included on the *Personal Care Plan* form which provides instruction to the nursing assistants regarding the resident's care needs and preferences. Maintenance services including range of motion will be documented on the *Nursing Maintenance Care Log*. A nurse will review the logs on a weekly basis. The appropriateness of services and the resident's response to services will be reviewed by the interdisciplinary team at least quarterly and with significant changes in function. A referral for occupational/ physical therapy will be made as needed to assure the highest practicable functional status. Changes in condition will be communicated using the *OT/PT Referral Form*.

Prior to December 3, 2014, all residents on a nursing maintenance program were screened by the occupational therapist for appropriateness of services. The occupational therapist and Director of Nursing reviewed the new and existing recommendations for restorative/maintenance care which were communicated to the direct care staff using the *Personal Care Plan* and the *Maintenance Program Master List* forms.

During the mandatory educational meeting November 20, 2014 the nursing staff were instructed that job performance expectations include being aware of and following the resident's maintenance plan of care and that services must be documented according to facility policy. The new maintenance care policies and

procedures will be communicated to the nursing staff by December 12, 2014 and reviewed during the December 18, 2014 mandatory nursing staff meeting.

Resident number 7 – The need for restorative services was reassessed by the occupational therapist November 18, 2014. The resident is now receiving occupational therapy five times per week for 30 days. Very recently the resident complained of shoulder pain; the goal of therapy is to decrease pain and improve range of motion to facilitate self-performance of activities of daily living. After discontinuation of occupational therapy, nursing maintenance care will continue based on the therapist's recommendations. The care plan has been updated accordingly.

Resident number 34 – The resident was screened by the occupational therapist November 29, 2014. The resident was walking at her prior level of function. No formal therapy or range of motion exercises are needed at this time. The nursing staff will continue to monitor for decline in function and will follow the therapist's recommendation to stretch the left ankle before the ankle brace is applied.

Resident number 30 – The resident was screened by the occupational therapist November 29,2014. No limitation in range of motion was noted. If limitations are observed, a request for a therapy evaluation will be initiated.

The Director of Nursing/designee will monitor compliance by auditing the *Nursing Maintenance Care Logs* weekly for the next three months to verify that maintenance services are provided and appropriately documented. The nurse manager will continue to review the care logs on a routine basis. If noncompliance is noted, additional training and staff education will be done. Compliance will be reviewed during the next quarterly Quality Assessment and Assurance Committee meeting.

Completion date: December 12, 2014

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 _____	R 11/12/2014

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 An on-site post certification revisit (PCR) was completed on November 12, 2014 to determine compliance with Federal deficiencies issued during a recertification survey exited on July 31, 2014. During this visit the following regulation was determined to be not corrected: F318.	{F 000}		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure range of motion (ROM) services were consistently documented to determine assessed needs are affective or new interventions are needed according to residents current history of maintaining, improving or declining in ROM services for 3 of 3 residents (R7, R34, R30) who were reviewed for ROM services. Findings Include: R7's quarterly Minimum Data Set dated 8/26/14, indicated R7 was diagnosed with congestive heart failure had moderate cognitive impairment. R7's rehabilitative (Rehab)-Nursing	{F 318}		

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

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 _____	R 11/12/2014

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 318}	Continued From page 1 Communication form from rehab services dated 1/4/14 indicated R7 was to have restorative therapy and read, "Please complete shoulder range of motion with focus on raise + [and] lower arms + [and] bringing arms across + [and] out to the side of the body-Also move neck to the left." R7's Occupational Therapy- Therapy and Therapist Progress & Discharge Summary dated 2/7/14 read, R7, "...has limited joint movement and was set up with restorative ex [exercise] program with AAROM [active assisted range of motion exercises] for R7's shoulders... Discharge Plan & Instructions: PT [patient] has HEP [home exercise program] for assisted UE [upper extremity] range with restorative." R7's personal care plan (PCP) read, " ROM-PROM [passive range of motion] to both UE [upper extremities] 1 x [time] a day." R7's progress notes were reviewed and no documentation was found related to ROM services. Documentation of monitoring for R7's ROM services was requested and none was provided. On 11/12/14 at 2:37 p.m. nursing assistant (NA)-A verified the PCP did not indicate specific therapy recommendations for the staff to complete for R7. R34's quarterly Minimum Data Set dated 9/8/14 indicated R34 was cognitively intact and was diagnosed with anxiety and depression. R34's rehabilitative (Rehab)-Nursing Communication form from rehab services dated 1-10-11 indicated R34 was to, "Ambulate 50' [feet] -150' [feet] with walker and assist q [one]	{F 318}		

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 _____	R 11/12/2014

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 318}	Continued From page 2 staff. Do PROM [passive range of motion] to bilateral knees prior to ambulation. 7-31-13 Hold ambulation because DR [doctor] order to DC [discontinue] foot brace. Continue ROM [range of motion] exercises." R34's personal care plan (PCP) read, "PROM [passive range of motion] to knees before ambulation especially RT [right] knee, apply Lt [left] foot splint 1 x [time] a day." R34's progress notes were reviewed and no documentation was found related to ROM services. Documentation of monitoring for R34's ROM services was requested and none was provided. On 11/12/14 at 2:37 p.m. when asked what ROM exercises staff was to provide to R34, NA-B stated R34 was to be ambulated daily by staff for her restorative program daily. NA-B did not state staff was to provide PROM [passive range of motion] to bilateral knees prior to ambulation. R30's quarterly Minimum Data Set dated 10/1/14 indicated R30 was diagnosed with dementia and had severe cognitive impairment. R30's personal care plan (PCP) read, "A/PROM [active/passive range of motion] to bilateral UE [upper extremities] + [plus] bilateral LE [lower extremities] 5 x [times] / [per] wk [week]. Secondary to pt. [patient] at risk for developing contractures." R30's progress notes were reviewed and no documentation was found related to ROM services. Documentation of monitoring for R30's ROM services was requested and none was	{F 318}		

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 _____	R 11/12/2014

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 318}	Continued From page 3 provided. On 11/12/14 at 2:32 p.m. NA-A stated she completed ROM to R30's legs and arms on the days she worked with her. NA-A stated the PCP did not indicate how many repetitions were to be completed and stated she usually completed four repetitions for each arm and leg. On 11/12/14 at 12:44 p.m. the director of nursing (DON) stated the nurse managers are to oversee the ROM services for the residents on their assigned wings as they are the ones that would receive the orders from therapy of any changes or recommendations to resident programs. The DON verified there was no documentation of monitoring ROM services for residents receiving the ROM services to determine if the assessed needs are affective or if new interventions are needed according to the residents' current history of maintaining, improving or declining in ROM. The DON verified nursing staff are only documenting resident refusals for ROM services. The DON verified there was no documentation of the audits completed for ROM. On 11/12/14 at 3:08 p.m. the DON verified the therapy recommendations for ROM for R7 and R34 did not match the instructions on the PCP the nursing assistants use as a guide to provide the ROM. The Range of Motion Exercises- procedure dated October 2010 read, "Documentation: You will find that the ROM to be completed is located on the PCP [personal care plan]. Please perform as instructed on the PCP [personal care plan] or by your nurse if a new order is given on that day. If a resident does not	{F 318}		

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 _____	R 11/12/2014

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 318}	Continued From page 4 perform, update your Nurse so they can document the following. 1. The date and time that the exercises were to be performed. 2. The name and title of the individual(s) who reported refusal by resident. 3. The type of ROM exercise missed (noted on PCP or chart) 4. Why the resident refused 5. Whether the exercise was active or passive 6. Whether they were offered throughout the day again. Reporting 1. Notify the supervisor if the resident refuses the exercises more than two days in a row. 2. Report other information in accordance with facility policy and professional standards of practice."	{F 318}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VFB5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/25/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : 11/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 11/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 3180

October 13, 2014

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

RE: Project Number S5359023

Dear Mr. Ziller:

On September 25, 2014, 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. In addition, at the time of the September 25, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5359020. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<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
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 4, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 25, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 25, 2015 (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

for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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 recertification survey was conducted and complaint investigation were also completed at the time of the standard survey. An investigation of complaint H5359020 was completed. The complaint was substantiated with a deficiency issued at F425.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner to promote dignity for 2 of 2 residents (R19, R48) observed to have uncovered catheter bags which were visible to other residents and families.	F 241 11-04-14 GPN	See Attachment 1	11-4-2014

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

[signature] CEO/Administrator 10-24-2014

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 _____ B. WING _____	09/25/2014

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 241	Continued From page 1 Findings include: R19's quarterly Minimum Data Set (MDS) dated 6/14/14 indicated R19 was diagnosed neurogenic (Is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition) bladder and had cognitively intact cognition. On 9/23/14 at 8:36 a.m. R19's was observed to be in bed and the catheter bag was not covered and was in view from the hallway. On 9/24/14 at 3:29 p.m. R19's was observed to be in bed and the catheter bag was again not covered and was in view from the hallway. On 9/24/14 at 3:32 p.m. nursing assistant (NA)-B verified R19 was in bed and the catheter bag was uncovered and visible from the hallway. NA-B stated the catheter bag should be covered at all times for privacy reasons. On 9/24/14 at 3:37 p.m. registered nurse (RN)-A verified R19 was in bed and the catheter bag was uncovered and visible from the hallway. RN-A stated the catheter bag should be covered when R19 was in the wheelchair or in bed. RN-A verified the catheter should be covered to maintain dignity for R19. On 9/24/14 3:42 p.m. RN-A stated it was facility policy catheter bags are to be covered at all times. On 9/25/14 at 10:41 a.m. the director of nursing (DON) stated catheters are to be covered especially when the resident is in the hallways. If residents are in their bed, she stated she could understand why staff would not want to interrupt	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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 241	Continued From page 2 the resident to check to ensure the catheter was draining if it was covered. The DON verified the facility policy indicated the catheter bags are to be covered at all times The Staff Orientation Handout undated titled: Dignity read, "The facility must with courtesy promote and care for a resident in a manner and environment that maintains or enhances the resident's dignity and respect in full recognition of the resident's individuality. The resident has the right to private medical and personal care except as needed for the safety and assistance of the resident. R48 was admitted on 10/14/13 according to the resident's face sheet. The physician's visit dated 9/9/14 indicated that R48's diagnoses included mid lung mass probably lung cancer and bladder atony (loss of muscle strength)/retention with chronic use of a Foley catheter. The quarterly Minimum Data Set (MDS) dated 7/14/14 indicated R48's brief interview for mental status (BIMS) was a 5, which indicated severe cognitive impairment. On 9/23/14 at 8:20 a.m. R48 was observed to be in bed. The urine catheter bag was not covered and was visible from the hallway. The medical records coordinator (MRC)-B confirmed that the catheter bag was uncovered and that she would make sure it was covered. At 8:28 a.m. R48 was observed to be in bed and the catheter bag was not covered and visible from the hallway. The nursing assistant (NA)-A verified that the catheter bag was not covered at this time. The undated policy titled Catheter Care Protocol instructed staff that bedside catheter bags are to	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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 241	Continued From page 3 be covered at all times for dignity/privacy.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure range of motion (ROM) services were included on the comprehensive care plan for 1 of 1 resident (R7) who was reviewed for ROM services. Findings Include: R7's quarterly Minimum Data Set (MDS) dated 8/26/14, indicated R7 was diagnosed with	F 279	See Attachment 2	11-4-2014

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 _____ OCT 31 2014 MN Dept of Health	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 congestive heart failure had moderate cognitive impairment. R7's comprehensive care plan was reviewed and did not address ROM. The last care plan review was completed on 9/2/14. R7's Rehabilitative-Nursing Communication form from rehabilitative (rehab) services dated 1/4/14 indicated R7 was to have restorative therapy and read, "Please complete shoulder range of motion with focus on raise + [and] lower arms + [and] bringing arms across + [and] out to the side of the body - Also move neck to the left." R7's Occupational Therapy- Therapy and Therapist Progress & Discharge Summary dated 2/7/14 read R7, " ...has limited joint movement and was set up with restorative ex [exercise] program with AAROM [active assisted range of motion exercises] for R7's shoulders ...Discharge Plan & Instructions: PT [patient] has HEP [home exercise program] for assisted UE [upper extremity] range with restorative." Review of R7's form titled Level II Restorative Program Master List designated for the 400 Wing had four residents listed. The form indicated R7 was to receive range of motion services. "PROM [passive range of motion] to both UE [upper extremities] 1 x [time] a day." On 9/25/14 at 8:55 a.m. the director of nursing (DON) verified R7's comprehensive care plan did not address ROM services. The DON stated her expectation was ROM services would be addressed on the care plan.	F 279		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312	See Attachment 3	11-4-2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	Continued From page 5 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the assessed need for assistance with facial grooming for 2 of 3 residents (R21, R65) reviewed for activities of daily living. Findings in include: R21's face sheet indicated that R21 was admitted on 7/14/14. The physician visit dated 9/11/14 indicated that R21's diagnoses included but was not limited to chronic obstructive pulmonary disease, congested heart failure, hypertension, dementia with delirium, and atrial fibrillation. The quarterly Minimum Data Set (MDS) dated 8/14/14 indicated that R21's brief interview for mental status (BIMS) was 12, indicating moderately impaired cognition. R21's care plan revised on 9/8/14 indicated that R21 needed assistance with personal hygiene, shaving, makeup application, oral care, partial bath for daily maintaining of appearance. The intervention instructed staff to provide constant supervision with physical assist i.e. comb hair, shave/apply make-up, etc. R21's nursing assistant instructions indicated that	F 312		

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 _____ OCT 31 2014 MN Dept of Health Surveyor	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 6 R21 was to have a bath on Sunday and was one assist for grooming. R21's body audit forms for the last 4 weeks had only one date 9/7/14 indicating that she received a tub bath. The nursing assistant's comment was "all good. " Nothing was checked under the area " shaved. " The nurse's progress notes dated 9/21/14 indicated that R21 had a bath that day and no new skin issues were noted. On 9/23/14 at 8:58 a.m. R21 was observed to have long and visible facial hair. On 9/24/14 at 12:30 p.m. during an interview with the director of nursing (DON), the DON confirmed that R21 had facial hair. She stated that R21 could be resistant at times to allow help with grooming. The DON stated that she would expect the staff to be asking the resident if she wanted to be shaved. R65's face sheet indicated that R65 was admitted on 2/12/13. The physician visit dated 7/1/14 indicated that R65 had diagnoses that included but not limited to hypertension, coronary artery disease, congested heart failure, type 2 diabetes with neuropathy, and depression/anxiety. The BIMS dated 6/14/14 was 14, indicating that R65 was cognitively intact. R65's care plan dated revised on 6/20/13 indicated that R65 required assistance for personal hygiene, shaving, makeup application, oral care, and partial bath for daily maintaining of appearance. The goal was to maintain good personal hygiene with assistance. The nursing assistant's care guide instructed that R65 was to have a bath every Wednesday evening, and	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 needed the assist of one for grooming. According R65's body audit form, dated 8/27/14, 9/3/14 and 9/10/14 R65 had no issues. There was nothing marked in the space titled " shaved. " On 9/23/14 at 8:58 a.m. during an interview with R65 it was observed that R65 had visible facial hair. On 9/24/14 at 12:15 p.m. during an interview with nursing assistant (NA)-A, NA-A stated that they usually shave the resident on bath day. NA-A stated that she will ask the resident if they want to be shaved. NA-A stated that the resident's don't seem to mind if they have facial hair. During an interview with the director of nursing and R65 on 9/24/14 at 12:30 p.m., the DON confirmed that R65 had facial hair. R65 stated that she did not have a razor. The DON stated the social worker would work on getting one. R65 stated that she used to use a tweezers to remove the facial hair. When the DON asked R65 if she would want the staff to assist her with the hair removal, R65 stated yes. When the DON was asked what her expectation would be for facial hair removal, she stated that she would expect the staff to be asking the resident if they would like to be shaved. The policy titled Shaving the Resident revised October 2010, indicated that the purpose of the procedure is to promote cleanliness and to provide skin are. The staff is to review the resident's care plan to assess for any special needs of the resident. Documentation recorded should include if the resident refused the	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 treatment, the reason(s) why and the intervention taken.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure range of motion (ROM) services were provided as assessed and a system of documenting to determine assessed needs are affective or new interventions are needed according to residents current history of maintaining, improving or declining in ROM services for 1 of 1 resident (R7) who was reviewed for ROM services. Findings Include: R7's quarterly Minimum Data Set dated 8/26/14, indicated R7 was diagnosed with congestive heart failure had moderate cognitive impairment. R7 ' s rehabilitative (Rehab)-Nursing Communication form from rehab services dated 1/4/14 indicated R7 was to have restorative therapy and read, " Please complete shoulder range of motion with focus on raise + [and] lower arms + [and] bringing arms across + [and] out to	F 318	See Attachment 4	11-4-2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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 318	Continued From page 9 the side of the body-Also move neck to the left." R7's Occupational Therapy- Therapy and Therapist Progress & Discharge Summary dated 2/7/14 read R7, "...has limited joint movement and was set up with restorative ex [exercise] program with AAROM [active assisted range of motion exercises] for R7's shoulders... Discharge Plan & Instructions: PT [patient] has HEP [home exercise program] for assisted UE [upper extremity] range with restorative." Review of R7 ' s form titled Level II Restorative Program Master List designated for the 400 Wing had four residents listed which included R7 as one of the four. The form indicated R7 was to receive range of motion services as reading, " PROM [passive range of motion] to both UE [upper extremities] 1 x [time] a day. " R7's Level II Restorative Program Master List documentation forms from July 2014, through September 23, 2014 were requested and revealed the following: July 2014: Out of 31 opportunities for ROM, R7 had a form signed by a nursing assistant (NA) one day on 7/7/14. No other days marked and no narrative documentation on the form to determine if the resident had refused or if the ROM had not been completed. August 2014: Out of 31 opportunities for ROM, R7 had a form signed by two nursing assistants (NAs) and a nurse one day on 8/3/14. Again no other days marked and no narrative documentation on the form to determine if resident refused or other reason not completed, or completed and not documented as being done.	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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 318	Continued From page 10 September 1, 2014 to September 23, 2014: Out of 23 opportunities for ROM, R7 had no documentation to show ROM services had been provided. On 9/24/14 at 1:55 p.m. (NA)-C stated there were restorative sheets for each wing and the staff assigned to the wing was responsible to sign the sheet after they completed the restorative programs listed and then they turn the form into the nurse on the wing. NA-C stated there was no other documentation completed ROM for services by the nursing assistants in regards to having completed the ROM as assessed. On 9/24/14 at 2:23 p.m. NA-D stated to her knowledge R7 was not receiving ROM services. NA-D stated she had never provided ROM services to R7 during her evening shifts and stated she worked ten days a pay period. NA-D stated there was a sheet that had a list of people on the wing that were to receive ROM on their shift and on that sheet there was a place for the NA and Nurse to sign it was completed. NA-D stated after the ROM service were provided by the NAs on the wing they signed sheet and gave it to the nurse. NA-D stated there was empty space on the sheet where staff could make notations regarding the ROM and stated she would tell the nurse of anything pertinent or different occurred with the resident's abilities to complete the ROM exercises. On 9/24/14 at 9:17 a.m. registered nurse (RN)-D stated it was the responsibility of the NAs on the wing to provide restorative services to residents and stated the NAs were to document on the restorative program master list. RN-D stated the POC (point of care, computer program) did not	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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 318	Continued From page 11 have an area to document ROM to the upper extremities at this time and stated this should be added. RN-D stated the residents that are receiving ROM have been recommended by therapy. On 9/24/14 at 11:36 a.m. the director of nursing (DON) stated the facility changed their restorative program in June 2014 as the facility is no longer completing restorative services for reimbursement and changed the format for documentation of restorative services. The DON provided documentation dated 7/17/14 and 8/3/14 and stated this indicated R7 received ROM services on those days and did state the facility was unable to find any further documentation R7 had received the service. The DON stated the staff was supposed to be completing the form daily and turning the form into the nurse on their wing. The DON stated there was not a way to document ROM to upper extremities by the nursing assistants in the POC where they document and the facility will be looking in to adding the ability to do so in the future. When the DON was asked how the facility monitored and assessed the effectiveness of the ROM programs in place, she responded the facility had interdisciplinary team (IDT) meetings twice a week and at these meeting the IDT reviewed residents that have been brought to their attention by staff for having changes and this would include any changes related to their ROM services. On 9/25/14 at 8:55 a.m. the DON stated the IDT was responsible for overseeing the restorative program through the weekly meetings. The DON stated the IDT count on the staff doing the daily cares to communicate through verbal communication any residents ' changes and	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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 318	Continued From page 12 stated there were no quarterly summaries or evaluations completed of residents restorative programs. The DON verified the facility was not following the ROM Exercises procedure for documentation. The DON stated her expectation was nursing staff was to chart on the ROM services provided to residents and stated re-education will be completed with the nursing staff. The Range of Motion Exercises- procedure dated October 2010 read, "The following information should be recorded in the resident's medical record: 1. The date and time that the exercises were performed. 2. The name and the title of the individual(s) who performed the procedure. 3. The type of ROM [range of motion] exercise given. 4. Whether the exercise was active or passive. 5. How long the exercise was conducted. 6. If and how the resident participated in the procedure or any changes in the residents ability to participate in the procedure. 7. Any problems or complaints made by the resident related to the procedure. 8. If resident refused the treatment, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data ... "	F 318		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425	See Attachment 5	11-4-2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 13 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain medications in a timely manner to prevent the use of an alternative medication which is not optimal for ongoing management of diabetes for 1 of 1 resident (R48) reviewed for unnecessary medications. Findings include: R48's diagnoses included dementia and diabetes. A Minimum Data Set (MDS) dated 7/14/14, indicated R48's cognition severely impaired. A physician order dated 9/8/14 revealed R48 was to receive a p.m. dose of Novolog 70/30 mix, 6 units subcutaneously one time daily. A progress note dated 9/23/14, at 11:48 p.m. indicated R48 had no insulin available at the facility and there was no backup insulin available	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 14 for R48. R48 is scheduled a 70/30 mix daily. A call was placed to the physician and the certified nurse practitioner called back and gave an order for NPH insulin (this was not the prescribed insulin but was available in the facility) 6 units for tonight and 18 units for the morning. On 9/25/14, at 9:11 a.m. an interview with the director of nurses (DON) stated nurses should reorder medication when visibly low or expiration dates were near. A facility policy Medication Ordering and Receiving from Pharmacy dated 2006, indicated reorder medication three days in advance of need to assure an adequate supply is on hand.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	See Attachment 6	11-4-2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 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 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure medications were labeled in accordance with currently accepted standards of practice for 5 of 54 residents (R10, R85, R46, R49, and ~~R14~~ R14.) Findings include: R10 was noted while observing a medication pass on 9/23/14; at 9:42 a.m. revealed R10's bupropion (antidepressant) tablets were labeled two 100 mg tablets in the morning and one 100 mg tablet at noon. R10's physician orders dated 9/22/14 directed staff to discontinue the noon dose of bupropion. Also R10's tramadol (pain reliever) container was labeled take 1 or 2 tablets by mouth every 4-6 hours as needed. R10's physician orders revealed tramadol one tablet by mouth two times a day. An interview on 9/23/14, at 9:42 a.m. with registered nurse (RN)-D revealed the floor nurses	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 16 check the medications when they come in from pharmacy. RN-D verified the bupropion and tramadol labels were incorrect. R85 was noted during a medication pass observation on 9/23/14, at 8:25 a.m. revealed R85's aspirin bottle labeled read, "take as directed." R85's physician orders dated 9/8/14 indicated aspirin table 325 milligram (mg) one tablet by mouth every day. RN-A verified the aspirin bottle label was incorrect and stated the bottle label should match the physicians order. An interview on 9/23/17, at 8:28 a.m. with RN-A indicated the medication carts are audited every Thursday night to look for expired medications and for correct directions on the medication labels. R46 was noted on 9/24/14, during a medication cart audit at 2:46 p.m. revealed R46's artificial tears ½ ounce bottle contained no prescription label to indicate who the artificial tears were for, when to give, how much to give, or indication for use of the artificial tears. R46's physician orders dated 9/19/14 indicated to instill artificial tears two drops in both eyes every four hours for dry itchy eyes. Licensed practical nurse (LPN)-A verified the artificial tears came from the house stock and pharmacy had not sent a label or a new bottle with a label on it. R49 was noted on 9/24/14, during a medication cart audit at 2:46 p.m. revealed R49's nystatin cream (antifungal) 100,000 units/gram directed staff to apply to the affected area two times a day as needed. R49's physician orders dated 9/8/17, directed staff to apply nystatin cream to groin topically as needed for rash two times a day.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	09/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 17 LPN-A verified there were no directions on the tube of nystatin cream of were staff were to apply the nystatin cream. R14 was noted on 9/24/14, during a medication cart audit at 2:46 p.m. revealed R14's Aspercreme (pain reliever) label directed staff to use as directed. R14's physician orders directed staff to apply Aspercreme to joints topically one time a day. LPN-A verified there were no directions on the tube of Aspercreme of were staff were to apply the Aspercreme. An interview on 9/24/14, at 11:47 a.m. with the director of nurses (DON) stated the nurses should check the medication orders and the medications when they come from pharmacy. The medication change over occurs every other Saturday. The DON verified the nurse did not catch the orders on the containers and the physician medication orders were different. The facility policy Medication Change Over dated 10/29/07, indicated a notation is placed alongside the residents name/medication list if the cassette differs from the list, if the medication is not there, doses received is not correct, etc. The policy also directs the nurse to check visually for medication that has been discontinued or dosage changes. The facility policy Administration of Medications review date 9/2014, directed staff to please review the label on the medication sent from ALL pharmacies. If found to be different that the medication administration record (MAR), refer to the chart for verification.	F 431		
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE	F 456		

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 _____ OCT 31 2014 MN Dept of Health Rochester	09/25/2014

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 456 SS=E	Continued From page 18 OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a washing machine used for personal laundry in a good state of repair. Findings include: During the tour of the laundry on 9/25/14 at 10:20 a.m. with the environmental services director (ESD), a washing machine was observed to have an area of rust around the top of the tub by the area where the fabric softener dispenser was located. The rust material was flaky. The ESD indicated that the washing machine was used for the resident 's personal laundry. The ESD stated that the machine had chemical settings to do the personal laundry. The ESD confirmed that the area had rust. The ESD stated that they do daily cleaning of the machines. When asked if this was to be repaired, the ESD stated that it was in need of replacing but have not pursued it yet with the board.	F 456	See Attachment 7	11-4-2014

Attachment 1

Regulation 483.15(a) Tag F241
Dignity

Pine Have Care Center promotes care for residents in a manner and an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

The staff routinely interacts with residents and provides cares and services that supports and enhances their self-esteem and self-worth including needed assistance with activities of daily living (grooming, dressing, bathing, eating) as identified in the comprehensive assessment and outlined in the plan of care.

During the mandatory training meeting, the nursing staff will be reminded of the resident's right to dignified and respectful treatment and reinstructed on the need to cover urinary collection bags. The Staff Development Coordinator will continue to instruct new employees on residents' rights as part of the orientation process. The residents' right to respect and dignity is also addressed as part of the annual employee education/training.

The care plans for residents number 19 and 48 have been revised to include instruction to cover the urinary collection bags whenever the resident is visible from a common area.

The Activity Director will monitor whether urine collection bags are covered two times per week for three weeks. Random spot checks will continue to be done by the supervisory nursing staff. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed during the next quarterly Quality Assurance and Assessment Meeting.

Date of completion: November 4, 2014

Attachment 2

Regulation 483.20(d) (k, 1) Tag F279
Comprehensive Care Plans

Pine Haven Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services.

The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented. Within seven days of completion of the comprehensive assessment, an interdisciplinary care plan is developed. The care plans of residents receiving restorative nursing services will be audited to assure the restorative services are accurately reflected.

During the mandatory training meeting, the nursing staff will be 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents' care plans must be current at all times and 3) instructed that care plans must address restorative services such as range of motion exercises.

The need for restorative services for resident number seven has been reassessed. The resident will continue to receive shoulder range of motion exercises; the care plan has been updated accordingly. The direct care staff are aware of the resident's restorative nursing plan which is outlined on the nursing assistant's personal care plan guide.

As part of the quarterly care conference process, the interdisciplinary team reviews the care plans for completeness, accuracy, and relevancy. For the next quarter, the MDS Coordinator will conduct focused audits on the accuracy of the care plans of residents who are receiving restorative services. If noncompliance is noted, additional monitoring will be done. Compliance will be reviewed during the next quarterly Quality Assessment and Assurance Committee meeting.

Completion Date: November 4, 2014

Attachment 3

Regulation 483.25(a)(3) Tag F312
Activities of Daily Living Care

Pine Haven Care Center provides the necessary services to maintain good nutrition, grooming, personal care and oral hygiene for residents who are unable to carry out activities of daily living independently. Based on the comprehensive resident assessment, the staff provides cares which assist the resident to maintain and enhance his/her self-esteem and self-worth including assistance with removal of facial hair according to resident preferences and as outlined in the plan of care. The residents' need for assistance with personal hygiene is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary.

During the mandatory educational meeting, the nursing staff will be 1) reinstructed on the facility's policies for providing personal hygiene to the residents 2) reminded that their job description requires knowledge of and responsibility for following the resident's plan of care and 3) instructed on the importance of removing excessive facial hair on female residents unless the resident/legal representative prefers otherwise. The need to provide cares as necessary to improve/enhance the residents' appearance, comfort, and dignity was emphasized.

The grooming plan of care for resident number 21 was reviewed and found appropriate in addressing the resident's personal care needs. The direct care staff are aware of the need to remove facial hairs as needed and as the resident allows to enhance the resident's appearance and dignity. The nursing assistant care guide has been updated accordingly.

The grooming plan of care for resident number 65 was reviewed. On September 25, 2014, the social worker offered to obtain a shaver for the resident. She declined the shaver and stated she would rather pluck or cut her own facial hairs. The nursing assistant care guide has been updated with instructions to offer assistance with removal of facial hair as necessary. The care plan has been updated to reflect the resident's preferences.

The Activity Director/designee will be responsible for monitoring compliance by randomly checking face hygiene for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the next quarterly Quality Assurance and Assessment Committee meeting.

Completion Date: November 4, 2014

Attachment 4

Tag F318 483.25(e)(2) Tag F318
Range of Motion

Pine Haven Care Center provides comprehensive care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of all residents. Pine Haven Care Center staff ensures that residents who enter the facility without limited range of motion do not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction is unavoidable.

Based on the initial comprehensive assessment and the routine reassessments, residents with limited range of motion receive appropriate treatment and services to increase range of motion to the highest possible level and/or to prevent further limitation in range of motion.

The policies and procedures for providing and documenting nursing restorative services were reviewed. The possibility of documenting restorative services on the electronic point of care system will be pursued. During the mandatory educational meeting, the nursing staff will be instructed that 1) that job performance expectations include being aware of and following the resident's restorative plan of care and 2) services must be documented according to facility policy.

The need for restorative services for resident number seven has been reassessed. The resident will continue to receive shoulder range of motion exercises; the care plan has been updated accordingly. The direct care staff are aware of the resident's restorative nursing plan which is outlined on the nursing assistant's personal care plan guide and the need to document provision of services.

The Director of Nursing/designee will monitor compliance by reviewing the *Level II Range of Motion Program Master List* twice per week for one month and then monthly for three months to ensure that restorative services are provided and appropriately documented. If noncompliance is noted, additional training and staff education will be done. Compliance will be reviewed during the next quarterly Quality Assessment and Assurance Committee meeting.

Completion date: November 4, 2014

Attachment 5

Regulation 483.60(a)(b) Tag F425
Pharmacy Services

Pine Haven Care Center provides pharmaceutical services (including accurate and timely acquiring, receiving, dispensing, and administering of drugs and biologicals) that meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of pharmaceutical procedures and services. The facility utilizes only persons authorized under state requirements to administer medications.

The policies and procedures for acquiring medications were reviewed and found appropriate. During the mandatory educational meeting, the nurses and trained medication aides will be instructed on the procedures for monitoring the supply of resident medications and for ordering medications in low supply or medications nearing the expiration date.

The Novolog insulin supply for resident number 48 is adequate and will continue to be monitored to assure the medication is reordered in a timely manner.

To monitor compliance, for 30 days the night nurse will check the adequacy of the insulin supply during the routine checks of insulin expiration dates. The results will be reviewed by the Director of Nursing. If low supplies are noted, additional monitoring and staff training will be done. Compliance will also be reviewed during the next quarterly Quality Assessment and Assurance Committee meeting.

Completion date: November 4, 2014

Attachment 6

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

Pine Haven Care Center provides pharmaceutical services that include accurate and timely acquiring, receiving, dispensing, and administering of all drugs and biologicals. A licensed pharmacist routinely collaborates with facility staff to coordinate pharmaceutical services and to guide development and implementation of related policies and procedures.

In accordance with State and federal law, the facility policy requires that drugs and biologicals are labeled in accordance with currently accepted professional principles and standards and that all drugs and biologicals are stored in a secure, locked location with access only by authorized personnel.

According to facility policy, if there is a change in medication administration instructions, an adhesive sticker stating "Directions Changed Refer To Chart" will be applied to the medication container to alert the staff to refer to the medication administration record for order changes.

The importance of medication label accuracy and the procedure for attaching the adhesive notification stickers to the containers when there is an order change will be reinforced during the mandatory nursing staff meeting. The medication labels for residents number 10, 14, 46, 49 and 85 have been audited and are consistent with physicians' orders or have labels alerting the staff to check the record for changes.

To monitor the accuracy of medication container labels, a licensed nurse will compare all current medication labels with the medication administration record. If inconsistencies are noted, the container will be labeled with the sticker alerting the nurse to check the resident's record for order changes. The audit results will be reviewed with the Director of Nurses, Consultant Pharmacist, and Quality Assurance and Assessment Committee to assess the need for any additional follow up/training. The procedures for routine ongoing random audits of label accuracy will continue.

Completion Date: November 4, 2014

Attachment 7

483. 70(c)(2) Tag F456
Safe Operating Equipment

Pine Haven Care Center has policies and procedures for maintaining all essential mechanical, electrical, and patient care equipment in safe operating condition.

A replacement part for the top of the washing machine used for the resident's personal laundry was ordered September 25, 2014, received September 30, 2014, and installed October 3, 2014.

The laundry staff will be instructed to promptly report problems with the laundry equipment to the Maintenance Department staff. The procedures for notifying the maintenance department of equipment malfunction or the need for repairs will be reviewed with the laundry staff.

Inspecting the condition of the laundry equipment will be added to the weekly laundry task list. The Environmental Services Director will monitor compliance by auditing the task checklist on a monthly basis for the next three months.

Completion date: November 4, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. 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 54 at the time of the survey.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2014**

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

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