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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WL8F

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 **08/11/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 08/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/21/2018 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245359
August 21, 2018

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

Dear Mr. Ziller:

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

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

Effective August 6, 2018 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 21, 2018

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

RE: Project Number S5359028

Dear Mr. Ziller:

On July 13, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 28, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 11, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 15, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 6, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 28, 2018, effective August 6, 2018 and therefore remedies outlined in our letter to you dated July 13, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WL8F

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/28/2018** (L34)

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

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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

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From (a) :
To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Kyla Einertson, HFE NE II — 07/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 08/14/2018 (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:

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 13, 2018

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

RE: Project Number S5359028

Dear Mr. Ziller:

On June 28, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (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 August 7, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 7, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 28, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement

of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 25, 26, 27 & 28, 2018, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop policies and procedures	E 026	Pine Haven Care Center has established and maintains an emergency	8/6/18

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

Electronically Signed | 07/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 1 in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under section 1135 act waiver. This had the potential to affect all 69 residents currently residing in the facility as well as visitors and staff. Findings Include: The facility Emergency policies and procedures were reviewed with the maintenance director (MD)-D. During the review it was revealed the facility did not have policies for the following: The facility's role in providing care and treatment at alternate care sites under section 1135 act waiver. On 6/27/18, at 1:17 p.m., the MD-D confirmed the above.	E 026	preparedness program that complies with applicable Federal, State and local emergency preparedness requirements. The emergency preparedness program describes the facility's comprehensive approach to meeting the health, safety, and security needs of the staff and resident population during an emergency or disaster situation. The program addresses how the facility will coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The comprehensive plan encompasses the elements for emergency preparedness based on the “all-hazards” definition specific to the location of the facility with the goal to meet the health, safety, and security needs of the staff and of the resident population. The emergency preparedness program is reviewed annually. The facility has revised the emergency plan to include policies and procedures that describe its role in providing care at alternate care sites during emergencies. Under the Section 1135 Act waiver, to assure continuity of care, the Pine Haven Care Center administrative staff would assess staff availability and assign staff to provide services at alternate care sites. Pine Haven Care Center administrative staff would collaborate with local emergency officials in designating alternate sites and providing staffing, equipment and supplies to the care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 2	E 026	alternate site(s). During the mandatory August 2, 2018 meeting, the staff will be reminded of the facility's comprehensive emergency preparedness plan and the possibility of being assigned to an alternate care facility in the event of an emergency. Ongoing and at least annually, the administrator will monitor compliance through review of the emergency preparedness plan content compared to the regulatory requirements and safety needs of the residents/staff. Compliance will also be reviewed during the monthly safety meetings and the quarterly October 2018 Quality Assurance and Assessment Committee meeting.	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs	E 033		8/6/18

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	245359	A. BUILDING _____ B. WING _____	06/28/2018

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

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E 033	Continued From page 3 under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a communication plan, which included a method for sharing information and medical documentation for residents under the facility care, with other health providers to maintain the continuity of care. This had the potential to affect all 69 residents currently residing in the facility. Findings include: On 6/27/18, at 1:17 p.m., the facility emergency policies and procedures were reviewed with the maintenance director (MD)-D. During the review it was revealed and verified the facility did not develop a communication plan, which included a	E 033	Pine Haven Care Center has established and maintains an emergency preparedness program that complies with applicable Federal, State and local emergency preparedness requirements. The emergency preparedness program describes the facility's comprehensive approach to meeting the health, safety, and security needs of the staff and resident population during an emergency or disaster situation. The program addresses how the facility will coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility).	

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E 033	Continued From page 4 method for sharing information and medical documentation for residents under the facility care, with other health providers to maintain the continuity of care. On 6/27/18, at 1:17 p.m., the MD-D confirmed the above.	E 033	The comprehensive plan encompasses the elements for emergency preparedness based on the “all-hazards” definition and specific to the location of the facility with the goal to meet the health, safety, and security needs of the staff and of the resident population. The emergency preparedness program is reviewed annually. The emergency preparedness plan will be revised to include a communication component which addresses the following: 1) a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health providers to maintain the continuity of care. Information will be provided in a timely manner to for a displaced resident including name, age, date of birth, allergies, current medications, reason for admission, blood type (if known), advanced directives, and next of kin/emergency contacts. 2) a means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) – a covered entity may use or disclose protected health information to notify, or assist in the notification of a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual’s location, general condition, or death.	

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E 033	Continued From page 5	E 033	3) a means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4)--a covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating and assisting such entities in the notification of a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death. During the mandatory August 2, 2018 meeting, the staff will be reminded of the facility's comprehensive emergency preparedness plan and the requirement to promote continuity of care through communication of relevant information and documentation to other care givers in the event of an evacuation. The administrator will monitor compliance through review of the emergency preparedness plan content compared to the regulatory requirements. The plan will be reviewed at least annually. Compliance will be reviewed during the quarterly October Quality Assurance and Assessment Committee meeting and ongoing.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)	E 035		8/6/18

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E 035	Continued From page 6 [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan included a method for sharing information the facility had determined appropriate, with clients and their families or representatives. This had the potential to affect all 69 clients currently residing in the home and their families/representatives. Findings include: On 6/27/18, at 1:17 p.m., the facility emergency policies and procedures were reviewed with the maintenance director (MD)-D. The MD-D stated the facility had not shared any information with clients and their families or representatives.	E 035	Pine Haven Care Center has established and maintains an emergency preparedness program that complies with applicable Federal, State and local emergency preparedness requirements. The emergency preparedness program describes the facility's comprehensive approach to meeting the health, safety, and security needs of the staff and resident population during an emergency or disaster situation. The program addresses how the facility will coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The comprehensive plan encompasses the elements for emergency preparedness based on the “all-hazards” definition and specific to the location of the facility with the goal to meet the health, safety, and security needs of the staff and of the resident population. The emergency preparedness program is	

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E 035	Continued From page 7	E 035	reviewed annually. The emergency preparedness plan will be revised to include a communication method for sharing appropriate information about the plan with residents and their families or representatives. An enclosure sent with the next billing statement will provide information about the facility's emergency preparedness plan. A notice informing residents and visitors about the plan will be clearly posted in the vicinity of the survey information; information about the plan will be presented at the next Resident Council meeting. New residents will be informed of the emergency preparedness plan at the time of admission. During the mandatory August 2, 2018 meeting, the staff will be reminded of the facility's comprehensive emergency preparedness plan and the requirement that information about the plan be made available to the residents and their families or representatives. The administrator will monitor compliance through review of the emergency preparedness plan content compared to the regulatory requirements. The plan will be reviewed at least annually. Compliance will be reviewed during the quarterly October Quality Assurance and Assessment Committee meeting and ongoing.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 8 On June 25, 26, 27 & 28, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		8/6/18

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F 550	Continued From page 9 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R2) reviewed for dignity with care. Findings include: R2's quarterly Minimum Data Set (MDS) an assessment dated 6/18/18, revealed R38 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs) such as bed mobility, eating, transferring and personal hygiene. R2's face sheet printed 6/27/18, indicated R2 had	F 550	Pine Haven Care Center staff treat residents with dignity and care for each resident in a manner and in an environment that enhances his or her quality of life. The staff provide resident-centered care with recognition and respect for each resident's preferences and individuality. The facility has policies and procedures that protect and promote the rights of all residents. The staff routinely interact with residents and provide care and services that support and enhance their self-esteem and self-worth including needed	

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F 550	Continued From page 10 the following diagnoses: Alzheimer's disease, dementia without behavioral disturbance, weakness and osteoarthritis. R2's care plan printed 6/27/18, had an intervention to, "provide assist cues and supervision of one staff for all meals." R2 was observed on 6/25/18, at 12:19 p.m. in the dining room sitting in a tilted back Broda chair (a type of positioning chair) and appeared to be positioned comfortably in a sitting position up to the table, R2 has a plate of food in front of her and nursing assistant (NA)-A was standing next to R2's right side assisting with feeding R2. NA-A then left resident alone to deliver more food trays. At 12:21 p.m. NA-B grabs R2's fork and stood over her right side putting the fork to R2's mouth and states to R2, "You want to eat?" R2 does not take the bite and does not respond. NA-B leaves after a short time to deliver more food trays to other residents. At 12:26 p.m. R2 sits up further in her chair and then lays back in chair, R2 has not attempted to feed herself. R2's plate contained mechanical soft country fried steak, mashed potatoes and gravy, and mixed vegetables. At 12:27 p.m. NA-B returns to help R2 and tries to give R2 another bite of her food while she stands over R2 and stated, "You want to go back to your room?" R2 stated, "No." NA-B then stated, "Would you like a bite?" R2 stated, "No." NA-B said to another NA located at the other end of the dining room, "[R2] ate a really good breakfast, she probably won't eat lunch, she usually eats one or the other." NA-B then walks away leaving R2 alone with no assistance or cues with eating, and began to deliver more food trays to other residents. At 12:31 p.m. R2 sat up in her Broda chair and is softly moaning unintelligibly. At	F 550	assistance with activities of daily living (grooming, dressing, bathing, eating, and toileting) as identified in the comprehensive assessment and outlined in the plan of care. The facility policy addressing dignity and quality of life was reviewed and found appropriate. During the August 2, 2018 mandatory meeting, the nursing staff will be 1) reminded of the residents' right to dignified and respectful treatment and 2) reeducated on feeding assistance procedures and techniques that foster a positive dining experience for the resident. Respecting resident's rights will continue to be addressed during new employee orientation. The care plan for resident number 22 was reviewed and found to appropriately instruct staff to assist the resident with eating. The resident's plan of care will continue to be reviewed and revised at least quarterly and with changes in condition. The social worker/designee will monitor compliance with a dignified dining experience by random observations of staff assisting residents with eating for two weeks. If noncompliance is observed, additional auditing and staff training will be done. Compliance will be reviewed at the October 2018 quarterly Quality Assurance and Assessment Committee meeting	

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F 550	Continued From page 11 12:33 p.m. Licensed practical nurse (LPN-A) started talking quietly to R2 in her ear and R2 stated, "No, No!" LPN-A left R2 alone and walked back down the hall towards the unit. At 12:34 p.m. (NA)-C walked up to the left side of R2 and grabbed a forkful of food to put in R2's mouth and R2 said, "No, No." NA-C walked away leaving R2 alone. At 12:38 p.m. (NA)-D sat in a chair on R2's right side and asked if she was hungry and if she wanted something to eat, R2 stated no. R2 agreed to lie down and NA-D wheeled R2 out of the dining area towards her room. R2 was observed not to eat any food or drinks for lunch. On 6/27/18, at 10:39 a.m. interim director of nursing (IDON) verified R2 needs assist with eating and further verified it was documented that R2 had been eating independently. IDON stated, "My expectation in regards to treating a resident with dignity and respect while assisting with eating is to not serve the plate of food until someone is available to sit with them." IDON further stated to assist them to eat while sitting next to and not stand over the resident while assistance with eating. Facility policy, Quality of Life-Dignity revised 3/2018, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. "Treated with Dignity," means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		8/6/18

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F 609	Continued From page 12 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of physical abuse to the state agency (SA) within 2 hours for 1 of 1 resident (R4) who reported an allegation of physical abuse. Findings include: R4 had diagnoses identified on the admission record that included depression, macular degeneration and malaise.	F 609	Pine Haven Care Center requires that all alleged resident mistreatment, neglect, abuse, and misappropriation of resident property be 1) reported immediately to the administrator and other appropriate officials and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action is taken. The facility	

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F 609	Continued From page 13 R4's admission Minimum Data Set (MDS) an assessment dated 3/23/18, identified R4 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated R4 was cognitively intact. The MDS further identified R4 required extensive assistance of one staff with all activities of daily living (ADL). R4's initial vulnerable report submitted to the SA on 6/12/18, at 4:57 p.m. included, "Social worker visited with resident today. Resident stated, "I have bruises on me because staff help me too much, when they lift my legs there [sic] fingers dig in." When asked if she was afraid of staff or that she thought they were hurtful. She responded, "not on purpose, when they help move my legs into bed they lift." She states, "most of the staff is nice but there a few that are more rough than the others." Review of the initial report made to the SA lacked documentation of how the facility social worker became aware of the abuse allegation and the time the social worker met with the R4 on 6/12/18. R4's investigative summary submitted to the SA on 6/14/18, at 6:09 p.m. included, R4 was interviewed by social worker about the comment she made to a staff member. R4 stated, "I have bruises on me because staff help me too much, when they lift my legs their fingers dig in." She indicated she was not afraid of any staff. She indicates that she doesn't think that this is done intentionally. She indicates most of the staff are nice but there are a few that are more rough then others. R4 was interviewed by the interim director of nursing (IDON). The IDON completed the body audit looking for bruising. When IDON asked R4 what happened, R4 stated, "that the bigger girls	F 609	intervenes to prevent further potential abuse while the investigation is in process. The facility's vulnerable adult policies and procedures for identifying, reporting and internally investigating incidents were reviewed and found appropriate. The policy language requires that the appropriate regulatory/government agencies are to be notified as soon as possible, but no later than two hours after becoming aware of alleged incidents involving resident abuse. The night nurse who first became aware of the allegation of abuse for resident number 4 did not have a valid pass code to the state agency web site which delayed the reporting process. The Interim Director of Nursing and Social Worker were notified of the alleged abuse and the required report was submitted to the State Agency within 48 hours. During the July 3, 2018 mandatory meeting, the nursing staff were reeducated on the requirements for timely reporting of resident abuse, neglect, exploitation, mistreatment, and misappropriation of funds. The nurses were assigned new pass codes to facilitate timely reporting to the State Agency. The care plan for resident number 4 was reviewed and found appropriate. The direct care staff was informed of her preference for gentle contact during personal cares. The resident was receiving the medication clopidogrel	

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F 609	Continued From page 14 are rougher with her." R4 indicates that she thinks they don't know their own strength. R4 stated that sometimes she needs a hand and the staff "get rough with her." When IDON talked to R4 about being independent, R4 got angry and stated, "sometimes she needed help with things." R4 stated the social worker was blowing this out of proportion, she didn't want to get anyone in trouble, she just wanted staff to be more gentle with her and not be so rough. R4's progress note dated 6/12/18, at 4:53 p.m. included Note Text: "Resident reported bruising from staff being too rough with resident. Full body audit was done by this writer at 430 p.m. Bruising noted to buttock. 2 small areas that were less than 1 cm by length and width. 2 bruises to left leg. There were also 2 bruises done on the arms. Resident stated she did not fear for her safety and she felt safe. SS was notified and VA [vulnerable adult] was completed due to resident stating staff are too rough with her." On 6/28/18, at 12:25 p.m. social services (SS)-A stated a staff member had a note left in her box regarding R4's concern staff were rough. SS-A stated she did not know when the note was left for her and she found the note on 6/12/18, when she checked her box. SS-A stated she followed up with R4 around noon on 6/12/18 and stated R4 "poo pooed" the concern. SS-A stated she asked nursing to do a body audit and complete follow up with R4. SS-A stated R4 said SS-A was overacting to the situation. SS-A verified the investigation did not include what time the report of rough treatment was initially made by the certified nursing assistant, as a note had been left in her box. SS-A stated she did not document the time she found the note that had been left for her	F 609	bisulfate which inhibits blood clotting and made her more susceptible to bleeding and bruising. The resident was discharged to a care facility closer to family July 11, 2018. Compliance will be monitored by the Social Workers through an audit of the incident reports and reporting time frames for one month. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed during the October Quality Assurance and Assessment Committee meeting and ongoing.	

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F 609	Continued From page 15 or the initial interview she completed with R4 around noon. SS-A stated allegation of abuse needed to be reported to the SA within two hours. SS-A verified rough treatment was considered an allegation of abuse. On 6/2/18, at 2:23 p.m. the administrator stated he expected staff to complete an initial report of abuse to the SA within two hours. The administrator verified rough treatment would be reportable in two hours. The administration verified staff did not follow their facility policy to report allegations of abuse within two hours to the SA. The Abuse Prevention Plan/Vulnerable Adult policy dated 3-2018 included, "Investigative Procedure: Any person with the knowledge or suspicion of suspected violations shall report immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours is events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials ..."	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		8/6/18

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F 655	Continued From page 16 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a written summary of the care plan to 1 of 1 resident (R62) reviewed as a new	F 655	Pine Haven Care Center staff has implemented policies and procedures for developing and implementing a baseline	

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F 655	Continued From page 17 admission. Findings include: R62 was admitted to the facility on 6/7/18, according to the facility admission record. During an interview on 6/25/18, at 1:57 p.m. R62 was asked, "Did you receive a written summary of your initial care plan after you were admitted?" R62 responded, "I do not remember getting a written summary of my care plan." R62's progress notes were reviewed and revealed there was no documentation R62 had been given a copy of her care plan. On 6/27/18, at 9:45 a.m. the interim director of nursing (IDON) stated the facility has not implemented having residents receive a copy their care plan at the facility yet. The IDON stated, "I went to a class about a month ago and thought the resident was supposed to receive their 24-hour care plan and sign off on it that they had received a copy, but that is about the extent of my knowledge on it." The IDON stated, "I will need to look up the regulation." The DON verified the facility did not have a policy or procedure developed for providing residents a summary copy of their care plan.	F 655	care plan for each resident within 48-hours of the resident's admission. The plan includes the instructions needed to provide effective and person-centered care that meets professional quality standards. The baseline care plan includes the minimum healthcare information necessary to properly care for a resident including the following: 1) Initial goals based on admission orders 2) Physician orders 3) Dietary orders 4) Therapy services 5) Social services 6) Preadmission Screening and Resident Review (PASARR) recommendations, if applicable According to Pine Haven Care Center policy, staff will provide a copy of the summary of the person-centered baseline care plan to the resident and their representative that includes at minimum the following: • The initial goals of the resident; • A summary of the resident's medications and dietary instructions; • Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and • Relevant information based on the development of the interdisciplinary care plan. During the mandatory August 2, 2018 meeting, the nursing staff will be reminded of the 1) regulations and facility policy	

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F 655	Continued From page 18	F 655	addressing the development of the baseline care plan 2) the procedures and care plan form used to comply with the regulatory requirements and 3) the need to provide a copy to the resident and his/her representative. The circumstances regarding providing a baseline care plan for resident number 62 were reviewed as part of the facility's continuing quality improvement program. Resident number 62 was discharged to her home June 26, 2018. The social workers will monitor for compliance through review of the records of all new admissions for the next month to ensure that a baseline care plan was developed within 48 hours of admission and that it was made available to the resident and his/her representative. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the October 2018 Quality Assurance and Assessment Committee meeting and ongoing.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		8/6/18

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F 689	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 resident (R166), who was reviewed for smoking, was assessed for smoking safety. Finding include: R166's admission Minimum Data Set (MDS), an assessment dated 4/4/18, indicated tobacco use and had moderate cognitive impairment. During interview on 6/26/18, at 9:37 a.m., R166 stated I smoke when my wife comes to visit. I have to go out on the street to smoke. R166 stated I make sure my oxygen is off when I smoke. R166 stated staff do not supervise him when he smokes. R166's resident progress notes included on 6/3/18, Resident was heading outside to smoke and his oxygen was stored on his wheelchair. Nurse stopped resident to remove oxygen before he went outside. Resident was compliant stating it can stay there. Nurse removed the tank and stored it while he was outside smoking with his wife. On 6/2/18, Resident was found to have matches and a lighter in his room. Talked with resident and he was very upset. Staff found cigarette butts in his room as well. Stated that he did not want to throw them in the street so he put them in a medication cup. Talked to the resident about the importance of not smoking in his room. He stated that he would never do that. R166's current physician orders included an order for oxygen 2 liters/minute via nasal cannula with exercise every shift. R166's treatment	F 689	Pine Haven Care Center, Inc. has policies and procedures to ensure that the residents' environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues with interventions to enhance and promote safety. The interdisciplinary care team comprehensively assesses each resident at the time of admission to identify safety risks and develops a plan of care with resident-centered interventions that enhances and promotes safety. The resident's safety needs/risks are reassessed quarterly and whenever there is a change in the resident's behavior, physical condition, and/or cognition that impacts safety and functional status. The resident's care plan is modified as necessary to assure maximum function with minimal risk of injury. The resident's safety interventions are communicated to the direct care staff during shift reports and through the nursing assistant care guides which are routinely updated. During the mandatory meeting August 2, 2018, the staff will be instructed on 1) ensuring that the residents' environment remains as free of accidents hazards as possible and to report identified	

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F 689	Continued From page 20 administration record, dated for the month of 6/18, identified R166 was receiving oxygen as ordered. Review of R166's record identified a smoking assessment for R166 had not been completed and R166's care plan lacked to include information regarding smoking. During interview on 6/28/17, at 2:57 p.m., registered nurse (RN)-A stated R166 does smoke and R166 did not have a smoking assessment completed. During interview on 6/28/18, at 3:29 p.m., the interim director of nursing (IDON) stated I know R166 smokes. We (facility) provide education and encourage smoking off the grounds, as we are a smoke free facility. That is why (smoke free facility) a smoking assessment was not completed for R166. We became aware of R166 smoking after he was admitted and still did not complete a smoking assessment, as the facility consultant advised not to do a smoking assessment due to the facility being a smoke free facility. The facility policy Smoking, dated reviewed 6/26/18, indicated IV. Procedure C. Staff is responsible for ensuring that smoking by residents is done in a safe manner.	F 689	risks/hazards 2) the revised resident smoking policy and 3) the procedures for completing the smoking assessment and care plan. At the time of admission the resident will be informed that the facility and grounds are smoke free and asked whether they have a recent history of tobacco use. If so, the resident/legal representative will be provided with a copy of the facility's smoking policy. A smoking assessment will be completed and the resident's care plan will address the smoking history/pattern and related goals and interventions. The social worker met with resident number 166 to review the facility's smoking policies and compliance procedures. The resident's care plan has been updated to reflect his smoking preferences and related interventions. The resident expressed awareness and understanding of the facility's smoking policies, his smoking plan of care, and the dangers of smoking during oxygen use and near oxygen storage cylinders. Compliance will be monitored by the Social Service Director through a three-month audit of records of residents who indicate tobacco use on the Minimum Data Set form. If the resident smokes tobacco, the Social Service Director will ensure that a smoking assessment and related care plan have been completed. If a noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the October Quality Assurance and	

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F 689	Continued From page 21	F 689	Assessment Committee meeting and ongoing.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		8/6/18

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F 690	Continued From page 22 possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to improve toileting ability, urinary incontinence and provide timely toileting services for 1 of 1 resident (R23), who had a decline with urinary incontinence. Findings include: R23's quarterly Minimum Data Set (MDS) an assessment dated 2/7/18, identified R23 required supervision for toilet use, was occasionally incontinent, and had moderate cognitive impairment. R23's annual MDS, dated 5/8/18, identified R23 required limited assist for toilet use. Was frequently incontinent and had moderate cognitive impairment. During observation and interview on 6/27/18, at 7:14 a.m., R23's door to room was closed and nursing assistant (NA)-E stated for morning cares she had placed clean sheets and laid out clothes for R23. NA-E stated I will go back in and check on R23. NA-E stated R23 was independent with transfers and toileting self. I try to catch R23 in the bathroom to provide pericares. With continuous observations at 7:16 a.m., NA-E entered R23's room. R23 was seated in her wheelchair, with upper body dressed. NA-E assisted R23 with pericares and dressing lower body (which included an incontinent product). NA-E wheeled R23 out of room into the dining room. NA-E lacked to offer use of the toilet to R23. At 7:39 a.m., NA-E assisted R23 to room to place dry socks on R23's feet and brought R23 back to the dining room. At 7:53 a.m., R23	F 690	Based on the resident's comprehensive assessment, Pine Haven Care Center ensures that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible and to prevent urinary tract infections. The facility further ensures that each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is medically necessary. Bowel and bladder function is considered an important part of the resident's comprehensive assessment and is recognized as having a significant impact on the residents' quality of life. The policies and procedures for assessing urinary/bowel function, incontinence, and intermittent catheter use were reviewed and found appropriate. During the August 2, 2018 mandatory meeting, the nursing staff will be instructed on the importance of 1) monitoring/tracking and comprehensively assessing bladder function and 2) implementing interventions to promote continence, manage incontinence and prevent infections. The certified nursing	

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F 690	Continued From page 23 remained in the dining room. At 8:26 a.m., R23 remained in the dining room eating breakfast. At 8:41 a.m., R23 wheeled self in wheelchair from the dining room into the hallway and talked to an unidentified staff person. At 8:47 a.m., R23 had wheeled self into her room and closed the door. At 9:08 a.m., R23 remained in her room with door to room closed. At 9:35 a.m., remains the same. At 9:46 a.m., remains the same. At 10:01 a.m., remains the same. At 10:09 a.m., NA-E entered R23's room, assisted with making R23's bed and asked R23 if she would like to lay down. NA-E assisted R23 to lay down in bed and walked out of R23's room. NA-E lacked to offer the use of the toilet to R23. R23's current care plan included requires assistance for the physical process of toileting related to: deconditioning, impaired mobility. Toilet resident upon arising, after breakfast, before and after lunch and supper meals, hs (bedtime) and prn (as needed). One person constant supervision and physical assist for safety i.e. adjust clothing/wash hands/pericare. Uses incontinent products, check and change with toileting as needed. Pericare with each incontinence, protective barrier product as needed. Requires minimal to no assistance for transferring from one position to another related to past cerebral vascular accident. R23's current nursing assistant care plan included toileting required. Uses incontinent products check and change with toileting as needed. Pericare with each incontinence, protective barrier product as needed. Toilet resident upon arising, after breakfast, before and after lunch and supper meals, hs and prn. Toileting one person constant supervision and	F 690	assistants will be counseled that job performance expectations include being aware of and following the resident's individualized plan of care for toileting. The bowel/bladder function and care plan for resident number 23 is being reassessed. During the minimum data set assessment period that identified a decline in bladder control, the resident was ill resulting in increased incontinence and additional assistance with activities of daily living including toileting. The resident has since returned to baseline and is able to independently toilet which is her preference. A 6/15/2018 trial of waking the resident to toilet during the night to improve continence was found to increase the resident's agitation and disrupt her sleep (took three hours for the resident to return to sleep). The certified nursing assistant's care worksheets were reviewed for accuracy. To monitor compliance, the MDS Coordinator will conduct a three-month audit of decline of urinary continence as identified on the minimum data set assessments. If a decline is noted, the clinical manager will determine whether the resident's toileting plan was appropriately reevaluated. The residents' bowel/bladder function and toileting needs will continue to be addressed during the quarterly interdisciplinary care conferences with modifications to the resident's plan of care made as necessary. If noncompliance with reassessments of bowel/bladder function	

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F 690	Continued From page 24 physical assist for safety i.e. adjust clothing/wash hands/pericare. R23's bladder assessment dated 5/9/18, included pattern continence for day, evening, night (no description of pattern included). Incontinent of bladder with some control present: frequently incontinent, gets to bathroom without help, manages clothing when toileting, communicates need to toilet. Able to transfer and ambulate without assistance: no. Requires assist with mobility. Functional and urge incontinence. Scheduled/Habit toileting: scheduled toileting at regular intervals on planned basis (reduces episodes of incontinence). Cognitively impaired; functionally disabled; caregiver dependent. Nurse completes note with pan noting decline/improvement: Comments: Plan to maintain current level. Resident not compliant with asking for assistance. PT (physical therapy)/OT (occupational therapy) screen requested. R23's record included a telephone order dated 4/18/18, PT/OT screen to see if resident can return to being independent in her room. Currently assist of one but not compliant at this time. A screen by OT dated 5/8/18, continue with prior recommendation of assist of one secondary to fall risk and poor safety awareness. R23's record lacked documentation of interventions to implement for decline of bladder incontinence from occasionally to frequently incontinent. During interview on 6/27/18., 10:40 a.m., registered nurse (RN)-A stated R23's care plan for toileting was upon arising, after breakfast,	F 690	and care planning is identified, additional auditing and staff training will be done. Compliance will be reviewed during the October 2018 Quality Assurance and Assessment Committee meeting.	

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F 690	Continued From page 25	F 690		

before and after lunch and supper meals, hs and prn. RN-A stated she would expect staff to ask and offer use of the toilet.

During interview on 6/28/18, at 10:23 a.m., registered nurse (RN)-A stated the PT and OT request she had written on R23's bladder assessment dated 5/9/18, was in reference to an order written for falls prior to the 5/9/18 bladder assessment. RN-A stated the recommendation had nothing to do with the bladder assessment, but was for a prior fall R23 had, to help reduce falls for R23. RN-A confirmed R23's Bowel/Bladder Assessment dated 5/9/18, read plan to maintain current level.

During interview on 6/28/18, at 10:48 a.m., the interim director of nursing (IDON) stated even though R23 refuses and self toilets at times, I would still expect staff to be offering toileting assistance. IDON stated with a decline in urinary incontinence she would expect a head to toe assessment to rule out no infection, issue with behaviors, and maybe start a more specific bladder program based on findings. If it was a matter of transferring, I think physical therapy and occupational therapy would be appropriate.

The facility policy Bowel and Bladder Protocol, dated revision 3/2018, included Purpose: The purpose of this is to gather information on urinary and bowel continence, bowel training program and bowel patterns. Each resident who may be incontinent or at risk for developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments, and/or devices) and services to achieve or maintain as normal elimination function as possible.

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	245359	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adaptive equipment to promote independence with eating for 1 of 1 resident (R2) reviewed for dining and who observed difficulty with eating independently. Findings include: R2's undated face sheet, indicated R2 had the following diagnoses: Alzheimer's disease, dementia without behavioral disturbance, weakness and osteoarthritis. R2's Quarterly Nutrition Assessment dated 4/2/18, identified R2 required a curved handled spoon to be provided at meals to promote independence with eating. Eating skills are varied being independent to extensive at times to requiring assist of 1 with supervision and usual intake is 50-75 percent (%). R2's quarterly Minimum Data Set (MDS) an assessment dated 6/18/18, identified R2 with severe cognitive impairment and required 1 person extensive assist with eating. R2's care plan printed 6/27/18, identified a focus of potential for alteration in nutrition related to cognitive decline and requires assist per staff with	F 810	Pine Haven Care Center provides special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. The facility has a variety of assistive devices for residents who need them to maintain or improve their ability to eat or drink independently. The facility also provides the appropriate staff assistance to ensure that residents can use the assistive devices when eating or drinking. During the August 2, 2018 mandatory meeting, the nursing and dietary staff will be reinstructed on the procedures for identifying residents who need adaptive eating equipment and to provide the adaptive equipment that is listed on the resident's tray cards. The care plan for resident number 2 was reviewed and found to appropriately instruct the staff to provide an adaptive curved spoon to improve self-performance in eating. The resident's ability to feed himself is assessed	8/6/18

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F 810	Continued From page 27 feeding and supervision when consuming foods and fluids. Identified a goal of, "resident to continue to feed self independently with tray set up, supervision and assist of 1 as needed and use of adaptive utensils." Intervention to, "Please give resident curved spoons at all meals and all snacks for increased independence with self-feeding after meal set up." R2's unlabeled and undated nursing assistant care sheet, identified R2 is independent with eating after setup, curved spoon at all meals and snacks, assist table for all meals and scheduled snacks. R2's Menu Card identified, "Curved spoon for self-feeding," under adaptive equipment. During observation on 6/25/18, at 12:26 p.m. during lunch, R2 sits up further in her broda chair and then lays back in chair, R2 has not attempted to feed herself. R2's plate contained mechanical soft country fried steak, mashed potatoes and gravy, and mixed vegetables. No curved spoon observed, regular fork observed sitting on the plate, and no one assisting her with cues. During observation on 6/26/18, at 9:05 a.m. during breakfast, R2 is sitting in her broda chair up to the table in the dining room with 3 other residents. R2 is not being assisted, pancake is cut up on her plate and R2 is eating it with her fingers. No curved spoon is observed, has regular silverware available. During observation on 6/27/18, at 8:37 a.m. during breakfast, R2 is sitting up to the table in her Broda chair, has a plate with a cut up pancake on it, and has regular silverware	F 810	quarterly and with changes in condition. The dining plan of care is updated as necessary. Compliance will be monitored by the Dietary Services Manager/designee for two weeks through random observations during meals times to ensure adaptive equipment is provided as identified in the resident's care plan and tray card. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the October Quality Assurance and Assessment Committee meeting.	

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F 810	Continued From page 28	F 810		

available. No curved spoon noted on the table.

During interview on 6/27/18, at 10:02 a.m. dietary manager (DM)-A stated the dietary staff are responsible for making sure residents have adaptive equipment, it will tell the specific equipment needed on each residents menu card. I also put this information in our communication book and I care plan it as well. DM-A verified R2 should have a curved spoon at all meal and snacks, it is used to promote independence with eating. "My expectation is for dietary staff to be using the menu cards to look for residents adaptive equipment, [R2] should have her rounded spoon given to her at every meal."

During interview on 6/27/18, at 10:39 a.m. interim director of nursing (IDON) verified R2 is care planned to have a curved spoon for all meals to promote independence with eating. "My expectation is for a resident who needs dietary adaptive equipment is, if dietary does not bring it out, the nursing assistants have it on their care plan and should be double checking to make sure the resident gets their adaptive equipment."

During observation on 6/27/18, at 12:41 p.m. R2 was observed to have eaten 100% of her Salisbury steak and ½ of her potatoes, curved spoon was sitting on R2's plate. Interview with trained medication aide (TMA)-A stated, R2 ate independently today, "I think it helps to have her curved spoon, she ate good today."

An undated facility policy, Adaptive (Assistive) Eating Devices identified, "The facility will provide special eating equipment and utensils for residents who need them and appropriate assistance to assure that the resident can use the

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F 810	Continued From page 29 adaptive device when consuming snacks and meals" 4. The food and nutrition services department will be responsible for ensuring that each individual receives feeding devices as ordered for each meal.	F 810		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		8/6/18

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F 880	Continued From page 30 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program, which included comprehensive surveillance of resident infections that did not	F 880	Pine Have Care Center has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable	

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F 880	Continued From page 31 require an antibiotic, analysis of infections and failed to report an outbreak of influenza A for 4 of 4 residents (R1, R8, R9 and R32), who had been diagnosed with influenza A. This had the potential to affect all residents in the facility. Findings include: Review of the Resident Infection Reports and facility monthly maps from 12/2017 through 5/2018, revealed the facility had tracking documentation (map, onset, resident, room, antibiotic order, site of infection, lab test, culture results, microbe, antibiotic appropriate, last day of antibiotic, resolved, hospital versus in house acquired) of infections that required an antibiotic and a map for the dates of 3/1/18 through 3/6/18 that they had influenza outbreak, which identified positive influenza results for four resident rooms. However, the Resident Infections Report for 3/18 lacked to include resident information for influenza. The facility was unable to provide any further information, logs or tracking tools for infections that did not require the use of an antibiotic in the facility and any information of analysis of infections from 12/2017 through 5/2018. In addition, the facility lacked to report an outbreak of influenza for the following: R1's Emergency Room report dated 3/4/18, identified diagnosis of influenza A. R8's lab results dated 3/3/18, identified influenza A positive. R9's lab results dated 3/5/18, identified influenza A positive.	F 880	environment and to prevent the development and transmission of communicable diseases and infections. The infection control program includes 1) identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. The IPCP will be reviewed annually and updated as necessary. Antibiotic stewardship and the infection control policy changes will be reviewed with the Medical Director. The facility's monthly infection control log tracks resident name, room, type/site of infection, onset/resolution of infection, causative organism (if cultured), where the infection was acquired, antibiotic treatment dates, and whether the antibiotic was appropriate, if applicable. Collected data is analyzed including identifying infection rates, trends and clustering. The monthly logs will be re reviewed during the monthly Safety Committee meetings; an infection surveillance and analysis summary will be presented at the quarterly Quality Assurance and Assessment Committee meetings. The nurses will use the Loeb Minimum Criteria protocol as a guide to determine whether to notify the medical practitioner of the symptoms of infection. Symptoms	

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F 880	Continued From page 32 R32's lab results dated 3/7/18, identified influenza A positive. During interview on 6/28/18, at 1:40 p.m., the interim director of nursing (IDON) stated four residents had tested positive for influenza A in the facility. Everyone (all residents) across the board received Tamiflu except one family refused. IDON stated I did not report (four residents positive for influenza A) to the State, I would be responsible for reporting to the State. IDON stated she did not have any information regarding analysis of infections. IDON confirmed the information provided above was all the information the facility had related to infections. The facility policy Reportable Diseases, dated revision 3/2018, included Reportable infectious, contagious, or communicable diseases will be reported to appropriate city, county and/or state health department officials. The facility policy Infection Control Program, dated revision 4/2018, included A. Surveillance Systematic data collection to identify infections, when transmission based precautions should be put in place, and identify education opportunities for staff, residents and resident families. B. 4. Documentation of individual infections, outbreaks, control measures and evaluations are kept by the Infection Preventionist and copied to the DON (director of nursing). The facility policy Antibiotic Stewardship Program, dated review 5/2018, included Accountability: Infection Preventionist: the Infection Preventionist Nurse will be responsible for surveillance, infection definition based on standards of	F 880	of infections not treated with an antibiotic will be tracked and analyzed. The newly assigned infection control nurse will review the infection control regulations with a focus on the requirements for infection surveillance and data analysis. A comprehensive infection control resource manual is available for reference. The infection control nurse or Director of Nurses will notify the Department of Health of reportable infections such as AIDS, HIV, influenza and tuberculosis. During the mandatory staff meeting August 2, 2018, the licensed nurses will be instructed on the criteria to consider when notifying the clinician of symptoms which may be indicative of an infection and the related documentation. The infection control nurse will attend the Monday through Friday interdisciplinary care team meetings at which time condition changes (including symptoms of infections) are identified. The infection control nurse follows up on reported infection-related symptoms/treatments. The Director of Nurses/designee will monitor compliance with regulatory requirements and facility policies for resident care infection control analysis/surveillance/reporting for the next three months through a review of the infection control tracking data and summary findings. If noncompliance is noted, additional training and auditing will be done. Compliance will be reviewed	

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F 880	Continued From page 33 practice, staff education, tracking, data management, analysis of data, and communication with the DON, Medical Director and Consultant pharmacist and ongoing system review.	F 880	during the October 2018 Quality Assurance and Assessment meeting and ongoing.	

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K 000	INITIAL COMMENTS 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 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 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 not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/20/2018

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.

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 protected by a full fire sprinkler system. 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 70 beds and had a census of 69 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)) This deficient practice could affect the safety of all (69) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include:	K 351	The items stored above acceptable levels in the closet of the Chapel Room have been relocated. The upper shelf in the closet has been removed to ensure proper clearance for fire sprinkler operation. Other closet areas have been checked to ensure proper clearance for the sprinkler heads. During the August 2, 2018 mandatory meeting, the staff will be	6/28/18

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K 351	Continued From page 3 On facility tour between 10:00 AM and 01:00 PM on 06/26/2018, observations and staff interview revealed the following: Observed during the walk-through inspection - high storage of materials in the closet of the Chapel Rm This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351	informed of the requirement to leave adequate space surrounding the fire sprinkler heads. The Maintenance Director/designee will be responsible for monitoring compliance with appropriate storage procedures in the vicinity of fire sprinkler heads.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect the safety of all (35) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include:	K 511	The electrical panel in the resident hallway of the 400 wing has been secured with a panel cover. All other electrical panels checked and found to be secure. The Maintenance Director/designee will be responsible for monitoring compliance with the security of electrical panels.	6/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2018**

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 511	Continued From page 4 On facility tour between 10:00 AM and 01:00 PM on Date, observations and staff interview the following: Observed during the walk-through inspection - unsecured electrical panel in the resident hallway of 400 Wing This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511		
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 914		8/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2018**

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

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K 914	Continued From page 5 The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99)) This deficient practice could affect the safety of all (35) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/26/2018, observation and documentation reviewed revealed the following: During documentation review no information was provided regarding receptacle testing being completed for the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914	Non-hospital grade electrical receptacles will be tested every 12 months. A log sheet has been developed that provides instruction on the test procedure/criteria and documents the test date and results. The Maintenance Director/designee will be responsible for monitoring compliance with the timely testing of electric receptacles.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**06/27/2018**

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 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 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 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 not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/20/2018

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 **02 - PINE HAVEN CARE CENTER** B. WING _____	**06/27/2018**

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Facility is an addition, a 1 story building with no basement, was constructed in 2016 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. 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. At the time of this survey the 34 bed addition was found not in compliance The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing	K 914		8/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**06/27/2018**

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K 914	Continued From page 2 Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99)) This deficient practice could affect the safety of all (34) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 06/26/2018, observation and documentation reviewed revealed the following: During documentation review no information was provided regarding receptacle testing being completed for the facility.	K 914	Non-hospital grade electrical receptacles will be tested every 12 months. A log sheet has been developed that provides instruction on the test procedure/criteria and documents the test date and results. The Maintenance Director/designee will be responsible for monitoring compliance with the timely testing of electric receptacles.	

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K 914	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914		

Electronically delivered
July 13, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5359028

Dear Mr. Ziller:

The above facility was surveyed on June 25, 2018 through June 28, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
	00148	A. BUILDING: _____ B. WING _____	06/28/2018

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 25, 26, 27 & 28, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to improve toileting ability, urinary incontinence and provide timely toileting services for 1 of 1 resident (R23), who had a decline with urinary incontinence. Findings include: R23's quarterly Minimum Data Set (MDS) an assessment dated 2/7/18, identified R23 required	2 910	Corrected	7/20/18

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2 910	Continued From page 3	2 910		

supervision for toilet use, was occasionally incontinent, and had moderate cognitive impairment. R23's annual MDS, dated 5/8/18, identified R23 required limited assist for toilet use. Was frequently incontinent and had moderate cognitive impairment.

During observation and interview on 6/27/18, at 7:14 a.m., R23's door to room was closed and nursing assistant (NA)-E stated for morning cares she had placed clean sheets and laid out clothes for R23. NA-E stated I will go back in and check on R23. NA-E stated R23 was independent with transfers and toileting self. I try to catch R23 in the bathroom to provide pericares. With continuous observations at 7:16 a.m., NA-E entered R23's room. R23 was seated in her wheelchair, with upper body dressed. NA-E assisted R23 with pericares and dressing lower body (which included an incontinent product). NA-E wheeled R23 out of room into the dining room. NA-E lacked to offer use of the toilet to R23. At 7:39 a.m., NA-E assisted R23 to room to place dry socks on R23's feet and brought R23 back to the dining room. At 7:53 a.m., R23 remained in the dining room. At 8:26 a.m., R23 remained in the dining room eating breakfast. At 8:41 a.m., R23 wheeled self in wheelchair from the dining room into the hallway and talked to an unidentified staff person. At 8:47 a.m., R23 had wheeled self into her room and closed the door. At 9:08 a.m., R23 remained in her room with door to room closed. At 9:35 a.m., remains the same. At 9:46 a.m., remains the same. At 10:01 a.m., remains the same. At 10:09 a.m., NA-E entered R23's room, assisted with making R23's bed and asked R23 if she would like to lay down. NA-E assisted R23 to lay down in bed and walked out of R23's room. NA-E lacked to offer the use of the toilet to R23.

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2 910	Continued From page 4 R23's current care plan included requires assistance for the physical process of toileting related to: deconditioning, impaired mobility. Toilet resident upon arising, after breakfast, before and after lunch and supper meals, hs (bedtime) and prn (as needed). One person constant supervision and physical assist for safety i.e. adjust clothing/wash hands/pericare. Uses incontinent products, check and change with toileting as needed. Pericare with each incontinence, protective barrier product as needed. Requires minimal to no assistance for transferring from one position to another related to past cerebral vascular accident. R23's current nursing assistant care plan included toileting required. Uses incontinent products check and change with toileting as needed. Pericare with each incontinence, protective barrier product as needed. Toilet resident upon arising, after breakfast, before and after lunch and supper meals, hs and prn. Toileting one person constant supervision and physical assist for safety i.e. adjust clothing/wash hands/pericare. R23's bladder assessment dated 5/9/18, included pattern continence for day, evening, night (no description of pattern included). Incontinent of bladder with some control present: frequently incontinent, gets to bathroom without help, manages clothing when toileting, communicates need to toilet. Able to transfer and ambulate without assistance: no. Requires assist with mobility. Functional and urge incontinence. Scheduled/Habit toileting: scheduled toileting at regular intervals on planned basis (reduces episodes of incontinence). Cognitively impaired; functionally disabled; caregiver dependent. Nurse	2 910		

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2 910	Continued From page 5	2 910		

completes note with pan noting decline/improvement: Comments: Plan to maintain current level. Resident not compliant with asking for assistance. PT (physical therapy)/OT (occupational therapy) screen requested.

R23's record included a telephone order dated 4/18/18, PT/OT screen to see if resident can return to being independent in her room. Currently assist of one but not compliant at this time. A screen by OT dated 5/8/18, continue with prior recommendation of assist of one secondary to fall risk and poor safety awareness.

R23's record lacked documentation of interventions to implement for decline of bladder incontinence from occasionally to frequently incontinent.

During interview on 6/27/18., 10:40 a.m., registered nurse (RN)-A stated R23's care plan for toileting was upon arising, after breakfast, before and after lunch and supper meals, hs and prn. RN-A stated she would expect staff to ask and offer use of the toilet.

During interview on 6/28/18, at 10:23 a.m., registered nurse (RN)-A stated the PT and OT request she had written on R23's bladder assessment dated 5/9/18, was in reference to an order written for falls prior to the 5/9/18 bladder assessment. RN-A stated the recommendation had nothing to do with the bladder assessment, but was for a prior fall R23 had, to help reduce falls for R23. RN-A confirmed R23's Bowel/Bladder Assessment dated 5/9/18, read plan to maintain current level.

During interview on 6/28/18, at 10:48 a.m., the

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

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2 910	Continued From page 6 interim director of nursing (IDON) stated even though R23 refuses and self toilets at times, I would still expect staff to be offering toileting assistance. IDON stated with a decline in urinary incontinence she would expect a head to toe assessment to rule out no infection, issue with behaviors, and maybe start a more specific bladder program based on findings. If it was a matter of transferring, I think physical therapy and occupational therapy would be appropriate. The facility policy Bowel and Bladder Protocol, dated revision 3/2018, included Purpose: The purpose of this is to gather information on urinary and bowel continence, bowel training program and bowel patterns. Each resident who may be incontinent or at risk for developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments, and/or devices) and services to achieve or maintain as normal elimination function as possible. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or Designee could ensure resident toileting needs are met by assessment to reduce incontinence for residents with incontinence and by educating all nursing staff on resident's with incontinence. Random audits of incontinent residents could be done. Random observations of resident's with incontinence could be done to ensure proper services are provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel	2 945		7/20/18

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2 945	Continued From page 7 Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adaptive equipment to promote independence with eating for 1 of 1 resident (R2) reviewed for dining and who observed difficulty with eating independently. Findings include: R2's undated face sheet, indicated R2 had the following diagnoses: Alzheimer's disease, dementia without behavioral disturbance, weakness and osteoarthritis. R2's Quarterly Nutrition Assessment dated 4/2/18, identified R2 required a curved handled spoon to be provided at meals to promote independence with eating. Eating skills are	2 945	Corrected.	

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2 945	Continued From page 8 varied being independent to extensive at times to requiring assist of 1 with supervision and usual intake is 50-75 percent (%). R2's quarterly Minimum Data Set (MDS) an assessment dated 6/18/18, identified R2 with severe cognitive impairment and required 1 person extensive assist with eating. R2's care plan printed 6/27/18, identified a focus of potential for alteration in nutrition related to cognitive decline and requires assist per staff with feeding and supervision when consuming foods and fluids. Identified a goal of, "resident to continue to feed self independently with tray set up, supervision and assist of 1 as needed and use of adaptive utensils." Intervention to, "Please give resident curved spoons at all meals and all snacks for increased independence with self-feeding after meal set up." R2's unlabeled and undated nursing assistant care sheet, identified R2 is independent with eating after setup, curved spoon at all meals and snacks, assist table for all meals and scheduled snacks. R2's Menu Card identified, "Curved spoon for self-feeding," under adaptive equipment. During observation on 6/25/18, at 12:26 p.m. during lunch, R2 sits up further in her broda chair and then lays back in chair, R2 has not attempted to feed herself. R2's plate contained mechanical soft country fried steak, mashed potatoes and gravy, and mixed vegetables. No curved spoon observed, regular fork observed sitting on the plate, and no one assisting her with cues. During observation on 6/26/18, at 9:05 a.m.	2 945		

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2 945	Continued From page 9	2 945		

during breakfast, R2 is sitting in her broda chair up to the table in the dining room with 3 other residents. R2 is not being assisted, pancake is cut up on her plate and R2 is eating it with her fingers. No curved spoon is observed, has regular silverware available.

During observation on 6/27/18, at 8:37 a.m. during breakfast, R2 is sitting up to the table in her Broda chair, has a plate with a cut up pancake on it, and has regular silverware available. No curved spoon noted on the table.

During interview on 6/27/18, at 10:02 a.m. dietary manager (DM)-A stated the dietary staff are responsible for making sure residents have adaptive equipment, it will tell the specific equipment needed on each residents menu card. I also put this information in our communication book and I care plan it as well. DM-A verified R2 should have a curved spoon at all meal and snacks, it is used to promote independence with eating. "My expectation is for dietary staff to be using the menu cards to look for residents adaptive equipment, [R2] should have her rounded spoon given to her at every meal."

During interview on 6/27/18, at 10:39 a.m. interim director of nursing (IDON) verified R2 is care planned to have a curved spoon for all meals to promote independence with eating. "My expectation is for a resident who needs dietary adaptive equipment is, if dietary does not bring it out, the nursing assistants have it on their care plan and should be double checking to make sure the resident gets their adaptive equipment."

During observation on 6/27/18, at 12:41 p.m. R2 was observed to have eaten 100% of her Salisbury steak and ½ of her potatoes, curved

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2 945	Continued From page 10 spoon was sitting on R2's plate. Interview with trained medication aide (TMA)-A stated, R2 ate independently today, "I think it helps to have her curved spoon, she ate good today." An undated facility policy, Adaptive (Assistive) Eating Devices identified, "The facility will provide special eating equipment and utensils for residents who need them and appropriate assistance to assure that the resident can use the adaptive device when consuming snacks and meals" 4. The food and nutrition services department will be responsible for ensuring that each individual receives feeding devices as ordered for each meal. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to assistance with eating and provide staff education related to the care of residents who use assistive devices to promote independence. The director of nursing or designee could develop an audit tool to ensure appropriate appropriate assistance and equipment are provided to promote resident independence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		7/20/18

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21375	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program, which included comprehensive surveillance of resident infections that did not require an antibiotic, analysis of infections and failed to report an outbreak of influenza A for 4 of 4 residents (R1, R8, R9 and R32), who had been diagnosed with influenza A. This had the potential to affect all residents in the facility. Findings include: Review of the Resident Infection Reports and facility monthly maps from 12/2017 through 5/2018, revealed the facility had tracking documentation (map, onset, resident, room, antibiotic order, site of infection, lab test, culture results, microbe, antibiotic appropriate, last day of antibiotic, resolved, hospital versus in house acquired) of infections that required an antibiotic and a map for the dates of 3/1/18 through 3/6/18 that they had influenza outbreak, which identified positive influenza results for four resident rooms. However, the Resident Infections Report for 3/18 lacked to include resident information for influenza. The facility was unable to provide any further information, logs or tracking tools for infections that did not require the use of an antibiotic in the facility and any information of analysis of infections from 12/2017 through 5/2018. In addition, the facility lacked to report an outbreak of influenza for the following: R1's Emergency Room report dated 3/4/18, identified diagnosis of influenza A.	21375	Corrected.	

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21375	Continued From page 12 R8's lab results dated 3/3/18, identified influenza A positive. R9's lab results dated 3/5/18, identified influenza A positive. R32's lab results dated 3/7/18, identified influenza A positive. During interview on 6/28/18, at 1:40 p.m., the interim director of nursing (IDON) stated four residents had tested positive for influenza A in the facility. Everyone (all residents) across the board received Tamiflu except one family refused. IDON stated I did not report (four residents positive for influenza A) to the State, I would be responsible for reporting to the State. IDON stated she did not have any information regarding analysis of infections. IDON confirmed the information provided above was all the information the facility had related to infections. The facility policy Reportable Diseases, dated revision 3/2018, included Reportable infectious, contagious, or communicable diseases will be reported to appropriate city, county and/or state health department officials. The facility policy Infection Control Program, dated revision 4/2018, included A. Surveillance Systematic data collection to identify infections, when transmission based precautions should be put in place, and identify education opportunities for staff, residents and resident families. B. 4. Documentation of individual infections, outbreaks, control measures and evaluations are kept by the Infection Preventionist and copied to the DON (director of nursing). The facility policy Antibiotic Stewardship Program,	21375		

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21375	Continued From page 13 dated review 5/2018, included Accountability: Infection Preventionist: the Infection Preventionist Nurse will be responsible for surveillance, infection definition based on standards of practice, staff education, tracking, data management, analysis of data, and communication with the DON, Medical Director and Consultant pharmacist and ongoing system review. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review infection control policies and procedures for infection control with staff. The director of nursing or designee could then develop an auditing system as part of the facility's quality assurance program to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		7/20/18

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21426	Continued From page 14 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R30 and R22) received a two-step tuberculin skin testing (TST): failed to ensure 2 of 5 employees (E-A and E-B) received a two-step tuberculin skin testing (TST) and 2 of 5 employees (E-A and E-C) received TB education according to the Centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. Findings include: TB TST RESIDENT: R30's admit date was 1/12/18 . R30 had a first step TST given on 1/12/18 and read on 1/14/18, with results of 0 mm (millimeters) and negative. A second step TST was given on 1/26/18, but lacked read results. R22's admit date was 1/22/18. R22 had a second step TST documented as given on 2/2/18 and read on 2/4/18, with results of 0 mm and negative. There was no evidence R22 had a first step TST completed upon admission. During interview on 6/28/18, at 1:04 p.m., interim director of nursing (IDON) stated R30 was in the hospital at the time the results for the second step TST was to be read. We should have	21426	Corrected.	

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repeated the second step TST when R30 returned from the hospital. IDON confirmed R22's record showed R22 had a second step TST documented, but no first step TST had been given.

TB TST EMPLOYEE:
E-A's hire date was 4/5/18. E-A had a first step TST given on 3/21/18, and read on 3/23/18, with results of 0 mm and negative. There was no evidence E-A had a second-step TST completed upon hire.

E-B's hire date was 4/26/18. E-B had a first step TST given on 4/24/18 and read on 4/26/18, with results of 0 mm and negative. There was no evidence E-B had a second-step TST completed upon hire.

During interview on 6/28/18, at 1:04 p.m., IDON confirmed the above.

TB EDUCATION:
E-A and E-C lacked TB education for TB pathogenesis and transmission, signs and symptoms of active TB and the facility TB infection control plan (how to implement early recognition, isolation and referral procedure).

During interview on 6/28/18, at 1:04 p.m., IDON confirmed the above.

The facility policy TB Control Plan-Residents, dated review 3/2018, included Admission 2-step TB skin testing of residents is mandatory at Pine Haven.

The facility policy TB Control Plan-Employees, dated review 3/2018, included 1. All employees,

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21426	Continued From page 16 unless certified in writing by a physician to have a positive reaction or other medical contraindication, will receive a mantoux upon hire. 2. A second step mantoux must be done one to three weeks later if the first mantoux is negative. Admission 2-step TB skin testing of residents is mandatory at Pine Haven. The facility policy TB Infection Control Program, dated revision 3/2018, included 4. The Inservice Coordinator will provide annual staff education regarding TB recognition and prevention. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise the facility's TB policies and procedures to ensure appropriate first and second step tuberculin testing was completed. Pertinent personnel could be re-trained on TB screening and prevention. An auditing system of newly hired staff could be developed for on-going compliance, with the results of those audits being presented to the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Seven (7) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		7/20/18

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21805	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R2) reviewed for dignity with care. Findings include: R2's quarterly Minimum Data Set (MDS) an assessment dated 6/18/18, revealed R38 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs) such as bed mobility, eating, transferring and personal hygiene. R2's face sheet printed 6/27/18, indicated R2 had the following diagnoses: Alzheimer's disease, dementia without behavioral disturbance, weakness and osteoarthritis. R2's care plan printed 6/27/18, had an intervention to, "provide assist cues and supervision of one staff for all meals." R2 was observed on 6/25/18, at 12:19 p.m. in the dining room sitting in a tilted back Broda chair (a type of positioning chair) and appeared to be positioned comfortably in a sitting position up to the table, R2 has a plate of food in front of her and nursing assistant (NA)-A was standing next to R2's right side assisting with feeding R2. NA-A then left resident alone to deliver more food trays. At 12:21 p.m. NA-B grabs R2's fork and stood over her right side putting the fork to R2's mouth and states to R2, "You want to eat?" R2 does not take the bite and does not respond. NA-B leaves after a short time to deliver more food trays to other residents. At 12:26 p.m. R2 sits up further in her chair and then lays back in chair, R2 has	21805	Corrected.	

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not attempted to feed herself. R2's plate contained mechanical soft country fried steak, mashed potatoes and gravy, and mixed vegetables. At 12:27 p.m. NA-B returns to help R2 and tries to give R2 another bite of her food while she stands over R2 and stated, "You want to go back to your room?" R2 stated, "No." NA-B then stated, "Would you like a bite?" R2 stated, "No." NA-B said to another NA located at the other end of the dining room, "[R2] ate a really good breakfast, she probably won't eat lunch, she usually eats one or the other." NA-B then walks away leaving R2 alone with no assistance or cues with eating, and began to deliver more food trays to other residents. At 12:31 p.m. R2 sat up in her Broda chair and is softly moaning unintelligibly. At 12:33 p.m. Licensed practical nurse (LPN-A) started talking quietly to R2 in her ear and R2 stated, "No, No!" LPN-A left R2 alone and walked back down the hall towards the unit. At 12:34 p.m. (NA)-C walked up to the left side of R2 and grabbed a forkful of food to put in R2's mouth and R2 said, "No, No." NA-C walked away leaving R2 alone. At 12:38 p.m. (NA)-D sat in a chair on R2's right side and asked if she was hungry and if she wanted something to eat, R2 stated no. R2 agreed to lie down and NA-D wheeled R2 out of the dining area towards her room. R2 was observed not to eat any food or drinks for lunch.

On 6/27/18, at 10:39 a.m. interim director of nursing (IDON) verified R2 needs assist with eating and further verified it was documented that R2 had been eating independently. IDON stated, "My expectation in regards to treating a resident with dignity and respect while assisting with eating is to not serve the plate of food until someone is available to sit with them." IDON further stated to assist them to eat while sitting next to and not stand over the resident while

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	00148	A. BUILDING: _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 19 assistance with eating. Facility policy, Quality of Life-Dignity revised 3/2018, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. "Treated with Dignity," means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. SUGGESTED METHOD OF CORRECTION: The administrator, director or nursing or designee could provide staff education related to dignified dining services and monitor for compliance TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of physical abuse to the state agency (SA) within 2 hours for 1 of 1 resident (R4) who reported an allegation of	21995	Corrected.	7/20/18

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21995	Continued From page 20 physical abuse. Findings include: R4 had diagnoses identified on the admission record that included depression, macular degeneration and malaise. R4's admission Minimum Data Set (MDS) an assessment dated 3/23/18, identified R4 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated R4 was cognitively intact. The MDS further identified R4 required extensive assistance of one staff with all activities of daily living (ADL). R4's initial vulnerable report submitted to the SA on 6/12/18, at 4:57 p.m. included, "Social worker visited with resident today. Resident stated, "I have bruises on me because staff help me too much, when they lift my legs there [sic] fingers dig in." When asked if she was afraid of staff or that she thought they were hurtful. She responded, "not on purpose, when they help move my legs into bed they lift." She states, "most of the staff is nice but there a few that are more rough than the others." Review of the initial report made to the SA lacked documentation of how the facility social worker became aware of the abuse allegation and the time the social worker met with the R4 on 6/12/18. R4's investigative summary submitted to the SA on 6/14/18, at 6:09 p.m. included, R4 was interviewed by social worker about the comment she made to a staff member. R4 stated, "I have bruises on me because staff help me too much, when they lift my legs their fingers dig in." She indicated she was not afraid of any staff. She indicates that she doesn't think that this is done	21995		

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21995	Continued From page 21	21995		

intentionally. She indicates most of the staff are nice but there are a few that are more rough then others. R4 was interviewed by the interim director of nursing (IDON). The IDON completed the body audit looking for bruising. When IDON asked R4 what happened, R4 stated, "that the bigger girls are rougher with her." R4 indicates that she thinks they don't know their own strength. R4 stated that sometimes she needs a hand and the staff "get rough with her." When IDON talked to R4 about being independent, R4 got angry and stated, "sometimes she needed help with things." R4 stated the social worker was blowing this out of proportion, she didn't want to get anyone in trouble, she just wanted staff to be more gentle with her and not be so rough.

R4's progress note dated 6/12/18, at 4:53 p.m. included Note Text: "Resident reported bruising from staff being too rough with resident. Full body audit was done by this writer at 430 p.m. Bruising noted to buttock. 2 small areas that were less than 1 cm by length and width. 2 bruises to left leg. There were also 2 bruises done on the arms. Resident stated she did not fear for her safety and she felt safe. SS was notified and VA [vulnerable adult] was completed due to resident stating staff are too rough with her."

On 6/28/18, at 12:25 p.m. social services (SS)-A stated a staff member had a note left in her box regarding R4's concern staff were rough. SS-A stated she did not know when the note was left for her and she found the note on 6/12/18, when she checked her box. SS-A stated she followed up with R4 around noon on 6/12/18 and stated R4 "poo pooed" the concern. SS-A stated she asked nursing to do a body audit and complete follow up with R4. SS-A stated R4 said SS-A was overacting to the situation. SS-A verified the

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21995	Continued From page 22 investigation did not include what time the report of rough treatment was initially made by the certified nursing assistant, as a note had been left in her box. SS-A stated she did not document the time she found the note that had been left for her or the initial interview she completed with R4 around noon. SS-A stated allegation of abuse needed to be reported to the SA within two hours. SS-A verified rough treatment was considered an allegation of abuse. On 6/2/18, at 2:23 p.m. the administrator stated he expected staff to complete an initial report of abuse to the SA within two hours. The administrator verified rough treatment would be reportable in two hours. The administration verified staff did not follow their facility policy to report allegations of abuse within two hours to the SA. The Abuse Prevention Plan/Vulnerable Adult policy dated 3-2018 included, "Investigative Procedure: Any person with the knowledge or suspicion of suspected violations shall report immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours is events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials ..." SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately reporting suspected abuse to the designated state agency. The director of nurses' could monitor incident reports for implementation of this requirement.	21995		

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21995	Continued From page 23 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		