DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2021

Administrator
Pine Haven Care Center Inc
210 Northwest 3rd Street
Pine Island, MN 55963

RE: CCN: 245359
Cycle Start Date: July 8, 2021

Dear Administrator:

On July 29, 2021, we notified you a remedy was imposed. On December 2, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 1, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 13, 2021 be discontinued as of December 1, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 29, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 8, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
August 11, 2021

Administrator
Pine Haven Care Center Inc
210 Northwest 3rd Street
Pine Island, MN 55963

RE: CCN: 245359
Cycle Start Date: July 8, 2021

Dear Administrator:

On July 29, 2021, we informed you of imposed enforcement remedies.

On July 22, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 22, 2021, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 13, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 13, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 13, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pine Haven Care Center Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 8, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 8, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 07/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/19/21 to 7/22/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F600 began on 6/5/21, when resident (R) 2 sustained verbal abuse and physical threats by R1, the facility's failures affected 8 other residents (R2, R3, R4, R5, R6, R7, R8, and R9) who suffered either verbal abuse, physical abuse, or were threatened harm by R1. The administrator, and DON were notified of the IJ for on 7/19/21, at 5:12 p.m. The IJ was removed on 7/22/21, at 2:58 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted on 7/21/21. At the time of the abbreviated survey, onsite investigation(s) were completed and the following complaint was found to be substantiated. H539060C (MN00074717) with deficiencies cited at F600, F609, and F645. The following complaint was found to be unsubstantiated: H5359061C (MN00074968), however during the investigation a deficient practice was identified and a citation issued at F770.	F 000		

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

Electronically Signed | 08/20/2021

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

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure safety and protect residents from physical and verbal abuse, during resident to resident altercations. This resulted in an immediate jeopardy (IJ) when	F 600	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	7/22/21

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F 600	Continued From page 2 resident (R) 1 who had a history of aggression would become abusive towards others. The Immediate Jeopardy began on 6/5/21, when the facility failed to protect R2 and other residents after R1 aggressively yelled and swung at her. There was 8 other residents (R2, R3, R4, R5, R6, R7, R8, and R9) identified to have had known suffering by either physical abuse, verbal abuse, or physical aggression. The IJ was identified on 7/19/21. The administrator and director of nursing (DON) were notified on 7/19/21, at 5:12 p.m. The IJ was removed on 7/22/21, at 2:58 p.m. after it could be verified the facility had implemented an acceptable removal plan, however, non-compliance remained at E severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's hospital discharge summary dated 10/12/21, indicated R1 had a psychiatric hospital stay related to worsening agitation and behavioral disturbance with aggression in the setting of major neurocognitive disorder (probable Alzheimer's and Lewy body dementia). The summary indicated R1 was prescribed medications for behavior/mood management. R1's face sheet dated 7/22/21, indicated R1 was admitted to the facility on 2/1/21 with diagnoses that included diagnoses of dementia with behavioral disturbance and insomnia. R1's Behavioral Care Area Assessment dated 2/10/21, included "R1 is new to Pine Haven, he is	F 600	statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. It is the policy and procedure for Pine Haven Care Center to ensure that residents who reside at the facility are free from abuse and that all abuse allegations will be reported, investigated, interventions are in place immediately after the alleged abuse, care plan and Kardex are updated timely. All nursing staff in-service covering our abuse policy and education provided on monitoring Interventions for effectiveness beginning on 07/19/2021 and will continue on 07/20/2021. All licensed nurses will be in-serviced on comprehensive abuse assessments, what needs to be completed in the assessment, completing a root cause analysis to determine what the potential cause leading to the alleged abuse was, ensuring that an intervention is in place immediately after the alleged abuse has occurred, removing all potential victims from the area where the aggressor is to ensure their safety, monitoring the aggressor to ensure they are safe and no one else is in potentially targeted, and how to update the care plan	

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F 600	Continued From page 3 here for respite care, he likes to walk, he is confused and used to be home with his wife." and was not fully completed. R1's quarterly Minimum Data Set (MDS) assessment dated 5/11/21, identified R1 had severe cognitive impairment, had signs and symptoms of delirium that was continuously present, had physical and verbal behavioral symptoms directed towards others 1 to 3 days during the assessment period, and rejection of care behaviors 1 to 3 days during the assessment period. R1 also had wandering behaviors daily. The MDS indicated R1 required supervision for transfers, limited assistance from staff to walk in room and in corridor, and supervision for locomotion on and off the unit. R1's behavioral care plan dated 6/24/21, included, R1 had alteration in memory, judgement, decision making and thought process related to diagnosis of dementia. R1 had behaviors of wandering, attempting to enter other residents rooms, exit seeking, threats of physical harm to staff, actual physical aggression to staff and residents, saying "play with him/it" and gestures to groin, yelling out "Help me!" "Let's go!" "Where are you!" Family reports resident becomes agitated when he sees mirrors/his reflection. Interventions included: -Mirrors removed from room 6/21/21. -Give medication as per physician orders (start date 2/11/2021) -Break activities into manageable subtasks. Give one instruction at a time to resident (start date 3/5/2021) -Ensure staff introduce themselves and are wearing name tags at initiation of each	F 600	and Kardex. All management nurses were educated on 07/20/2021 for reviewing to ensure the comprehensive abuse assessment was completed, reviewing to ensure the root cause analysis was completed, reviewing to ensure an intervention was implemented immediately after the alleged abuse, and reviewing that the care plan and Kardex to ensure it was updated correctly. Any employee that missed this in-service was contacted to set up a time to complete this in-service prior to be allowed to return to work. Employees will not be allowed to work until in-□serviced. Resident R1 all had a root cause analysis, interventions in place, care plan and Kardex were all updated on 7/19/2021. This has a potential to affect all 70 residents. All other resident were assessed to ensure they were free from any abuse on 07/21/2021. Audits for all abuse will be checked to ensure that our abuse policy was followed, comprehensive assessment was completed, root cause analysis was completed, interventions were implemented to prevent reoccurrence, care plan and Kardex are updated will begin 7/21/2021 daily x 10 days, weekly x 4 weeks then monthly to ensure compliance. DNS, Administrator and/or designee will be responsible for compliance. Any deviations to the policy will be immediately reported to the DNS and Administrator for immediate review and	

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F 600	Continued From page 4 interaction with resident (start date 3/5/2021) -Use only one staff member for cares, multiple staff around me make me agitated (start date 3/5/2021) -Wally responds well to praise. When participating in cares, acknowledge that he is participating well (start date 3/5/2021) -If resident has behaviors, it may be due to not understanding what is being done, use soft gentle tone, soothing words. (start date 3/5/2021) -If I enter other resident's rooms, do not tell me I can't be in there. Tell me "See you later [R1]" or "We should go into this room instead" (start date 3/5/2021) -Allow R1 to assist with simple tasks, like carrying his snack back to his room, and say things like "Good job [R1] (start date 5/26/2021) -I am easily over stimulated by too much noise or too many people (start date 5/28/2021) -Keep resident away from mirrors when possible to avoid agitation (start date 6/18/2021) R2's quarterly MDS dated 6/11/21, identified R2 did not have cognitive impairment During observation and interview on 7/19/21, 3:34 p.m. R2's room had a Velcro mesh netting with a STOP sign strung across her doorway. R2 sat up in her chair. When asked "what is the stop sign for?" R2 replied, it was to stop R1 from entering; he goes up and down the hallways looking for his wife. R2 stated she was aware of R1's behaviors of wandering into residents' rooms and yelling at other residents. R2 stated before the stop sign was placed, (R2 could not recall the date), R1 came in the room, R2 put on her call light right away, she was scared and shaking, she then told R1 he was in the wrong room. R2 stated R1 became hostile, walked over	F 600	recommendations. These will be presented at QAPI for on-going review.	

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F 600	Continued From page 5 to where she was sitting in her chair and got 2 inches from her face, started yelling back at her but could not recall what his words were. R2 stated she thought he was going to hit her. R2 stated she couldn't get up without assistance from staff. R2 indicated R1 left on his own and shut the door behind him, stated R1 had been in her room for about 5 minutes and staff had not responded while he was in her room. R2 stated she reported the incident and concerns to staff. staff were aware of how scared she is of him. R2 stated R1 had not been back in her room since then but continues to be very frightened, R1 continued to stand behind the stop sign and looks in, "I just fall to pieces when I see him, I tremble in fear." R2 stated she didn't know what he would do, "one day he was standing out there and he was trying to take the sign down. He just scares me." R2 stated, she did not feel very safe and even though she continues to report fear to staff, she doesn't think they have done anything about his behaviors. R9's admission MDS dated 6/14/21, identified R9 had moderate cognitive impairment. During an interview on 7/19/21, at 3:44 p.m. R9's room had a Velcro mesh netting with a STOP sign strung across her doorway. When asked what the stop sign was for, R9 stated it was to prevent R1 from entering his room. R9 stated R1 had entered his room recently, (could not recall the date) R1 started going through his drawers, when R9 told him to get out, R9 walked over to him and "swatted me in the head". R9 stated R1 hit him with an open hand however, it really hurt. R9 stated he had put on his call light as soon as R1 had entered his room, however, staff did not respond to prevent him from getting hit. R9	F 600		

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F 600	Continued From page 6	F 600		

indicated after R9 had hit him, he left the room, and soon after staff responded, R9 reported the incident, and staff came back with that stop sign. R9 indicated R1 had not come in his room again, however does linger outside his door, "I hope I never get in his way!"

R1's progress notes included:
5/29/21, at 3:10 p.m. "Resident [R1] was wandering into others rooms with another resident. Staff attempted to redirect, resident who became agitated very quickly and was giving a strangling motion to another resident. Resident was given a snack at the nurse's station."

6/2/21, at 2:02 p.m. "Resident [R1] was wandering halls around 1300 [1:00 p.m.] and walked into [number of a resident's room] room when staff attempted to redirect him and he became aggravated swinging his fists around. Another resident, [initial of a resident] in [room number of that resident], was also walking down that hall and attempted to speak to [R1] and redirect him from entering said room when he grabbed onto her wrist and swung it away from him. Staff unable to remember which wrist. The two were separated by staff and walked their separate ways."

6/5/21, at 10:29 p.m. "Resident [R1] was yelling at a female resident very aggressively. Female resident did not say anything to him. He then swung at her quite hard and missed her by less than an inch because she flinched backwards. A resident asked to go to her room because she was "scared of that man, he is so angry, he is going to hurt someone" Staff had to remove him from other resident's room's multiple times. One

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time in particular, the other resident, whose room it was, was screaming because she was scared and this resident was screaming back at her to "shut up" and "let's go" he was also trying to get over to her in her recliner. This is when he grabbed this nurses arm and squeezed it very hard. He also punched and slapped this nurse trying to get to the scared resident. This resident hit and slapped this nurse and other nurses multiple times when he walked by. For no reason what so ever."

6/6/2021, at 9:40 p.m. "Resident [R1] intruding into many residents rooms this shift. Yelling at several residents which has made them afraid to come out of their rooms due to this behavior. Resident went into [room number of a victim] room and [victim] yelled at him to get out. This resident [R1] got very angry and began to yell. Staff was able to redirect him away from the room. [Victim] was told to talk to him calmly if he comes into their room.
During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, one of the residents was identified as R2 and the other resident(s) were not able to be identified. DON stated the incident was not reported to the State Agency.

6/7/21, progress note indicated new orders were given to increase R1's antipsychotic medication.

6/8/21, at 11:30 p.m. "Resident [R1] entered a female resident's room and would not get out when she asked him and it was difficult to remove him with the help of staff as well. Female

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resident cannot move herself and was scared and crying. This agitated and angered this resident more. Resident came out of the room and soon was distracted by something else. Female resident is requesting a Velcro stop sign to be placed in her doorway to help prevent this resident from entering again."

R1's physician visit note dated 6/9/21, did not address aggressive behaviors toward other residents. The note included, "Updates obtained from nursing and patient. He has had some refusal of cares. He has also had behaviors of urinating inappropriate places. To help ensure he is safe in redirectable his Seroquel (antipsychotic) has been titrated." "It was noted that he was sleeping more yesterday, but has been up and witnessed ambulating around building again today. He often wonders [sic] throughout the building." The note also included, "Difficulty and risks with staff providing cares is indication for this dose being titrated up." Will be monitored closely and adjusted appropriately.

R1's progress note dates on 6/13/21, at 2:34 p.m., indicated R1 attempted to elope from the facility. The note then included, "This writer and another nurse tried to bring resident inside which agitated him even more and was grabbing and pushing staff members while another resident was watching and crying because she was scared. Staff members were eventually able to bring resident back inside and lie him down in bed."

R1's physician visit note dated 6/15/21, did not address the behavior noted 6/13/21. Note included, "On 6/7/21 patient was noted to have

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increased behaviors during bedtime regimen including agitation grabbing at wrists of staff and difficult to redirect. Seroquel medication regimen was readjusted to providing him with a dose of Seroquel at bedtime." The note indicated since then "he has been directable with less behaviors. Staff continues to educate numerous staff on approach with [R1] which seems to be the most effective."

6/16/21, at 8:12 p.m. "Resident [R1] easily agitated this shift. Resident noted to be restless (wandering halls) throughout the shift. Resident displayed verbal and physical aggression towards staff and verbal aggression towards other residents. Resident would wave fist in air and yell unintelligible sounds/garbled speech at other residents. Resident would attempt to move others in wheel chairs if they were in the path of resident."

6/17/2021, at 12:20 p.m. "Resident [R1] has been aggressive towards staff and other residents today. Resident was easily directed at times with food. However, there were situation where he needed to directed away from the scene. Cooperative with mediation administration."

6/17/21, at 12:45 p.m. "Resident [R1] walking down to DR [dining room] by the windows. [R4] said hi. [R1 name] went behind her and punched her in the back and called her an asshole. Staff intervened and removed this resident from the scene. Resident remained agitated despite agitation."

6/18/21, at 8:22 a.m., note indicated DON, and administrator aware of the situation between R1

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and another resident on 6/17/21. The note indicated the care plan would not be changed and staff would continue to redirect the resident to a "more calm environment".

6/26/21, at 2:39 p.m. "Resident [R1] wandered into [R5's] room. [R5] asked him to leave in which he started yelling and acting like he was going to hit resident. Staff escorted resident out of room and redirected him into own room."

6/30/21, at 3:15 p.m. "At 1515 [3:15 p.m.] on 6/30/21 Resident [R1] slapped another resident on their left arm. Resident had been arguing with another resident moments before and was upset r/t [related to] that."

7/12/21, at 3:15 p.m. "Resident" [R1] asked another resident [R7] a question and the other resident didn't hear him and said, "what did you say." This angered resident and he hit the other resident twice with the back of his right hand on the side of the other resident's upper left arm. This nurse got in between the two residents and took the other resident down the hall to use the bathroom."

7/13/21, at 4:30 p.m. "Resident [R1] was walking up and down the halls and passed in front of a couple of ladies watching a program on TV One of the ladies [victim not identified] who has dementia yelled, "Why don't you get out of the way." This resulted in an argument and resident 2 [R1] grabbed resident 1 [victim] by her right forearm with his left hand squeezing and twisting. He let go of her arm as this writer ran toward the situation. Resident one [sic] walked away. Resident 2 [sic] started crying and saying, "He

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twisted my arm." Both resident's forgot about this altercation shortly after it happened."

7/16/21, at 3:55 p.m. progress note indicated leadership team discussed resident's continued behaviors and agitation. Indicated increased agitation typically in afternoon beginning at 1:30 p.m. and continuing until 5:00 p.m. "He becomes agitated easily and at times hits staff members and has hit residents. Area of concern is the common area on 200/300/400 units. Resident is having acute visit on 7/19/2021 to addressed continued and increased behaviors. Updated care plan and kardex for staff to walk with resident on 500/600 units as he previously enjoyed this when his room was on the 600 unit. Writer updated hall nurse and communication page."

Observations on 7/19/21:
-At 11:30 a.m. during the initial facility tour, multiple resident rooms were observed to have mesh netting with a stop sign strung between the door frames.
-At 12:06 p.m. R1 walked out of the dining room. Registered nurse (RN)-A assisted R1 back into the dining room.
-At 12:21 p.m. R1 was wandering in and out of the dining room calling out for his wife. An unidentified staff member informed R1 his wife was not here and walked away.
-At 12:27 p.m. R1 was sitting at the dining room table and began walking out of dining room, unidentified nursing assistant (NA) asked if he wanted a cookie and returned R1 to the dining room table.
-At 1:20 p.m. R1 wandered up and down the hallway in front of the nursing station, residents

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F 600	Continued From page 12 were in the vicinity. -At 3:15 p.m. R1 sat in the front entry way eating a snack, other residents were near R1. Observation on 7/21/21: -At 7:55 a.m. it was observed that some rooms that had stop signs up on 7/20/21, were not in place. -At 9:32 a.m. R1 sat in a chair down the 200 hallway. At 9:34 a.m. R1 was wandering in the hallway without supervision. The stop signs continued to be down. -At 11:21 a.m. multiple stop signs continued to be down. -At 12:25 p.m. multiple stop signs continue to be down in most resident rooms -At 12:35 p.m. administrator stated stop signs were supposed to be up at all times whether residents were in their rooms or not. Administrator was informed stop signs had not been up since first observation made. -At 1:08 p.m. stop signs continued to not be in place. -At 4:25 p.m. stop signs continued to not be in place. R1 was observed wandering down the 300-hallway unsupervised, R1 entered 2 residents rooms that previously had stop signs on them, one resident was in her bed sleeping. An unidentified nursing assistant was walking with another resident in front of R1. NA asked R1 to follow them, R1 stated "no", dietary assistant (DA)-1 attempted to redirect R1 to follow her to the dining room several times, however R1 became agitated and slapped DA-1 on the shoulder. -At 4:35 p.m. administrator was made aware of the observations.	F 600		

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F 600	Continued From page 13 Observations on 7/22/21: -At 7:25 a.m. stop signs were not up on residents rooms. -At 7:41 a.m. R1 came out of his room and urinated on the doors that lead to the 500/600 unit, after several minutes licensed practical nurse (LPN)-A responded to the scene. -At 8:44 a.m. stop signs to resident's rooms continued to be not in place. Administrator inquired with LPN-A where the stop signs were. Administrator supervised R1 until other staff were nearby to supervise resident. -At 9:24 a.m. R1 finished his snack and wandered unsupervised down the 200 hallways, R1 stopped and entrances to resident rooms and looked inside. At 9:25 a.m. a staff member walked passed him and said "hi" and kept walking. -At 11:11 a.m. director of nursing (DON) indicated an awareness that staff were not monitoring/supervising R1 when R1 was wandering in order to keep residents safe. -at 12:29 p.m. all stop signs to resident rooms were observed to be in place. During an interview on 7/19/21, at 11:37 a.m. licensed practical nurse (LPN)-A stated R1 had aggressive behaviors and got agitated with redirection. LPN-A stated R1 would hit you, indicated when R1 demonstrated aggressive behaviors, staff were supposed to leave him alone and reproach him, offer him food, or toilet him. LPN-A stated if a resident tried to tell him something he didn't want to do, R1 would get agitated/aggressive toward them too. LPN-A stated R1's behaviors of aggression were unpredictable.	F 600		

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F 600	Continued From page 14 During an interview on 7/19/21, at 11:41 a.m. LPN-C indicated she was not aware of all of the R1's incidents of physical/verbal abuse against residents. LPN-C stated if R1 was agitated we would remove him away from other residents and offer a snack. LPN-C indicated R1 had very short-term memory loss, he would forget what he was doing in seconds. LPN-C stated R1 would get agitated with noise and a lot of people, behaviors started to increase around 1:30 p.m., staff were supposed to take him to a different unit when he got agitated. LPN-C stated R1 calms down as fast as he got agitated, no rhyme or reason for his behaviors, and his aggression was very unpredictable. During an interview on 7/19/21, at 12:05 p.m. LPN-B stated R1 wandered a lot. LPN-B stated R1 got agitated and aggressive, he didn't always comprehend what staff are telling him. LPN-B stated R1 has pretended to take a swing at her. LPN-B indicated R1 was not always supervised when he wandered, residents would tell him to get out and he would get frustrated. When asked how residents are protected from R1 if he wandered into a residents room and became frustrated, LPN-B stated "I like to keep a close eye on him" LPN-B stated R1 didn't have a lot of behaviors on the day shift, R1 had more behaviors on the evening shift, around shift change is when behaviors started. LPN-B stated R1 was triggered by a lot of commotion and visitors coming into the building. During an interview on 7/19/21 at 1:52 p.m. medical doctor (MD)-A stated an awareness of R1 history of aggressive behaviors. MD-A indicated nurse practitioner had increased his	F 600		

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antipsychotic medications on 6/7/21, for an increase in behaviors; at the follow-up visit around 6/15/21, there had been an improvement. MD-A stated an unawareness of increase of physical/verbal aggressive behaviors after the NP had evaluated him. MD-A stated staff should have notified him/NP when R1 demonstrated physical/verbal/threatening behaviors toward other residents and/or with increase in behaviors after the medication dose adjustment. MD-A indicated an expectation non-pharmacological behavioral intervention be utilized and evaluated for effectiveness. MD-A indicated because R1 was ambulatory, difficult to redirect, limited successful non-pharmacological approaches, elements of behavioral unpredictability, and concerns with stress on residents and their safety, medication management was warranted in addition to good behavioral approaches.

During an interview on 7/20/21, 7:51 a.m. nursing assistant (NA)-A stated R1 had aggressive behaviors toward staff and residents. NA-A stated his behaviors are unpredictable and doesn't like to be told what to do. NA-A stated when he is agitated we offer him something to eat, bathroom, or take him for a walk to the other unit where it is quieter, and he likes being told he does a good job.

During an interview on 7/20/21 at 8:11 a.m. registered nurse (RN)-A indicated she was the nurse manager of the unit in which R1 resided. RN-A reviewed R1's progress notes that identified incidents of physical/verbal abuse and threatening behaviors towards residents. RN-A verified immediate interventions to protect residents were not developed and/or

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implemented after each occurrence and the care plan had not been revised. RN-A stated any incidents of abuse or threatening behaviors toward other residents should be immediately reported to the administrator or the DON. RN-A stated it should have been made clear who those residents were and that they were safe, and immediately protected from R1. RN-A confirmed R1's physician was not notified of the physical/verbal abuse inflicted on other residents, confirmed physicians of the residents who suffered abuse were not notified, and confirmed psychosocial assessments, monitoring, or services were offered to those victims.

During an interview on 7/21/21, at 11:10 a.m. NA-C indicated R1 had aggressive behaviors and he had good days and bad days. NA-C stated he would get agitated when he was not ready to be helped with something or if there was too much commotion. Staff could tell if he was agitated if he wandered around looking for his wife. NA-C stated when R1 was agitated, staff offered him food, or take him away from the commotion. NA-C indicated R1 wandered around the unit. When asked how were staff aware if R1 had wandered into a residents' room, NA-C responded the resident would put on their call light. NA-C stated R1's behaviors were sometimes unpredictable, if R1 was having a bad day and a resident told him to get out, he would not leave unless directed by staff. NA-C stated recently she had to step in-between him and R3 because they were having words back and forth and he looked like he was going to hit her. NA-C stated she redirected R1, and removed him from the location. NA-C stated R1 has grabbed and hit her before, and R1 would probably have the

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F 600	Continued From page 17 same aggressive behaviors towards residents. During an interview on 7/21/21, at 11:56 a.m. licensed social worker (LSW) indicated her assistant covered the unit in which R1 resided however, had awareness of R1's aggressive behaviors towards residents because every morning the leadership team had a meeting to review/discuss progress notes/events from the previous day. R1's record was reviewed with LSW, when asked how the facility was protecting residents from R1, LSW stated residents were provided with stop signs, "I know staff don't always do that, we have provided education" on ensuring they were up. LSW indicated all residents who resided on the same unit had not been interviewed and/or evaluated after R1's documented abusive incidents. LSW indicated the facility had not completed a comprehensive assessments and/or monitoring of residents who suffered R1's abusive behaviors, indicated the residents were checked on, but the "checks" were not documented or evaluated. LSW indicated nursing was supposed to be documenting behaviors, however the documentation did not reflect how may occurrences of each behavior occurred on each shift and the effectiveness of the intervention used. During an interview on 7/21/21, at 1:08 p.m. DON confirmed the lack of documentation and/or incident report completion. DON stated that the notes that indicated verbal aggression were not reported to the State agency because they were deemed as arguments between residents even though the documentation indicated residents were fearful of R1. DON indicated after further	F 600		

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investigation on 7/20-7/21, residents who were affected were identified after further investigation and vulnerable adult reports were submitted to the state agency for those that were not previously reported. When asked how residents were being protected from R1, DON indicated residents that resided on the same unit were protected by putting stop signs up that prevented R1 from entering and staff were supposed to take R1 for a walk to the 500/600 hallway when he demonstrated agitation, however, could not articulate how long R1 was supposed to be walked and if R1 was supposed to be monitored after the walk. DON stated R1's agitation was unpredictable. DON stated as of 7/21/21, all residents who resided on R1's unit had not been interviewed in order to determine if R1 had demonstrated verbal/physical aggression towards them. DON indicated that interventions including medication should be monitored and evaluated for effectiveness, confirmed the record lacked analysis of the effectiveness of interventions. DON stated "stop signs" on resident rooms should be up at all times and staff had been provided education.

Facility policy Pine Haven Abuse and Neglect Policy and Reporting dated 1/2021, included the following definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical charm, pain or mental anguish. Willful as used in

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F 600	Continued From page 19 this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It is the policy of Pine Haven Care Center, that each resident will be free from "Abuse". Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The policy also outlined reporting and investigation requirements including the protection of the vulnerable adults during the investigation. The immediate Jeopardy was removed on 7/22/21, at 2:58 p.m. when it could be determined the facility had completed the following: 1) All staff were educated on the abuse policy, monitoring interventions for effectiveness, completing a comprehensive abuse assessment, and completing root cause analysis leading to the alleged abuse, and implementing immediate interventions to protect residents from abuse. 2) R1's behaviors and interventions were comprehensively assessed, and interventions were developed, care planned, and implemented to protect facility residents from further abuse. 3) Facility residents who sustained alleged abuse were evaluated for any impact on mental well-being and facility residents. 4) Facility conducted abuse investigations to determine root cause analysis including interviewing all residents residing on same unit in order to determine if any other residents were affected. 5) An auditing system for compliance with the abuse policy, comprehensive assessments, root	F 600		

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	245359	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 600	Continued From page 20 cause analysis, and implementation of interventions was developed and implemented.	F 600		
F 609 SS=E	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 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 allegations of resident to resident physical and verbal abuse and	F 609	1. It is the policy and procedure for Pine Haven Care Center to ensure that any allegation of abuse, neglect,	9/3/21

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F 609	Continued From page 21 threatening behaviors from R1 to the State Agency within 2 hours for 9 of 9 residents (R2, R3, R4, R5, R6, R7, R8) reviewed for allegations of abuse. Findings include R1's progress note dated 5/29/21, at 3:10 p.m. "Resident [R1] was wandering into others rooms with another resident. Staff attempted to redirect, resident who became agitated very quickly and was giving a strangling motion to another resident. Resident was given a snack at the nurse's station." R1's progress note dated 6/2/21, at 2:02 p.m. "Resident [R1] was wandering halls around 1300 [1:00 p.m.] and walked into [number of a resident's room] room when staff attempted to redirect him and he became aggravated swinging his fists around. Another resident, [initial of a resident] in [room number of that resident], was also walking down that hall and attempted to speak to [R1] and redirect him from entering said room when he grabbed onto her wrist and swung it away from him. Staff unable to remember which wrist. The two were separated by staff and walked their separate ways." R1's progress note dated 6/5/21, at 10:29 p.m. "Resident [R1] was yelling at a female resident very aggressively. Female resident did not say anything to him. He then swung at her quite hard and missed her by less than an inch because she flinched backwards. A resident asked to go to her room because she was "scared of that man, he is so angry, he is going to hurt someone" Staff had to remove him from other resident's room's	F 609	mistreatment, misappropriation of property and injury of unknown origin are reported timely to the administrator and appropriate state agency within the required reporting time. All allegation of abuse were reported to the appropriate state agency for resident R2, R3, R4, R5, R6, R7 and R8 were reported on 07/20/2021. 2. This has the potential to affect all 66 residents. All residents charts will be reviewed for compliance on 8/23/2021 and any allegations not previously reported will be reported to the appropriate state agency. 3. All staff were educated on our abuse policy for reporting to the appropriate state agency on 08/24/2021. All staff were given examples of situations of potential allegations to review and determine if those were indeed allegations that should be reported and why or why not we would report to the appropriate state agency from 08/27/2021 to 08/31/2021. 4.Audits for reporting any abuse, neglect, mistreatment, misappropriation and injury of unknown origin to prevent reoccurrence will begin on 08/25/2021 daily x 10, weekly x6 and monthly x 1 to ensure compliance the social worker or designee will be responsible for compliance. Any deviations to the policy will be immediately reported to the DNS and Administrator for immediate review and recommendations. These will be presented at QAPI for on-going review.	

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F 609	Continued From page 22 multiple times. One time in particular, the other resident, whose room it was, was screaming because she was scared and this resident was screaming back at her to "shut up" and "let's go" he was also trying to get over to her in her recliner. This is when he grabbed this nurses arm and squeezed it very hard. He also punched and slapped this nurse trying to get to the scared resident. This resident hit and slapped this nurse and other nurses multiple times when he walked by. For no reason what so ever." During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, the residents was identified as R2 and R3. DON stated the incident was not reported to the State Agency. R1's progress note dated 6/6/2021, at 9:40 p.m. "Resident [R1] intruding into many residents rooms this shift. Yelling at several residents which has made them afraid to come out of their rooms due to this behavior. Resident went into [room number of a victim] room and [victim] yelled at him to get out. This resident [R1] got very angry and began to yell. Staff was able to redirect him away from the room. [Victim] was told to talk to him calmly if he comes into their room. During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, one of the residents was identified as R2 and the other resident(s) were not able to be identified.	F 609		

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F 609	Continued From page 23	F 609		

DON stated the incident was not reported to the State Agency.

R1's progress note dated 6/8/21, at 11:30 p.m. "Resident [R1] entered a female resident's room and would not get out when she asked him and it was difficult to remove him with the help of staff as well. Female resident cannot move herself and was scared and crying. This agitated and angered this resident more. Resident came out of the room and soon was distracted by something else. Female resident is requesting a Velcro stop sign to be placed in her doorway to help prevent this resident from entering again."

During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, the resident was identified as R2. DON stated the incident was not reported to the State Agency.

R1's progress note dated 6/13/21, at 2:34 p.m. Note indicated R1 attempted to elope from the facility. The note then included, "This writer and another nurse tried to bring resident inside which agitated him even more and was grabbing and pushing staff members while another resident was watching and crying because she was scared. Staff members were eventually able to bring resident back inside and lie him down in bed."

During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON indicated upon further investigations completed on 7/20/21, the resident was not identified. The DON stated

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F 609	Continued From page 24	F 609		

the incident was not reported to the State Agency.

R1's progress note dated 6/16/21, at 8:12 p.m. "Resident [R1] easily agitated this shift. Resident noted to be restless (wandering halls) throughout the shift. Resident displayed verbal and physical aggression towards staff and verbal aggression towards other residents. Resident would wave fist in air and yell unintelligible sounds/garbled speech at other residents. Resident would attempt to move others in wheel chairs if they were in the path of resident."
R1's progress note dated 6/17/2021, at 12:20 p.m. "Resident [R1] has been aggressive towards staff and other residents today. Resident was easily directed at times with food. However, there were situation where he needed to directed away from the scene. Cooperative with mediation administration."

6/17/21, at 12:45 p.m. "Resident [R1] walking down to DR [dining room] by the windows. [R4] said hi. Wally went behind her and punched her in the back and called her an asshole. Staff intervened and removed this resident from the scene. Resident remained agitated despite agitation."

During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident(s) the progress note referred to on 6/17/21 at 12:20 p.m., DON indicated upon further investigations completed on 7/20/21, it could not be determined which resident(s) the progress note at 12:20 p.m. referred. DON indicated the incidents were not reported to the State Agency.

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F 609	Continued From page 25 R1's progress note dated 6/26/21, at 2:39 p.m. "Resident [R1] wandered into [R5's] room. [R5] asked him to leave in which he started yelling and acting like he was going to hit resident. Staff escorted resident out of room and redirected him into own room." During an interview on 7/21/21, at 1:08 p.m. DON stated the incident was not reported to the State Agency. 7/12/21, at 3:15 p.m. "Resident" [R1] asked another resident [R7] a question and the other resident didn't hear him and said, "what did you say." This angered resident and he hit the other resident twice with the back of his right hand on the side of the other resident's upper left arm. This nurse got in between the two residents and took the other resident down the hall to use the bathroom." During an interview on 7/21/21, at 1:08 p.m. (DON) stated the incident was not reported to the State Agency. Facility policy Pine Haven Abuse and Neglect Policy and Reporting dated 1/2021, included G. REPORTING AND RESPONSE: "It is the policy of this facility that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported per Federal and State Law. The facility will ensure that all alleged violation 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	F 609		

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F 609	Continued From page 26 that cause the allegation do not involve abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property and do not result in serious bodily injury are reported no later than 24 hours to the administrator of the facility and to other officials ...."	F 609		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645		9/3/21

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F 645	Continued From page 27 (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced	F 645		

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F 645	Continued From page 28 by: Based on document review and interview, the facility failed to ensure a Level I preadmission screening (PAS) was completed prior to long term care admission to determine whether residents with mental illness or intellectual disability qualified for additional services. This had the potential to affect 1 of 1 resident (R1) reviewed for preadmission screening. Findings include R1's hospital discharge summary dated 10/12/21, indicated R1 had a psychiatric hospital stay related to worsening agitation and behavioral disturbance with aggression in the setting of major neurocognitive disorder (probable Alzheimer's and Lewy body dementia). The summary indicated R1 was prescribed medications for behavior/mood management. The summary included the primary diagnosis of Major Neurocognitive disorder with Behavioral Disturbance. R1's physician letter dated 1/28/21, indicated R1 had dementia, and required temporary respite care at the facility. R1's physician letter dated 2/15/21, indicated R1's primary physician was writing the letter on behalf of R1. The letter included, "[R1] has dementia and is going to be entering long term care at Pine Haven Care Center today. This letter should serve as an order for long term care placement." R1's quarterly Minimum Data Set (MDS) dated 5/11/21, identified R1 had severely impaired	F 645	1. It is the policy and procedure for Pine Haven Care Center to ensure that all admits to the facility have a PAS completed prior to admission to determine whether residents with mental illness and intellectual disability qualify for additional services. A PAS was completed on 07/21/2021 for resident R1. 2.This has the potential to affect all 66 residents. All residents have been reviewed to ensure they have had a PAS completed on 08/16/2021. 3. All social service and admission staff have been educated on our policy for completing PASs on 07/21/2021. they have been educated on our admission checklist to ensure that PAS was done prior to admission or day of admission to the facility. that checklist is turned into the administrator or designee upon admission to the facility. 4.Administrator or designee will be responsible to ensure compliance for PAS being completed. Audits will begin on 08/20/2021 and will be completed daily x 10 Weekly x6 and then monthly x 1 to prevent reoccuance. Results will be reviewed by our Quality committee for further recommendation.	

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F 645	Continued From page 29 cognitive skills for daily decision making, had signs and symptoms of delirium that was continuously present, had physical and verbal behavioral symptoms directed towards others 1 to 3 days during the assessment period, and rejection of care behaviors 1 to 3 days during the assessment period. R1 also had wandering behaviors daily. R1's record identified the Initial Pre-Admission Screening was not submitted to the Senior Linkage Line until 6/2/21. The PAS indicated R1 had an actual admission date of 2/1/21, and the anticipated length of stay was 91+ days. During an interview on 7/21/21, at 11:56 a.m. licensed social worker (LSW) reviewed R1's record and verified the PAS was not completed until 6/2/21, and indicated the PAS should have been completed prior to admission to the facility. During an interview on 7/21/21, at 1:08 p.m. director of nursing (DON) reviewed R1's record and confirmed the PAS was not completed until 6/2/21, and indicated the PAS should have been completed prior to admission to the facility. Facility policy Admission Criteria dated 3/2019, included the following: 9) All new admissions and readmissions are screened for Mental disorders, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review process.	F 645		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the	F 770		9/3/21

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F 770	Continued From page 30 quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to obtain physician ordered laboratory tests according to the hospital discharge summary for 1 of 1 residents (R12) reviewed for gastrointestinal bleeding. Findings include R12's hospital discharge summary dated 7/9/21, indicated R12 was hospitalized related to diagnosis of acute on chronic congestive heart failure on 6/29/21, and required intravenous diuresis, "Recommend BMP [basic metabolic panel) on 7/12/21. The summary also indicated R12 was found to be anemic in the hospital and was transfused with two doses of iron. The summary section Consults and Follow-up Appointments included "Recommendations: BMP/CBC [complete blood count]". The discharge summary indicated R12 was discharged from the hospital on 7/9/21 to the facility. R12's face sheet dated 7/22/21, identified R12 was admitted to the facility on 7/9/21, with diagnoses that included acute on chronic heart failure, atrial fibrillation, presence of a cardiac pacemaker, long term use of anticoagulants, and chronic wasting disease. R12's record lacked evidence the recommended	F 770	1. It is the policy and procedure for Pine Haven Care Center to ensure all laboratory orders order when a resident is discharge from the hospital be followed up on. 2. This has the potential to affect all 66 residents. All recent discharges from hospital have been reviewed to ensure compliance on 8/20/2021. 3. All licensed staff were educated on our policy for laboratory tests being followed up on and completed timely for all residents on 08/31/2021. All licensed staff were educated on the nursing admission checklist to ensure that all orders are entered by the nurse who received orders then confirmed by a 2nd nurse to ensure accuracy. 4. DNS or designee will be responsible to ensure compliance laboratory test being scheduled and followed up on beginning 08/25/2021. Audits will be completed daily x 10, weekly x 4 and monthly x 1 to prevent reoccurrence. Results will be reviewed by our Quality committee for further recommendation.	

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F 770	Continued From page 31 labs according to the hospital discharge summary were collected and/or completed. During an interview on 7/22/21, at 2:00 p.m. registered nurse (RN)-B stated she was the nurse manager for the transitional care unit, however did not complete R12's admission. RN-B reviewed R12's hospital discharge summary and confirmed the labs were not obtained. RN-B indicated the discharging hospital should have called and arranged for the lab blood draws. RN-B stated the admission nurse would transcribe the order into the treatment administration record. During an interview on 7/21/21, at 1:08 p.m. director of nursing (DON) reviewed R12's hospital discharge summary and confirmed the orders for the follow-up lab testing for BMP/CBC were not completed. DON indicated the nurse manager who does the admission was responsible for making sure all follow-up appointments and labs were ordered. DON indicated it was missed. Facility policy Lab and Diagnostic Test Results-Clinical Protocol dated 11/2018 included, 1) The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2) The staff will process test requisitions and arrange for the test.	F 770		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2021

Administrator
Pine Haven Care Center Inc
210 Northwest 3rd Street
Pine Island, MN 55963

Re: Event ID: SIPD11

Dear Administrator:

The above facility survey was completed on July 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	C 07/22/2021

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/19/21 to 7/22/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will	2 000		

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2 000	Continued From page 1 be completed. The following complaint was found to be SUBSTANTIATED: HH539060C (MN00074717) no licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5359061C (MN00074968), 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 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		