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

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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: Reinspection Results
Event ID: M75X12

Dear Administrator:

On October 28, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 2, 2021. At this time these correction orders were found corrected.

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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
September 29, 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 September 2, 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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.

As we notified you in our letter of July 29, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from However, due to the extended survey the new NATCEP loss date is July 8, 2021.

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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 January 8, 2022 (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 64900
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 09/02/2021

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 9/1/21 to 9/2/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5359062C (MN76196), with deficiencies cited at F600, F609, F610, F656. The following complaints were found to be UNSUBSTANTIATED: H5359063C (MN76251 and MN76230), however a deficiency was identified at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	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	F 600		10/15/21

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

Electronically Signed | 10/09/2021

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 600	Continued From page 1 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 interview and document review the facility failed to prevent resident to resident abuse for 2 of 3 (R8, R9) who were reviewed for abuse. R1 became agitated and grabbed R8's right forearm. R1 yelled and chased R9 which resulted in R9 to become emotionally upset. Findings include: R1's Face Sheet indicated an admission on 2/1/21. R1 had a diagnosis of dementia with behavioral disturbances, R1's Physician Order dated 2/3/21, indicated to monitor for target behaviors of restlessness, agitation, intrusion of other residents' rooms, threats of physical harm and restlessness at night. R1's Elopement Evaluation dated 5/11/21, indicated R1's wandering behavior likely affected the safety or well-being of self/others and likely affected the privacy of others. R1's Long Term Care Evaluation dated 8/5/21, indicated R1 was confused, disoriented, required cues, in attention, had disorganized thinking and short-term memory loss. R1 rarely or never	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 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. 1.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. 2.OHFC reports were filed for resident R8 and R9 on 09/01/2021 for alleged abuse by resident R1. R1 was placed on	

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F 600	Continued From page 2 understood others nor made himself understood. R1 received psychotropic medication that were affective. R1 had a chronic behavior which potentially could cause harm to self or others. R1's progress note (PN) dated 8/6/21, at 11:31 p.m. indicated R1 was aggressive and squeezed LPN-C's hand hard and shook his fist at staff. R1 wandered into other resident s rooms. R1's PN dated 8/7/21, at 7:55 p.m. indicated R1 went into another residents room. After lunch RN-B heard angry voices and noted R1 was upset with another resident. R1 and the other resident talked loud at each other. R1 placed his hand on resident's property but was redirected. R1's Psychotropic Evaluation dated 8/8/21, indicated chronic behavior which potentially caused charm to self and others; R1 had behaviors (i.e., combativeness, verbal disruptions) that was harmful to self and others. The use of medication has decreased behaviors and agitation. Staff were to encourage relaxation techniques, implement safety interventions, and utilize distraction techniques. R1's PN dated 8/8/21, at 4:38 p.m. R1 had moments of agitation, gruff comments but was able to be redirected. R1 was restless and walked the halls. In the morning, R1 voided and was not able to get changed right away due to his agitation. R1's Incident Reported dated 8/10/21, indicated an incident of physical aggression in the hallway. R1 walked down the hall toward the dining room and R8 asked R1 if he was lost. R1 got upset and grabbed R8's right forearm. R1 and R8 were	F 600	one-on-one intervention to prevent reoccurrence on 09/01/2021. 3.All staff in-service covering our abuse policy beginning on 10/07/2021 continuing on 10/08/2021. 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. 4.Audits for all abuse will be checked to ensure that our abuse policy was followed will begin on 10/09/2021 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 recommendations. These will be presented at QAPI for on-going review.	

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F 600	Continued From page 3	F 600		

separated using a non-threatening and calm approach. No injury noted at the time of the altercation. R1 was taken for a walk and offered a snack.

R1's quarterly Minimum Data Set (MDS) dated 8/11/21, indicated server cognitive impairment. R1 required supervision (oversight, encouragement, or cueing) while he walked was in the corridor or in his room; required extensive assist to get dressed and use the toilet. R1 had physical, and verbal behavioral symptoms directed toward others, behavioral symptoms not directed toward others and rejected care four to six days a week. R1 wandered daily.

R1's Elopement Evaluation dated 8/11/21, indicated R1 wandered. R1's wandered aimlessly, or non-goal directed which affected the safety or wellbeing of others and affected the privacy of others. No clinical suggestions were provided.

R1's Provider Visit dated 8/13/21, indicated R1 recently had problematic interactions with residents and staff. R1 had an incident were another resident talked to him and he reached and grabbed their arm. R1 had other behaviors such as wandering, and inappropriate voiding.

R1's PN indicated 8/14/21, at 3:15 a.m. indicated R1 wandered the hallways and went into other residents' rooms. R1 had facial grimacing when he walked.

R1's Incident Report dated 8/15/21, indicated at 1:20 p.m. R1 wandered into another residents room. R1 chased NA-E with his hand in a fist like he was going to hit her when NA-E tried to redirect R1 out of the other resident's room. At

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F 600	Continued From page 4	F 600		

1:25 p.m. LPN-C stood at the nurse's cart and saw R9 and R16 visit, then R1 yell at R9. R1 had his hand in a fist and chased R9. R1 and R9 were separated. R9 cried, appeared scared, and did not want to let go of LPN-C's hand. No residents were physically injured. R16 stated at the time of the incident she was visiting with R9 when R1 came from nowhere. R1 yelled at them and chased R9.

R1's Provider Visit dated 8/16/20, indicated R1 had recent problematic interactions with residents and staff.

R1's PN dated 8/24/21, at 1:36 p.m. indicated R1 had verbal and physical behaviors toward staff and resident when he became overstimulated. Speech Therapy went over how cares could be tailored to meet R1s needs and had worked on strategies to reduce agitation.

R1's Provider Visit dated 8/27/21, indicated R1 continued to require and use as needed Seroquel doses related to his behaviors that do interfere with his and other residents care.

R1's Provider PN dated 9/1/21, indicated R1 continued to have events of behavioral dyscontrol.

R1's Behavior Monitoring dated 8/21/21 to 9/2/21, indicated R1 exhibited 19 incidents of physical behavioral symptoms director toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually.) R1 exhibited 17 incidents of verbal behavioral symptoms directed towards others. R1 exhibited behavioral symptoms not directed towards others 16 times. R1 had a behavior 10 times that put R1 at

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F 600	Continued From page 5	F 600		

significant risk for physical illness or injury. R1's behaviors put others at significant risk for physical injury 11 times. R1's behavior significantly intruded the privacy or activity of others 12 times

R1's care plan dated 9/3/21, indicated R1 had behaviors to wander make verbal threats of physical harm to staff and residents, had actual physical aggression to staff and residents. Interventions included:
-provide one to one for safety,
-Address by name, provide time to process information, use simple words, speak before task, and explained step by step what is done and to not startle R1.
-Allow R1 to assist with simple tasks and praise him/tell him good job. Explain each activity and care procedure prior to beginning it.
-break activities into manageable subtasks; give one instruction at a time.
-introduce themselves at initiation of each interaction and have a daily routine.
-gently redirect activities when R1 made inappropriate actions
-mediation per orders
- R1 was easily overstimulated by too much noise or too many people,
-If R1 entered other resident's rooms to not tell him he can't be instead there but stated "see you later [R1]" or we should go into this room instead.
-R1's behaviors may be due to not understanding what was being done. Staff should use soft gentle tone and soothing words when R1 had behaviors.
- modify environment to prevent situations that trigger inappropriate behaviors,
-Use more than one method of communication.
-R1 responded best to use two- or three-word sentences or instructions and use hand gesture to point where R1 should be walking to or sitting

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F 600	Continued From page 6	F 600		

R8's care plan dated 7/22/21, indicated vulnerability related to impaired cognition.

R8's annual MDS dated 7/29/21, indicated intact cognition and had delusions. R2 was independent and required a walker for mobility.

R8's PN dated 8/10/21, at 4:15 p.m. indicated R1 walked down the hall toward the dining room. R8 asked R1 if he was lost. R1 got upset and grabbed R8's right forearm.

R9's Diagnoses Sheet dated 6/25/21, indicated diagnoses of fracture of lower end of left ulna, muscle weakness, pain, anxiety, displaced fracture of surgical neck of left humerus, fracture of the sacrum, dementia, Alzheimer's disease, and artificial right hip joint.

R9's annual MDS dated 8/13/21, indicated severe cognitive impairment and wandered one to three days a week. R9 hallucinated and had delusions. R9 required extensive assist with transfers; was independent with locomotion on and off the unit; required a walker and wheelchair for mobility. R9 had an impairment on one side or her upper extremity

R9's progress note dated 8/15/21, at 2:49 p.m. indicated R1 wandered by R9 and R16 while they visited. R1 stopped and started to yell at R9. R9 tried to back away from R1 but R1 moved forward with his hand in a fist.

R9's Progress note dated 8/15/21, at 2:56 p.m. indicated LPN-C removed R9 from R1. R9 started to cry and held LPN-C's hand. R9 refused to let go of LPN-C's hand.

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F 600	Continued From page 7	F 600		

R9's care plan dated 11/24/21, indicated vulnerability related to trouble to express her needs. The goal was R9 would be free from abuse. Staff were directed to report any incidence of abuse or neglect. The supervisor would report to appropriate authorities.

During an interview on 9/1/21, at 9:11 a.m. NA-C stated staff were to back off for their and R1's safety when R1 asked to be left alone. When R1 got swore and hit people. NA-C stated there where time he had hurt other residents and NA-C had to step in to intervene. NA-C stated recently she had to step in between R1 when he tried to raise his arm at another resident. NA-C stated staff were to redirect, distract and remove R1 when he gets agitated. NA-C stated staff offer R1 a cookie or ask to go for a walk to help distract R1, but this did not always work.

During an interview on 9/1/21, at 9:20 a.m. LPN-B stated R1 would try to hit and occasionally got aggressive with other residents. LPN-B further stated R1 tried to push other residents in the hall when he walked by, and LPN-C offered R1 a cookie to help redirect him.

During an interview on 9/1/21, at 9:30 a.m. R13 stated R1 came into his room and yelled at him but R13 did not "give a shit." R13 stated if you confront R1 he will talk in a "gruff" voice and "scream at you." R13 further stated R1 was noted to get physically aggressive and R13 did not trust R1. R13 also stated recently R1 yelled at R13 in the hallway and staff did not intervene. R13 stated R1 abused staff and he tried to protect them as R13 was bigger than R1.

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 09/02/2021

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 600	Continued From page 8	F 600		

During an interview on 9/1/21, at 10:53 a.m. R15 stated she had a stop sign outside of her door to keep R1 out. R15 stated the stop sign helped R15 feel safer as R1 got upset when she spoke to him.

During an interview on 9/1/21, at 12:45 p.m. licensed practical nurse (LPN)-C stated on 8/15/21, R1 wandered into R11's room as the Velcro on the stop sign was loose. LPN-C stated R1 started to yell, shuffle fast with fist and tried to punch NA-E when NA-E tried to redirect out of the resident's room. NA-E did not want to get hurt therefore ran into the nurse's station. LPN-C stated R1 went past her down the 200 hall and walk past R9 and R16 but R1 turned around. LPN-C further stated R1 yelled with aggression and put his hand in a fist again and went toward R9 who was in her wheelchair. Another unidentified staff member took R1 down the hallways while LPN-C took R9 to the nurse's station. LPN-C stated R16 was fine but R9 cried and was freighted by the incident. LPN-C stated she assured R9 she did not do anything wrong. LPN-C further stated after the incident R9 had tears and appeared to have been affected emotionally. LPN-C stated they will continue to keep an eye on R1 and intervene to prevent further incidents.

During an interview on 9/1/21, at 2:24 p.m. NA-C stated there was education on how to respond to R1 when he was agitated. NA-C further stated they were taught to provide short commands, offer a cookie, step away and remove other residents when R1 got aggressive toward staff or residents.

During an interview on 9/1/21, at 2:27 p.m. NA-A

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 09/02/2021

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 600	Continued From page 9	F 600		

stated on 8/10/21, there was an incident in the lobby when R1 walked towards R8 and R8 asked R1 if he was lost. NA-A stated R1 got upset and grabbed R8's right forearm. Staff separated R1 and R8. NA-A stated she was not sure of the reason for why R1 got upset or if there were any interventions put into place after the incident. NA-A stated on 8/15/21, there was another incident with R1 but was not aware of the details.

During an interview on 9/1/21, at 2:43 p.m. director of nursing (DON) reviewed the facility incident report dated 8/10/21, that indicated R1 grabbed R8's wrist. The DON verified the incident did happen but did not result in an injury. DON reviewed the incident report dated 8/15/21, that indicated R1 got verbally upset and yelled at R9. The DON stated the incident did not result in resident injury. The DON stated all staff were last provided on 7/19/21; education centered on measures to take when staff identified R1 recognized escalating agitation and safety to residents by removing them from the area. The DON stated the facility used stop signs in front of resident doors (keep R1 from entering) which were sometimes effective, Also, the DON indicated R1 did not have continuous supervision, staff would communicate R1's where abouts using walkie talkies when R1 was out of his room. The DON stated R1 was not being monitored on 8/15/21 when he entered another resident's room unattended and yelled at R9. room. The DON stated an expectation that when R1 showed an escalation or demonstrated aggressive/agitative behaviors, staff would immediately remove residents from the area to protect them and then attempt to redirect R1. If the redirection or intervention were not effective, DON stated staff should leave R1 alone and then reapproach R1.

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 09/02/2021

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 600	Continued From page 10	F 600		

During an interview on 9/1/21, at 2:58 a.m. R13 stated R1 was verbally aggressive earlier that day as R1 had his had in a fist and walked at a rapid pace passed his room. R13 further stated he was about to intervene as it appeared R1 was about to hurt someone.

During an interview on 9/2/21, at 9:29 a.m. family member (FM)-A stated he did not feel it was appropriate that R1 was allowed to go into R2's room unattended shortly after R1 hurt R2. FM-A stated they were looking into putting a restraining order on R2. FM-A further he wanted the facility to be proactive and fix the issue with R1's behaviors before something serious happened.

During an interview on 9/2/21, at 9:48 a.m. NA-H stated R1 got agitated and mad because of noises and lights. NA-H stated on 8/10/21, it was very load and noisy just prior to the incident when R1 tried to hit but grabbed R8's wrist. There were two residents who were laughing and talking together which NA-H felt made R1 agitated. NA-H stated staff tried to keep an eye on R1 but there was only so many staff could do.

During an interview on 9/2/21, at 9:56 a.m. NA-E stated she remembered the incident that involved R1 on 8/15/21. NA-E stated when she went in to try to get R1 out, R1 started hitting her and chased her down the hallway. NA-E stated R9 was sitting by the nurse's station along with another resident. NA-E indicated there was a nurse at the nursing station who tried to calm R1 down, R1 punched me and scared R9. NA-E stated she had removed R9 from the area.

During an interview on 9/2/21, at 10:15 a.m. R13

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 09/02/2021

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 600	Continued From page 11	F 600		

stated a familiarity with R1 and his aggressive behaviors especially towards staff members. R13 stated he had problems with R1 invading his privacy by coming into his room. R- stated R1 has yelled at him before when he was out in the hallway, one time I ran over his toe by accident, and he started hollering at me. R13 stated he has seen R1's physical aggression towards staff and verbal aggression towards resident in common areas and staff did their best to move residents out of the way, however, sometimes were not able to remove them all. R13 stated a belief that other residents were frightened of R1 and wouldn't be surprised if residents stayed in their rooms to avoid him.

During an interview on 9/2/21, at 10:25 a.m. R12 stated he had concerns coming into his room and yelling at him as he walked down the hallway to therapy. R12 stated within the last couple of weeks R1 came into his room, when R12 told R1 to get out, R1 became argumentative, walked over to R12 reclining chair he was sitting in and hit him, R1 then left the room on his own without staff assistance. R12 stated he had not reported the incident to staff because he knew R1 had dementia. R12 stated when the incident happened there was not a stop sign on his door. R12 stated staff just replaced his stop sign either late last week or on Monday, the sign was replaced sometime after the incident. R12 stated he has witnessed to R1 yelling at other residents within the last 2 weeks. R12 family member called during the interview. (FM)-B, with raised voiced stated "What is being done to protect [R12]!? I want that psycho kept out of R12s room! That psycho [R1] hit [R12], [R12] is vulnerable and cannot protect himself! What is being done?!" FM-B stated she thought R12 had

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 09/02/2021

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 600	Continued From page 12	F 600		

reported the incident to staff and was not aware R12 had not reported the incident to staff.

During an interview on 9/2/21, at 10:35 a.m. LPN-B stated he was not aware of R1's triggers as it could be suddenly. LPN-B further stated R1 was a strong guy and can hold. R1 had been seen to kick staff members. LPN-B stated it appeared that sometimes when R1 got mad it was because R1 thought staff were tried to prevent him from doing something. LPN-B stated to prevent R1 from getting angry staff tried to keep a distance as R1 might hit them. LPN-B stated R1 got upset with other residents if they crossed his path in the hallway.

The 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, r mental anguish. Willful as used in 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

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 09/02/2021

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 600	Continued From page 13 protection of the vulnerable adults during the investigation.	F 600		
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 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 immediately report to the state agency but no later than 2 hours and allegation of	F 609	1. It is the policy and procedure for Pine Haven Care Center to ensure that any allegation of abuse, neglect,	10/15/21

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 09/02/2021

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 609	Continued From page 14 sexual abuse for 1 of 1 resident (R3) reviewed for abuse. A Facility Reported Incident (FRI) submitted to the State Agency on 8/27/21, at 5:38 p.m. indicated R3 alleged unwanted sexual contact that had occurred on 8/26/21, at 12:00 a.m. The description of the incident included, "alleged inappropriate physical contact not report to facility staff until the next day/afternoon." During an interview on 9/1/21, at 9:20 a.m. registered nurse (RN)-C stated on 8/27/21, R3 had reported to the therapies director (TD)-A shortly after lunch that the evening nurse molested her. RN-C stated she had not mentioned anything to her about the allegation all morning despite having multiple interactions. RN-C indicated TD-A then reported R3's allegation to administration. During an interview on 9/1/21, at 9:40 a.m. TD-A stated on 8/27/21, R3 had requested a meeting with her; during the meeting R3 had alleged RN-D had touched her inappropriately when he put his stethoscope underneath her nightgown. TD-A stated R3 had reported the allegation between 12:00 and 12:30 p.m. TD-A stated after R3 finished reporting the allegation she immediately went and reported to director of nursing (DON) and social worker. During an interview on 9/1/21, at 10:25 social services designee (SSD) stated on 8/27/21, at approximately 12:30 or 12:40 p.m. TD-A had reported R3 had alleged sexual assault that happened on the evening on 8/26/21, by the evening nurse. SSD stated she had immediately called law enforcement to report the allegation	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. 2. This has the potential to affect all 66 residents. 3. All staff were educated on our abuse policy for reporting to the appropriate state agency and 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 on 10/07/2021 continuing on 10/08/2021. 4.Audits for reporting any abuse, neglect, mistreatment, misappropriation and injury of unknown origin to prevent reoccurrence will begin on 10/09/2021 daily x 10, weekly x4 and monthly x 2 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.	

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 09/02/2021

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 609	Continued From page 15	F 609		

and then she and the DON proceeded to interview R3. SSD stated the DON made the Report to the State Agency and indicated the allegation should have been submitted no later than 2 hours after the allegation was made. SSD stated an unawareness as to why the allegation was not reported to the State Agency until 5:38 p.m.

During an interview on 9/1/21 at 10:41 a.m. DON indicated TD-A reported the allegation around 1:00 p.m. DON confirmed the allegation was not reported until 5:38 p.m., indicated she had lost track of time because the day was busy. DON stated the allegation should had been reported within 2 hours of becoming aware of the allegation.

Based on interview and document review the facility to report an allegation of verbal and physical altercation of abuse for 2 of 2 residents (R8, R9) who were reviewed for abuse. The facility failed to report an incident when R1 got upset and grabbed R8's forearm. The facility also failed to report an incident when R1 chased and yelled at R9 and made her cry.

Findings include:

R1's Incident Reported dated 8/10/21, indicated an incident of physical aggression in the hallway. R8 asked R1 if he was lost. R1 got upset and grabbed R8's right forearm. R1 and R8 were separated and there was no injury noted at the time of the altercation.

R1's Provider Visit dated 8/13/21, indicated R1 had problematic interactions with residents and staff. R1 had an incident were another resident

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 09/02/2021

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 609	Continued From page 16	F 609		

talked to him and he reached and grabbed their arm.
During an interview on 9/1/21, at 2:27 p.m. registered nurse (RN)-A stated there was an incident on 8/10/21, when R8 asked R1 if he was lost when R8 left the dining room. RN-A further stated R1 got upset and grabbed R8's right forearm. RN-A stated this incident was not reported to the state agency as R8 did not have any noted skin issues.

During an interview on 9/1/21, at 2:43 p.m. director of nursing (DON) reviewed the facility incident report dated 8/10/21, that indicated R1 got upset and grabbed R8'arm. The DON indicated the incident was not reported to the State Agency because the act did not result in an injury. DON stated since the incident was not reported to the State Agency a thorough investigation was not completed, root cause/causal factors were not identified, and interventions were not identified that would prevent and/or reduce the risk of re-occurrence.

A Facility Incident Report dated 8/15/21, indicated R1 wandered into another residents (403) room and NA-E redirected R1 out. R1 chased NA-E with his hand in a fist like he was going to hit her. NA-E got out of R1's way and R1 wandered down the 200 halls. At 1:25 p.m. LPN-C stood at the nurse's cart and saw R9 and R16 visiting. R1 looked over and saw R1 yelling at R9. R1 had his hand in a fist and chased R9. R1 and R9 were separated. R9 cried and appeared scared and did not want to let go of LPN-C's hand. No residents were physically injured.
During an interview on 9/1/21, at 12:30 p.m. registered nurse (RN)-A stated she did not investigate or follow up after the incident on

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 09/02/2021

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 609	Continued From page 17	F 609		

8/15/21. RN-A stated she was not aware it had happened as she must have missed the incident when she read the 24-hour report and was e was not sure if the incident was reported to the state agency.

During an interview on 9/1/21, at 12:45 p.m. LPN-C stated she did not report the incident on 8/15/21, to the state agency as R9 had no physical harm. LPN-C also stated after the incident R9 appeared to have been affected emotionally as she had tears and would not let go of her hand.

During an interview on 9/1/21, at 2:43 p.m. the DON reviewed the incident report dated 8/15/21, that indicated R1 yelled at R9 and chased her with his hand in a fist. The DON stated the incident was not reported to the State Agency as an allegation because R1's actions did not result in resident injury. DON stated since the incident was not reported to the State Agency a thorough investigation was not completed, root cause/causal factors were not identified, and interventions were not identified that would prevent and/or reduce the risk of re-occurrence. DON stated the facility used a decision tree from a provider organization to determine if allegations were reportable and when she used the tree, the tree advised the incidents were not reportable.

The facility Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy dated 1/2021, indicated 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

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 09/02/2021

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 609	Continued From page 18 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 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 thoroughly investigate an incident of resident-to-resident abuse for 1 of 3 residents (R2) who were reviewed for abuse.	F 610	1. It is the policy and procedure for Pine Haven Care Center to ensure that any allegation of abuse, neglect, mistreatment, misappropriation of	10/15/21

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 09/02/2021

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 610	Continued From page 19 Findings include: The Sheriff's Offices Incident report dated 8/26/21, at 12:28 p.m. to 1:58 p.m. indicated an activity of sexual assault. There was a report filed to the county attorney. The Sheriff's Office Narrative Reported dated 8/26/21, indicated on 8/26/21 at approximately 12:28 p.m. the deputy (D)-B got a call related to possible past action sexual assault at the facility. Family member (FM)-B stated R1 exposed himself to R2. FM-A and FM-B placed a surveillance camera in R2's room for her safety. There was a history when R1 assaulted and hit R2's arm on 6/30/21. On 8/26/21, FM-B realized the security camera notified motion on 8/18/21, at 5:13 a.m. The camera footage showed R1 expose his genitals to R2. FM-B wanted to make sure R2 was safe and that R1 could not get into R2's room. FM-B was advised on how to obtain a restraining order. The video showed an older male in stripped pajamas sting near the end of R2's bed while R2 laid motionless (possibly sleeping). The video shows R1 faced away from the camera and toward R2 with his pants down below his exposed butt. It sounded like R1 stated "help" multiple times. R1 pulled his pants up and exited the room. FM-B listened while D-B spoke to R2. The report indicated R2 she did not remember what happened or was asleep but R2 thought R1 was bad and did not want to be around him-B advised RN-A that R2 be banned from R2's room and to not have contact. D-B also advised the administrator to make sure R1 was not allowed in R2's room under any circumstance.	F 610	property and injury of unknown origin are thoroughly investigated. 2. This has the potential to affect all 66 residents. 3. All Management nurses and Social Services were educated on our abuse policy for thoroughly investigating any allegations of abuse, neglect, mistreatment of a resident, misappropriation of resident property, or injury of unknown origin the appropriate on 10/07/2021 continuing on 10/08/2021. 4.Audits for investigating any abuse, neglect, mistreatment, misappropriation and injury of unknown origin to prevent reoccurrence will begin on 10/09/2021 daily x 10, weekly x4 and monthly x 2 to ensure compliance the administrator 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.	

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 09/02/2021

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

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F 610	Continued From page 20	F 610		

During an interview on 9/1/21 at 11:24 a.m. registered nurse (RN)-A stated after the incident she followed up with other residents but did not follow up with staff who worked during the incident or investigate further. RN-A stated she thought services (SS)-A or the director of nursing (DON) may have investigated the incident further.

During an interview on 9/1/21, at 11:59 a.m. social services (SS)-A stated she interviewed some residents after the incident on and did not investigate the situation further.

During an interview on 9/1/21, at 12:10 a.m. the administrator stated after the facility became aware of the incident, he did not interview the staff. The administrator stated he thought RN-A might have as she oversaw the investigation.

During an interview on 9/1/21, at 12:18 a.m. the DON stated she did not interview staff after the incident. The DON stated RN-A delt with most of the investigation after D-B informed the facility that R1 exposed himself to R2. The DON stated the facility thought R1 tried to urinate in R2's room but was not exactly sure.

During an interview on 9/1/21, at 2:27 p.m. RN-A verified she was not aware if the root cause was to be determined in investigations.

The facility Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy dated 1/21, indicated an investigation is the process to determine what happened. A root cause investigation and analysis would be completed. The investigation would include who was involved, resident statements, involved staff and witness statements of events, a description

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 09/02/2021

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F 610	Continued From page 21 of the residents' behavior and environment at the time of the incident, injuries presented, observation of resident and staff behaviors during the investigation and environmental considerations.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		10/15/21

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 09/02/2021

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

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F 656	Continued From page 22 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement person centered interventions for 1 of 1 resident (R1) reviewed for comprehensive care plans. R1's behaviors started to escalate and continued when he tried to defecate in the lobby. Staff did not implement interventions from R1's behavioral care plan to address the increased agitation and aggression. Findings Include: During an observation on 9/1/21, at 9:07 a.m. R1 nursing assistant (NA)-C and NA-D tried to assist in changing R1 brief. R1 yelled, "I don't want it." NA-C told NA-D they would try again in five minutes since R1 was agitated. During an observation on 9/1/21, at 9:18 a.m. a walkie talkie indicated R1 refused cares. During an observation on 9/1/21, at 3:07 p.m. NA-B walked beside R1. R1's face grimaced and appeared upset as he clapped his hand in the direction of NA-B. NA-A came to help NA-B. NA-A directed R1 to a chair by the nurses station. LPN-A approached R1 and offered him a cold	F 656	1. It is the policy and procedure for Pine Haven Care Center to ensure that all residents have been assessed and have a comprehensive person centered care plan. Resident R1 care plan was reviewed and updated on 09/01/2021 to reflect this resident's behaviors. 2. This has the potential to affect all 66 residents. all resident's care plans were reviewed and updated to ensure compliance 3. All licensed staff were educated on our comprehensive care plan policy on 09/30/2021. 4.Audits for compliance to ensure all residents have a comprehensive care plan to prevent reoccurrence will begin on 10/11/2021 daily x 10, weekly x4 and monthly x 2 to ensure compliance the DNS or designee will be responsible for compliance. Any deviations to the policy will be immediately reported to the Administrator for immediate review and recommendations. These will be presented at QAPI for on-going review.	

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F 656	Continued From page 23	F 656		

glass of water and asked how the kids were doing.

During an observation on 9/1/21, at 3:10 p.m. R9 propelled herself in her wheelchair past R1 and stopped six feet from him. Another resident came out and sat in his wheelchair by R1.

During an observation on 9/1/21, at 3:18 a.m. R1 got up from a chair by the nurse's station and walk in the direction toward the hallway past the nurse's cart. NA-B followed R1 and R1 told NA-B to just keep going but NA-B continued to follow R1. R1 got upset and stated, "oh my gosh" and turned around and walked back toward the nursing station. NA-B asked R1 if he wanted to watch television and directed R1 to the lobby. R1 entered the lobby pulled his pants down exposed his genitals/buttocks to staff, residents, and the main entrance glass doors. R1 told NA-B to "suck his balls" while he had his pants down. LPN-B approached and tried to help R1 pull his pants back up but R1 tried to push, hit, and kick the staff. At this point there was feces on the lobby chair when R1 stood back up with his pants down. NA-B stated there was poop on the chair and NA-B asked R1 to pull his pants up but R1 formed a fist and aimed it at NA-B. R1 sat down again in the lobby chair with his buttock directly on the chair cushion and pants still down.

During an observation on 9/1/21, at 3:23 p.m. R1 stood up with his pants still below his buttock and tried to pull his pants up on his own. LPN-B offered to help pull R1's pants up but R1's grabbed her hand and pulled at her wrist. R1's face grimaced while he stated, "you are not going after my things, and I don't give a shit." R9 who was in the adjacent room by the nurse's station

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F 656	Continued From page 24	F 656		

yelled, "he is crazy." NA-B Stated R1's pants were falling off and tried to help pull them up. NA-A arrived at the lobby and approached R1 in a calm, high pitched tone and R1 pulled his pants up. NA-A rubbed R1's back and directed him out of the lobby toward the nurses station. R1 was directed to walk through a ~ two-foot opening and walked directly past R10 and was directed R1 toward he tub room.

During an observation on 9/1/21, at 3:33 p.m. R1 was heard through the tub room door to yell at the staff who were with him.

R1's Face Sheet indicated an admission on 2/1/21. R1 had a diagnosis of dementia with behavioral disturbances.

R1's Elopement Evaluation dated 5/11/21, indicated R1's wandering behavior likely to affect the safety or well-being of self/others and likely affected the privacy of others.

R1's provider note dated 7/30/21, indicated on 7/27/21, R1 kicked nursing staff in the leg when they tried to direct him out of another residents room. On 7/26/21, R1 raised his hand toward a staff member when they tried direct him from urinating in the hallway. R1 continued to have periods of aggression toward staff and was at risk toward other residents. R1's episodes of aggression seemed to escalate quickly, and which made it hard to provide the as medication intervention.

R1's Long Term Care Evaluation dated 8/5/21, indicated R1 was confused, disoriented, required cues, in attention, had disorganized thinking and short-term memory loss. R1 rarely or never

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 09/02/2021

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

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F 656	Continued From page 25	F 656		

understood others nor made himself understood.

R1's PN dated 8/6/21, at 11:31 p.m. indicated R1 was aggressive and squeezed LPN-C's hand hard and shook his fist at staff.

R1's PN dated 8/7/21, at 7:55 p.m. indicated RN-B heard angry voices and noted R1 was upset with another resident. R1 and the other resident talked loud at each other. R1 placed his hand on residents' property but was redirected.

R1's Psychotropic Evaluation dated 8/8/21, indicated chronic behavior which potentially caused harm to self and others; R1 had behaviors (i.e., combativeness, verbal disruptions) that was harmful to self and others. The use of medication has decreased behaviors and agitation. Staff were to encourage relaxation techniques, implement safety interventions, and utilize distraction techniques.

R1's PN dated 8/8/21, at 4:38 p.m.R1 wanted into other residents' rooms and was found to rest on their beds. R1 had moments of agitation, gruff comments but was able to be redirected. R1 was restless and walked the halls. In the morning R1 voided in the hall with his pants down and was not able to get charged right away due to his agitation.

R1's quarterly Minimum Data Set (MDS) dated 8/11/21, indicated severe cognitive impairment. R1 required supervision (oversight, encouragement, or cueing) while he walked was in the corridor or in his room; required extensive assist to get dressed and use the toilet. R1 had physical, and verbal behavioral symptoms directed toward others, behavioral symptoms not

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	245359	A. BUILDING _____ B. WING _____	C 09/02/2021

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F 656	Continued From page 26	F 656		

directed toward others and rejected care four to six days a week. R1 wandered daily.

R1's Elopement Evaluation dated 8/11/21, indicated R1 wandered. R1's wandered aimlessly, or non-goal directed which affected the safety or wellbeing of others and affected the privacy of others. No clinical suggestions were provided.

R1's Provider Visit dated 8/13/21, indicatedR1 had a lot of behaviors such as wandering, and inappropriate voiding.

R1's PN dated 8/18/20, at 2:13 p.m. indicated R1 wandered into the hall that morning and urinated on the floor. At 8:30 a.m. R1 attempted to urinate on the floor but was able to be redirected to the bathroom. R1 got agitated and grabbed LPN-C hand and arm when LPN-C tried to help R1 get dressed. Around 11:00 a.m. R1 got aggressive when LPN-C tried to remove R1's soiled brief.

R1's PN dated 8/20/21, at 12:41 p.m. indicated R1 wandered around and stated, "help me." R1 was coached and redirected to the bathroom. R1 would not sit on the toilet and went to the bathroom on his pants. R1 refused four times with a NA and one time with RN-B. R1 kicked and punched RN-B but RN-B was able to move away to prevent any further aggressive assaults. R1 pulled his pants down when he came out of his room and had a soaked brief with stool.

R1's PN dated 8/21/21, at 2:16 p.m. indicated R1 yelled at a NA and refused to get changed. R1 was reapproached 30 minutes later by a different staff and was changed. R1 yelled at staff but was easily redirected.

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 09/02/2021

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F 656	Continued From page 27	F 656		

R1's Behavior Monitoring dated 8/21/21, until 9/2/21, indicated R1 exhibited 19 incidents of physical behavioral symptoms director toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually.) R1 exhibited 17 incidents of verbal behavioral symptoms directed towards others. R1 exhibited behavioral symptoms not directed towards others 16 times. R1 had a behavior 10 times that put R1 at significant risk for physical illness or injury. R1's behaviors put others at significant risk for physical injury 11 times. R1's behavior significantly intruded the privacy or activity of others 12 times

R1's PN dated 8/24/21, at 1:36 p.m. indicated R1 had verbal and physical behaviors toward staff and resident when he became overstimulated. R1 wandered daily and frequently urinated in hallways. There was a discussion of hospice. Speech Therapy went over how cares could be tailored to meet R1s needs and had worked on strategies to reduce agitation. Family was encouraged to bring in personal items to make R1's room more home like.

R1's PN dated 8/25/21, at 1:51 p.m. indicated R1 attempted to urinate at the end of the 300 hallway but RN-A directed him back to his room to use the restroom but R1 refused. R1 became agitated when RN-A tried to assist R1. RN-A attempted to have R1 help change his pants and brief which had a bowel movement on it. RN-A waited for a brief period and reattempted again. R1 became agitated, stated to swat at RN-A and squeezed RN-A hand. R1 laid in bed to rest. RN-A opened the curtains and turned a sound machine to help R1 relax.

R1's PN dated 8/25/21, at 2:07 p.m. indicated at

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	245359	A. BUILDING _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 28	F 656		

1:40 p.m. R1 tried to urinate in the 300 hallways. R1 swatted at the NA when she attempted to assist R1.

R1's PN dated 8/25/21, at 2:22 p.m. indicated RN-A was able to calm R1 down on the 300 hallways by lightly rubbing his back. R1 stated he needed to use the restroom. RN-A assisted R1 to the use the restroom which RN-A was able to coach and assist R1.

R1's PN dated 8/26/21, at 12:19 p.m. indicated R1 repeatedly stated, "I need to do that. What do I do." R1 stated, "I don't want them to let me go." R1 believed he worked at the facility and did not know what his job was which was likely contributing to his behaviors and wandering. When R1 was given a task to watch something his facial muscles released and appeared calmer. R1 commented "good I'll do that or thank when asked to do these tasks. The facility will trial this as an intervention to assist to provide R1 a calming atmosphere and sense of purpose.

R1's PN dated 9/1/21, at 12:26 p.m. indicated R1 attempted to urinate at the end of the 300 hallway. RN-A approached R1 slowly and calmly. R1 got agitated when RN-A tried to approach him to the bathroom therefore was directed back to his room. RN-A was able to clean R1 and change him.

R1's PN dated 9/1/21, at 4:26 p.m. indicated R1 pulled down his pants near the front door area of the facility and sat down in a chair. Staff spoke with R1 to try to get him to come with them to the bathroom. R1 was resistive, grabbed staff's arm and yelled at them.
Another staff member approached R1, and he

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 09/02/2021

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

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F 656	Continued From page 29	F 656		

went with her to get changed and the other staff member the bowl movement that R1 left on the chair he sat on without pants on.

R1's care plan dated 9/3/21, indicated R1's had an alteration in memory, judgement, decision making and thought process related to dementia. R1 had behaviors to wander, attempt to enter other residents' rooms, refuse cares, make verbal threats of physical harm to staff and residents. R1 had actual physical aggression to staff and residents. Interventions included:
-provide one to one for safety,
-Address by name, provide time to process information, use simple words, speak before task, and explained step by step what is done and to not startle R1.
-Allow R1 to assist with simple tasks and praise him/tell him good job. Explain each activity and care procedure prior to beginning it.
-Break activities into manageable subtasks; give one instruction at a time.
-introduce themselves at initiation of each interaction and have a daily routine.
-Gently redirect activities when R1 made inappropriate actions
-Provide two choices when decisions were presented.
- R1 was easily overstimulated by too much noise or too many people,
-R1's behaviors may be due to not understanding what was being done. Staff should use soft gentle tone and soothing words when R1 had behaviors.
- modify environment to prevent situations that trigger inappropriate behaviors,
-provide cues and prompts to ensure R1 made attempts at own care before assisting him;
used with more than one method of communication.

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	245359	A. BUILDING _____ B. WING _____	C 09/02/2021

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F 656	Continued From page 30	F 656		

R1 responded best to use two- or three-word sentences or instructions and use hand gesture to point where R1 should be walking to or sitting
- Use one staff member for care as multiple staff around made him agitated; R1 responded well to praise.
-Utilize activity box when R2 becomes restless or agitated.
-During cares provide easy instructions.

During an interview on 9/1/21, at 9:05 a.m. NA-C stated R1 had the cognition of a 1.5-year-old. NA-C stated when R1 asked staff to leave him alone staff were to back away for R1's safety and their own. NA-C stated she has had to intervene when R1 tried to hit other residents. NA-C stated she tried to redirect R1 by providing him a cookie or offering him to go on a walk.

During an interview on 9/1/21, at 9:20 a.m. licensed practical nurse (LPN)-B stated R1 wandered and got aggressive. R1 tried to hit and occasionally got aggrieve with other residents. LPN-B also stated he would offer R1 a cookie to redirect him during cares.

During an interview on 9/1/21, at 12:18 a.m. the director of nursing (DON) stated staff were to use a walkie talkie to communicate where R1 was. The DON stated education had been done on how to react when R1 did not know what to do and that they should try to assist him with tasks and work with R1's dementia to keep him occupied.

During an interview on 9/1/21, at 2:43 p.m. DON stated an expectation that when R1 showed an escalation or demonstrated aggressive/agitative behaviors, staff were to immediately remove

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 09/02/2021

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 656	Continued From page 31	F 656		

residents from the area to protect them and then attempt to redirect R1. If the redirection or intervention were not effective, the DON stated staff should leave R1 alone and then reapproach R1.

During an interview on 9/1/21, at 3:38 p.m. NA-A stated she worked with R1 often and R1 appeared to like her a lot. NA-A stated she was able to help NA-B and LPN-A redirect R1 when he started to get upset in the hallway then again in the lobby when he pulled down his pants. NA-A stated R1 cooperated with her because of the way she approached R1. NA-A further stated R1 was more cooperative when staff approached him with an upbeat tone, used simple, encouraging words, and told him it won't take long. NA-A also stated R1 did not like to have more than one staff help him as R1 got overwhelmed. NA-A stated when R1 pulled down his pants it indicated R1 had to use the bathroom. NA-A verified R10 was not removed from the scene when R1 was directed directly by him. NA-A also stated R1 agitation may have increased as there were more than one staff who assisted him, and he preferred one staff.

During an interview on 9/1/21, at 3:43 p.m. NA-B stated the cause of R1's agitation could have been the way she approached him. NA-B further stated R1 got worked up after she told R1 to do something. NA-B also stated when she told R1 repeatedly to pull his pants up it made him even more upset. NA-B further stated she felt R1 turned aggressive when LPN-A tried to physically pull his pants up.

During an interview on 9/2/21, at 10:35 a.m. LPN-B stated he was not aware of what triggered

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	245359	A. BUILDING _____ B. WING _____	C 09/02/2021

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F 656	Continued From page 32	F 656		

R1 as his behavior could happen suddenly. LPN-B stated it was important to how staff approached R1 and tried to redirect him as his behaviors happen suddenly.

During an interview on 9/2/21, at 3:46 p.m. LPN-E stated he received training for R1 and remembered he liked one on one cares, he got agitated if there was more than one person, and that he like short simple sentences.

During an interview on 9/2/21, at 3:51 p.m. the DON stated the facility provided training on dementia care for R1. The DON stated R1's behaviors triggered usually when he would not know what to do therefore it was important to intervene prior. The DON further stated she expected staff to keep R1 busy and provide tasks from his habits prior to his dementia. The DON verified not all interventions were care planned for R1. The care plan did not indicate R1 enjoyed his back rubbed, hand holding which is helpful but were not in the care plan. The DON stated education was if those with dementia exhibit behaviors usually was that their needs were not met. The DON stated her expectation would be for staff to follow the care plan, do room checks, and make sure R1's needs were met. The DON stated it was her expectation that if R1 exhibited behaviors that other residents were moved away from the area. The DON stated her expectation was to keep all residents safe.

The facility Dementia-Clinical Protocol Policy dated 11/2018, indicated the interdisciplinary care team (IDT) would identify a resident centered care plan to maximize remaining function and quality of life. Residents' needs will be communicated to direct care staff through care

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F 656	Continued From page 33	F 656		

plan, conference, communication at shift change and through written documentation. The IDT will adjust intervention and overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical condition or complications, changes in a residents or family wishes and other relevant factors.

The facility Behavioral Health Services Policy dated 2/2019, indicated services are provided as part of the interdisciplinary, person centered approach to care. Staff must promote dignity, autonomy, privacy, socialization, and safety as appropriate for each resident. Staff training include to recognize changes in behavior that indicate psychological distress, implement care plan interventions that appropriate to the initials needs, monitor care plan interventions and report changes in condition.

The facility Behavioral Assessment, Intervention and Monitoring policy dated 3/2019, indicated the facility will provide residents behavioral health services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Residents will have mimical compilations associated with the management of altered or impaired behavior. Behavior can be a way an individual in distress communicates unmet needs, indicate discomfort or express thoughts that cannot be articulated. The IDT team will thoroughly evaluate new or changing behavioral symptoms to identify the cause and address the resident condition. Interventions will be individuals and part of an overall care environment that supports physical functional and psychosocial needs, and strives to understand,

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F 656	Continued From page 34 prevent, and relieve the resident's distress or loss of abilities.	F 656		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 29, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: M75X11

Dear Administrator:

The above facility was surveyed on September 1, 2021 through September 2, 2021 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

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

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 09/02/2021

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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 9/1/21, to 9/2/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT 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 be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5359062C (MN76196) with a licensing order issued at tag 0565. The following complaint was found to be UNSUBSTANTIATED: H5359063C (MN76251 MN76230). 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 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	2 000		

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2 000	Continued From page 2 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		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement person centered interventions for 1 of 1 resident (R1) reviewed for comprehensive care plans. R1's behaviors started to escalate and continued when he tried to defecate in the lobby. Staff did not implement interventions from R1's behavioral care plan to address the increased agitation and aggression. Findings Include: During an observation on 9/1/21, at 9:07 a.m. R1 nursing assistant (NA)-C and NA-D tried to assist in changing R1 brief. R1 yelled, "I don't want it." NA-C told NA-D they would try again in five minutes since R1 was agitated.	2 565	Corrected	10/15/21

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2 565	Continued From page 3 During an observation on 9/1/21, at 9:18 a.m. a walkie talkie indicated R1 refused cares. During an observation on 9/1/21, at 3:07 p.m. NA-B walked beside R1. R1's face grimaced and appeared upset as he clapped his hand in the direction of NA-B. NA-A came to help NA-B. NA-A directed R1 to a chair by the nurses station. LPN-A approached R1 and offered him a cold glass of water and asked how the kids were doing. During an observation on 9/1/21, at 3:10 p.m. R9 propelled herself in her wheelchair past R1 and stopped six feet from him. Another resident came out and sat in his wheelchair by R1. During an observation on 9/1/21, at 3:18 a.m. R1 got up from a chair by the nurse's station and walk in the direction toward the hallway past the nurse's cart. NA-B followed R1 and R1 told NA-B to just keep going but NA-B continued to follow R1. R1 got upset and stated, "oh my gosh" and turned around and walked back toward the nursing station. NA-B asked R1 if he wanted to watch television and directed R1 to the lobby. R1 entered the lobby pulled his pants down exposed his genitals/buttocks to staff, residents, and the main entrance glass doors. R1 told NA-B to "suck his balls" while he had his pants down. LPN-B approached and tried to help R1 pull his pants back up but R1 tried to push, hit, and kick the staff. At this point there was feces on the lobby chair when R1 stood back up with his pants down. NA-B stated there was poop on the chair and NA-B asked R1 to pull his pants up but R1 formed a fist and aimed it at NA-B. R1 sat down again in the lobby chair with his buttock directly on the chair cushion and pants still down.	2 565		

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2 565	Continued From page 4 During an observation on 9/1/21, at 3:23 p.m. R1 stood up with his pants still below his buttock and tried to pull his pants up on his own. LPN-B offered to help pull R1's pants up but R1's grabbed her hand and pulled at her wrist. R1's face grimaced while he stated, "you are not going after my things, and I don't give a shit." R9 who was in the adjacent room by the nurse's station yelled, "he is crazy." NA-B Stated R1's pants were falling off and tried to help pull them up. NA-A arrived at the lobby and approached R1 in a calm, high pitched tone and R1 pulled his pants up. NA-A rubbed R1's back and directed him out of the lobby toward the nurses station. R1 was directed to walk through a ~ two-foot opening and walked directly past R10 and was directed R1 toward he tub room. During an observation on 9/1/21, at 3:33 p.m. R1 was heard through the tub room door to yell at the staff who were with him. R1's Face Sheet indicated an admission on 2/1/21. R1 had a diagnosis of dementia with behavioral disturbances. R1's Elopement Evaluation dated 5/11/21, indicated R1's wandering behavior likely to affect the safety or well-being of self/others and likely affected the privacy of others. R1's provider note dated 7/30/21, indicated on 7/27/21, R1 kicked nursing staff in the leg when they tried to direct him out of another residents room. On 7/26/21, R1 raised his hand toward a staff member when they tried direct him from urinating in the hallway. R1 continued to have periods of aggression toward staff and was at risk toward other residents. R1's episodes of	2 565		

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2 565	Continued From page 5	2 565		

aggression seemed to escalate quickly, and which made it hard to provide the as medication intervention.

R1's Long Term Care Evaluation dated 8/5/21, indicated R1 was confused, disoriented, required cues, in attention, had disorganized thinking and short-term memory loss. R1 rarely or never understood others nor made himself understood.

R1's PN dated 8/6/21, at 11:31 p.m. indicated R1 was aggressive and squeezed LPN-C's hand hard and shook his fist at staff.

R1's PN dated 8/7/21, at 7:55 p.m. indicated RN-B heard angry voices and noted R1 was upset with another resident. R1 and the other resident talked loud at each other. R1 placed his hand on residents' property but was redirected.

R1's Psychotropic Evaluation dated 8/8/21, indicated chronic behavior which potentially caused harm to self and others; R1 had behaviors (i.e., combativeness, verbal disruptions) that was harmful to self and others. The use of medication has decreased behaviors and agitation. Staff were to encourage relaxation techniques, implement safety interventions, and utilize distraction techniques.

R1's PN dated 8/8/21, at 4:38 p.m.R1 wanted into other residents' rooms and was found to rest on their beds. R1 had moments of agitation, gruff comments but was able to be redirected. R1 was restless and walked the halls. In the morning R1 voided in the hall with his pants down and was not able to get charged right away due to his agitation.

R1's quarterly Minimum Data Set (MDS) dated

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2 565	Continued From page 6 8/11/21, indicated severe cognitive impairment. R1 required supervision (oversight, encouragement, or cueing) while he walked was in the corridor or in his room; required extensive assist to get dressed and use the toilet. R1 had physical, and verbal behavioral symptoms directed toward others, behavioral symptoms not directed toward others and rejected care four to six days a week. R1 wandered daily. R1's Elopement Evaluation dated 8/11/21, indicated R1 wandered. R1's wandered aimlessly, or non-goal directed which affected the safety or wellbeing of others and affected the privacy of others. No clinical suggestions were provided. R1's Provider Visit dated 8/13/21, indicatedR1 had a lot of behaviors such as wandering, and inappropriate voiding. R1's PN dated 8/18/20, at 2:13 p.m. indicated R1 wandered into the hall that morning and urinated on the floor. At 8:30 a.m. R1 attempted to urinate on the floor but was able to be redirected to the bathroom. R1 got agitated and grabbed LPN-C hand and arm when LPN-C tried to help R1 get dressed. Around 11:00 a.m. R1 got aggressive when LPN-C tried to remove R1's soiled brief. R1's PN dated 8/20/21, at 12:41 p.m. indicated R1 wandered around and stated, "help me." R1 was coached and redirected to the bathroom. R1 would not sit on the toilet and went to the bathroom on his pants. R1 refused four times with a NA and one time with RN-B. R1 kicked and punched RN-B but RN-B was able to move away to prevent any further aggressive assaults. R1 pulled his pants down when he came out of his room and had a soaked brief with stool.	2 565		

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2 565	Continued From page 7	2 565		

R1's PN dated 8/21/21, at 2:16 p.m. indicated R1 yelled at a NA and refused to get changed. R1 was reapproached 30 minutes later by a different staff and was changed. R1 yelled at staff but was easily redirected.

R1's Behavior Monitoring dated 8/21/21, until 9/2/21, indicated R1 exhibited 19 incidents of physical behavioral symptoms director toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually.) R1 exhibited 17 incidents of verbal behavioral symptoms directed towards others. R1 exhibited behavioral symptoms not directed towards others 16 times. R1 had a behavior 10 times that put R1 at significant risk for physical illness or injury. R1's behaviors put others at significant risk for physical injury 11 times. R1's behavior significantly intruded the privacy or activity of others 12 times

R1's PN dated 8/24/21, at 1:36 p.m. indicated R1 had verbal and physical behaviors toward staff and resident when he became overstimulated. R1 wandered daily and frequently urinated in hallways. There was a discussion of hospice. Speech Therapy went over how cares could be tailored to meet R1s needs and had worked on strategies to reduce agitation. Family was encouraged to bring in personal items to make R1's room more home like.

R1's PN dated 8/25/21, at 1:51 p.m. indicated R1 attempted to urinate at the end of the 300 hallway but RN-A directed him back to his room to use the restroom but R1 refused. R1 became agitated when RN-A tried to assist R1. RN-A attempted to have R1 help change his pants and brief which had a bowel movement on it. RN-A waited for a brief period and reattempted again. R1 became agitated, stated to swat at RN-A and squeezed

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 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 565	Continued From page 8	2 565		

RN-A hand. R1 laid in bed to rest. RN-A opened the curtains and turned a sound machine to help R1 relax.

R1's PN dated 8/25/21, at 2:07 p.m. indicated at 1:40 p.m. R1 tried to urinate in the 300 hallways. R1 swatted at the NA when she attempted to assist R1.

R1's PN dated 8/25/21, at 2:22 p.m. indicated RN-A was able to calm R1 down on the 300 hallways by lightly rubbing his back. R1 stated he needed to use the restroom. RN-A assisted R1 to the use the restroom which RN-A was able to coach and assist R1.

R1's PN dated 8/26/21, at 12:19 p.m. indicated R1 repeatedly stated, "I need to do that. What do I do." R1 stated, "I don't want them to let me go." R1 believed he worked at the facility and did not know what his job was which was likely contributing to his behaviors and wandering. When R1 was given a task to watch something his facial muscles released and appeared calmer. R1 commented "good I'll do that or thank when asked to do these tasks. The facility will trial this as an intervention to assist to provide R1 a calming atmosphere and sense of purpose.

R1's PN dated 9/1/21, at 12:26 p.m. indicated R1 attempted to urinate at the end of the 300 hallway. RN-A approached R1 slowly and calmly. R1 got agitated when RN-A tried to approach him to the bathroom therefore was directed back to his room. RN-A was able to clean R1 and change him.

R1's PN dated 9/1/21, at 4:26 p.m. indicated R1 pulled down his pants near the front door area of the facility and sat down in a chair. Staff spoke

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 09/02/2021

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) COMPLETE DATE
2 565	Continued From page 9	2 565		

with R1 to try to get him to come with them to the bathroom. R1 was resistive, grabbed staff's arm and yelled at them.
Another staff member approached R1, and he went with her to get changed and the other staff member the bowl movement that R1 left on the chair he sat on without pants on.

R1's care plan dated 9/3/21, indicated R1's had an alteration in memory, judgement, decision making and thought process related to dementia. R1 had behaviors to wander, attempt to enter other residents' rooms, refuse cares, make verbal threats of physical harm to staff and residents. R1 had actual physical aggression to staff and residents. Interventions included:
-provide one to one for safety,
-Address by name, provide time to process information, use simple words, speak before task, and explained step by step what is done and to not startle R1.
-Allow R1 to assist with simple tasks and praise him/tell him good job. Explain each activity and care procedure prior to beginning it.
-Break activities into manageable subtasks; give one instruction at a time.
-introduce themselves at initiation of each interaction and have a daily routine.
-Gently redirect activities when R1 made inappropriate actions
-Provide two choices when decisions were presented.
- R1 was easily overstimulated by too much noise or too many people,
-R1's behaviors may be due to not understanding what was being done. Staff should use soft gentle tone and soothing words when R1 had behaviors.
- modify environment to prevent situations that trigger inappropriate behaviors,
-provide cues and prompts to ensure R1 made

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	00148	A. BUILDING: _____ B. WING _____	C 09/02/2021

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

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2 565	Continued From page 10	2 565		

attempts at own care before assisting him; used with more than one method of communication.
R1 responded best to use two- or three-word sentences or instructions and use hand gesture to point where R1 should be walking to or sitting
- Use one staff member for care as multiple staff around made him agitated; R1 responded well to praise.
-Utilize activity box when R2 becomes restless or agitated.
-During cares provide easy instructions.

During an interview on 9/1/21, at 9:05 a.m. NA-C stated R1 had the cognition of a 1.5-year-old. NA-C stated when R1 asked staff to leave him alone staff were to back away for R1's safety and their own. NA-C stated she has had to intervene when R1 tried to hit other residents. NA-C stated she tried to redirect R1 by providing him a cookie or offering him to go on a walk.

During an interview on 9/1/21, at 9:20 a.m. licensed practical nurse (LPN)-B stated R1 wandered and got aggressive. R1 tried to hit and occasionally got aggrieve with other residents. LPN-B also stated he would offer R1 a cookie to redirect him during cares.

During an interview on 9/1/21, at 12:18 a.m. the director of nursing (DON) stated staff were to use a walkie talkie to communicate where R1 was. The DON stated education had been done on how to react when R1 did not know what to do and that they should try to assist him with tasks and work with R1's dementia to keep him occupied.

During an interview on 9/1/21, at 2:43 p.m. DON stated an expectation that when R1 showed an

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 09/02/2021

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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) COMPLETE DATE
2 565	Continued From page 11	2 565		

escalation or demonstrated aggressive/agitative behaviors, staff were to immediately remove residents from the area to protect them and then attempt to redirect R1. If the redirection or intervention were not effective, the DON stated staff should leave R1 alone and then reapproach R1.

During an interview on 9/1/21, at 3:38 p.m. NA-A stated she worked with R1 often and R1 appeared to like her a lot. NA-A stated she was able to help NA-B and LPN-A redirect R1 when he started to get upset in the hallway then again in the lobby when he pulled down his pants. NA-A stated R1 cooperated with her because of the way she approached R1. NA-A further stated R1 was more cooperative when staff approached him with an upbeat tone, used simple, encouraging words, and told him it won't take long. NA-A also stated R1 did not like to have more than one staff help him as R1 got overwhelmed. NA-A stated when R1 pulled down his pants it indicated R1 had to use the bathroom. NA-A verified R10 was not removed from the scene when R1 was directed directly by him. NA-A also stated R1 agitation may have increased as there were more than one staff who assisted him, and he preferred one staff.

During an interview on 9/1/21, at 3:43 p.m. NA-B stated the cause of R1's agitation could have been the way she approached him. NA-B further stated R1 got worked up after she told R1 to do something. NA-B also stated when she told R1 repeatedly to pull his pants up it made him even more upset. NA-B further stated she felt R1 turned aggressive when LPN-A tried to physically pull his pants up.

During an interview on 9/2/21, at 10:35 a.m.

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 09/02/2021

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

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2 565	Continued From page 12 LPN-B stated he was not aware of what triggered R1 as his behavior could happen suddenly. LPN-B stated it was important to how staff approached R1 and tried to redirect him as his behaviors happen suddenly. During an interview on 9/2/21, at 3:46 p.m. LPN-E stated he received training for R1 and remembered he liked one on one cares, he got agitated if there was more than one person, and that he like short simple sentences. During an interview on 9/2/21, at 3:51 p.m. the DON stated the facility provided training on dementia care for R1. The DON stated R1's behaviors triggered usually when he would not know what to do therefore it was important to intervene prior. The DON further stated she expected staff to keep R1 busy and provide tasks from his habits prior to his dementia. The DON verified not all interventions were care planned for R1. The care plan did not indicate R1 enjoyed his back rubbed, hand holding which is helpful but were not in the care plan. The DON stated education was if those with dementia exhibit behaviors usually was that their needs were not met. The DON stated her expectation would be for staff to follow the care plan, do room checks, and make sure R1's needs were met. The DON stated it was her expectation that if R1 exhibited behaviors that other residents were moved away from the area. The DON stated her expectation was to keep all residents safe. The facility Dementia-Clinical Protocol Policy dated 11/2018, indicated the interdisciplinary care team (IDT) would identify a resident centered care plan to maximize remaining function and quality of life. Residents' needs will be communicated to direct care staff through care	2 565		

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2 565	Continued From page 13	2 565		

plan, conference, communication at shift change and through written documentation. The IDT will adjust intervention and overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical condition or complications, changes in a residents or family wishes and other relevant factors.

The facility Behavioral Health Services Policy dated 2/2019, indicated services are provided as part of the interdisciplinary, person centered approach to care. Staff must promote dignity, autonomy, privacy, socialization, and safety as appropriate for each resident. Staff training include to recognize changes in behavior that indicate psychological distress, implement care plan interventions that appropriate to the initials needs, monitor care plan interventions and report changes in condition.

The facility Behavioral Assessment, Intervention and Monitoring policy dated 3/2019, indicated the facility will provide residents behavioral health services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Residents will have mimical compilations associated with the management of altered or impaired behavior. Behavior can be a way an individual in distress communicates unmet needs, indicate discomfort or express thoughts that cannot be articulated. The IDT team will thoroughly evaluate new or changing behavioral symptoms to identify the cause and address the resident condition. Interventions will be individuals and part of an overall care environment that supports physical functional and psychosocial needs, and strives to understand, prevent, and relieve the resident's distress or loss

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2 565	Continued From page 14 of abilities. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		