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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 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 November 18, 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 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 11/18/2021

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 11/18/21, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct multiple complaint investigations. Pine Haven Care Center was found to not be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5359079C (MN78528); non-compliance cited at F550. The following complaints were found to be unsubstantiated: H5359075C (MN78296) H5359076C (MN78114); however, unrelated non-compliance cited at F697. H5359077C (MN78452) H5359078C (MN77392) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 11/24/2021

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

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F 000	Continued From page 1 your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		12/1/21

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be

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F 550	Continued From page 2 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignified treatment for 1 of 3 residents (R3) reviewed for reported concerns related to staff treatment. Findings include: R3's annual Minimum Data Set (MDS), dated 11/5/21, indicated R3 was cognitively intact and had no hearing deficits. R3's Diagnosis Report dated 11/18/21 indicated R3's primary reason for admission was related to a right femur (upper leg bone) fracture. During interview on 11/18/21, at 10:51 a.m. R3 stated on 11/14/21 nursing assistant (NA)-A had helped her back into her bed after transferring her back from the bathroom and was helping her to get into bed. R3 stated she requested NA-A help her by putting a pillow under her head and NA-A stood over her and yelled at her stating, "Straighten you body out, of course it hurts, if you would just listen to me, you need to straighten out your body." R3 stated, "She was hollering at me and made me feel she wasn't listening to me." During interview on 11/18/21, at 11:14 a.m. registered nurse (RN)-A stated on 11/14/21 she recalled the incident with R3, and stated she was in the room next door to R3 and could hear through the adjoining bathroom NA-A yelling at R3. RN-A stated she could hear NA-A yelling, "If	F 550	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 all residents be treated with dignity. NA-A was removed from the building on 11/14/2021 and will not return to the facility. 2.This has the potential to affect all 66 residents. 3.All direct care staff were educated on the facility resident rights and dignity policy, stress management per National Alliance on Mental Illness (NAMI) guidelines, and communication techniques for communicating effectively with senior care residents for direct care staff on professional and courteous	

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F 550	Continued From page 3 you would just straighten out your body, of course it hurts. You need to just listen to me and straighten out your body." RN-A stated she entered R3's room and NA-A was standing over R3 yelling at her and R3 had her fingers in her ears and R3 stated to NA-A, "See, she hears you too," when R3 saw RN-A enter the room. Review of NA-A's Pool Nursing Assistant Orientation competency checklist, dated 10/20/21, did not include training on resident rights or training on communication with residents. Review of the facility's orientation content for pool nursing assistants did not include content on resident rights. During interview on 11/18/21, at 9:54 a.m. director of nursing (DON) stated the expectation with all staff is they should always treat residents with dignity and not raise their voices with resident's who have no difficulty with hearing. DON stated NA-A's communication with R3 did not meet those expectations. During interview on 11/18/21, at 2:06 p.m. DON stated the facility did not have record of NA-A being trained in resident rights. In references to training on resident rights DON stated, "If it is not in the the orientation binder and not on their orientation checklist we don't have documentation that it happened." Facility policy titled Resident Rights, dated December 2016, indicated "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a) a dignified existence;"	F 550	treatment of the resident beginning on 11/24/2021-11/30/2021. 4.Audits on dignified existence, self-determination, and communication will begin on 11/26/2021 daily x 10, weekly x6 and monthly x 1 to ensure compliance the social worker or designee will be responsible for compliance. Any deviations to the policy will be immediately reported to the DNS and Administrator for immediate review and recommendations. These will be presented at QAPI for on-going review.	
F 697 SS=D	Pain Management	F 697		12/1/21

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CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure acute, severe complaints of knee pain were comprehensively assessed and diagnostics completed in a timely manner to provide comfort and reduce the risk of complications for 1 of 3 residents (R2) reviewed for change of condition.

Findings include:

R2's significant change Minimum Data Set (MDS), dated 9/9/21, identified R2 had cognitive impairment with demonstrated poor short-term memory and required extensive assistance with most of his activities of daily living (ADLs). Further, the MDS outlined R2 received both scheduled and as-needed (PRN) medication for pain relief, and voiced 'occasional' complaints of pain which was rated at "05" out of 10 (being the highest level).

R2's care plan, dated 10/29/21, identified R2 was at risk for pain related to his functional decline, dementia, and the sustained femoral metadiayphsis fracture (knee). The care plan listed a goal for R2 to not have an interruption in normal activities due to his pain along with several interventions to help R2 meet this goal; including evaluating the effectiveness of pain

Provider's Plan of Correction:

1.It is the policy and procedure for Pine Haven Care Center to ensure that all residents are fee of pain and the pain is managed so the resident is as comfortable as possible. Resident R2 pain was assessed and reviewed on 11/18/2021.
2.This has the potential to affect all 66 residents. All residents have been reviewed to ensure they have a pain management plan in place on 11/26/2021.
3.All licensed staff were educated on the facility policy on pain management to assess, monitor, implement appropriate interventions and the new acute progress note for any resident who has new acute, or a change in their pain level beginning on 11/24/2021-11/30/2021.
4.Audits on pain management for resident with new acute or changed level of pain will begin on 11/26/2021 and will be completed daily x 10 Weekly x6 and then monthly x 1 to ensure compliance by the Director of Nursing or Designee. Results will be reviewed by our Quality committee for further recommendation.

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interventions, recording any pain characteristics, and monitoring for any changes in routines or patterns.

During observation on 11/18/21, at 9:38 a.m. R2 was laying in his bed with his eyes closed. R2 appeared comfortable at this time with no obvious grimacing or physical indication of pain present; however, did not respond to verbal stimulation or interact with the surveyor.

On 11/18/21, at 10:16 a.m. R2's family member (FM)-C was contacted for a telephone interview. FM-C was interviewed on 11/18/21 at 11:22 a.m. and stated R2 had resided at the nursing home for several years and had worsening dementia which, at times, lead to him self-transferring and falling. FM-C verified R2 had recently sustained a fracture in his right knee, and she explained, to her understanding, it occurred after R2 self-transferred to the toilet and when he went from a standing position to attempt to sit down, R2's knee and leg made a motion which had caused it to fracture. FM-C expressed immediately following the incident, nobody from the nursing home had "said anything" about it happening; however, she recalled R2 contacting her repeatedly via telephone and voicing "he had pain" in his knee. FM-C reiterated R2 "kept calling me" and complaining of pain in his knee which was unusual and noticeably different than when he had complained of pain in the past. FM-C voiced this continued for another day or so until FM-C requested an x-ray be obtained of the knee. FM-C explained R2's hospice agency then expressed an x-ray was something they would not pay for, which resulted in another potential delay, however, R2 did finally get an x-ray completed on his knee which they found was

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fractured. As a result, R2 was then downgraded to a hoyer lift for transfers which caused him fear as R2 "was scared [of the hoyer lift] and didn't like it." FM-C expressed concern with the amount of time it took to get R2's acute knee pain to get x-rayed as R2 used a mechanical standing lift for transfers, even after the incident on 10/26/21, until they discovered the fracture on 10/29/21.

R2's progress note(s) were reviewed. The following recorded entries were identified:

On 10/26/21, "Nurse was informed by [nursing assistant] that resident twisted his right kneel [sic] why [sic] trying to set [sic] on the toilet. Resident complained of pain, administered Voltaren gel on right kneel [sic]." Later, on 10/26/21, R2 was provided as-needed oxycodone (a narcotic medication) for pain which he rated eight (8) out of 10. The note concluded, "Resident states the medication was initially effective, but currently pain is at 8/10. Writer placed call to hospice to notify and request orders for increased pain relief." In addition, on 10/26/21 at 12:16 p.m. (approximately 7.5 hours after R2 was recorded as twisting his knee) another dose of as-needed oxycodone was administered for pain in his knee.

On 10/26/21, at 1:15 p.m. the record outlined, "New order from Moment's Hospice ... scheduled Oxycodone 2.5 mg [milligrams] by mouth twice daily for pain." The note included a bolded question which read, "Started Acute monitoring if needed[?]" which was answered by staff, "Yes. Acute pain monitoring starting for left [right] knee."

Later on 10/26/21, at 9:43 p.m. (approx. 17 hours after R2 twisted his knee) a note was completed

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F 697	Continued From page 7	F 697		

by registered nurse (RN)-B which recorded, "Resident crying, unable to move right leg due to increased pain in right knee. Stated 'it hurt so bad I want to see the doctor." Oxycodone 0.5 mg given as needed for pain rate at 10 on a 0-10 scale, right leg elevated with pillow in bed. Resident sleeping at the time of this report [9:55 p.m.]."

On 10/28/21 (two days after R2 twisted his knee), R2's FM-C was recorded as asking if hospice would order an x-ray for R2's right knee "due to the increased pain lately and resident having rods and pins in that leg." The note concluded, "Writer stated that hospice would be contacted about this concern and would let wife know the answer." Later on 10/28/21, a note outlined, "Hospice nurse was contacted ... X ray was requested per [FM-C]. Nurse also updated on resident not eating/drinking and having increased pain on the overnight. Hospice nurse to be contacting [FM-C] and will be at the facility around 4 [p.m.] today to see resident." Further, on 10/28/21 at 5:46 p.m. an additional note was recorded which read, "Resident refused supper, continue to complained [sic] of right knee pain. Hospice nurse was at facility to see resident, received the following change in order ... Discontinued Oxycodone 2.5 mg [twice daily], start Oxycodone 2.5 mg [four times daily], and continue Oxycodone 2.5 mg [every six hours as-needed] ... Nurse spoke with hospice nurse concerning resident [FM-C] wanting x-ray on resident right kneel [sic], hospice nurse explained that she have called resident [FM-C] without success, left a voice[mail] for [FM-C] to call back."

On 10/29/21, R2 was recorded "complained of pain 10/10 this morning. Administered his

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	245359	A. BUILDING ______ B. WING ______	C 11/18/2021

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

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F 697	Continued From page 8 scheduled oxycodone." Later, on 10/29/21, a note was recorded which read, "On 10/26/21 [NA] notified hall nurse resident twisted his knee during a toileting transfer. [R2] states he felt a 'pop' ... Hospice was notified and evaluated resident and gave orders for pain control ... [FM-C] wanted an xray of knee ... results were reviewed by writer at [4:15 p.m.] via fax from Mayo ... showing a new acute non-displaced fracture of the distal femoral metadiayphsis ... notified all parties ... review xray results with wife and hospice nurse who states she is reviewing with her medical team for next steps. Resident will be a hoyer lift with assist of [two] to keep non weight bearing status of [right leg] for the time being." R2's medical record was reviewed and lacked evidence R2 had been comprehensively assessed for pain or physical injury until 10/28/21, despite having reported 'twisted' his knee two days prior on 10/26/21, with resulted increased complaints of right knee pain. Further, there was no evidence a diagnostic test (i.e., x-ray) had been sought, ordered, or obtained prior to 10/29/21, despite these increased complaints of pain after a potential physical injury and family repeatedly requesting such diagnostic be obtained. When interviewed on 11/18/21 at 10:53 a.m., licensed practical nurse (LPN)-B stated she recalled R2's knee fracture and described they felt it could have likely been a compression fracture as it "all the sudden" happened and did not result from a fall or other obvious traumatic injury to her knowledge. LPN-B voiced she recalled R2's complaints of knee pain describing the pain and complaints as being "new" for him.	F 697		

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F 697	Continued From page 9 LPN-B reviewed R2's medical record, including the completed progress notes outlining the complaints of pain, and voiced if a resident starts complaining of newly identified pain, or worsening symptoms of pain, it should be assessed and recorded in the progress notes or "risk management" section of the record. LPN-B reviewed these areas of the medical record and verified it lacked evidence R2 had been comprehensively assessed for pain, or the need for potential prompt diagnostic (i.e., x-ray) of such until 10/29/21, which was three days after R2 reportedly 'twisted' his knee and started to complain of severe pain as a result. LPN-B stated the assessment, and corresponding diagnostic process, should have been completed "right away" for R2 and added she had not received any re-education or been alerted to any process changes to ensure a situation like R2's was addressed more timely in the future. LPN-B added, "We need a more clear policy on what to do." During interview on 11/18/21 at 10:51 a.m., registered nurse (RN)-B verified he entered the progress note for R2 (dated 10/26/21) which identified R2 as crying and complaining of pain in his knee. RN-B stated he had heard "in report" R2 had "hit his knee and was having some problems" as a result. RN-B stated he did not pursue more immediate diagnostic intervention, or conduct a comprehensive assessment of the pain, as he had been instructed to talk to "people in the building" before seeking physician input since he was contracted and "from the pool." RN-B voiced he felt the knee pain was addressed "in the morning" of the following day but voiced he recalled R2 as having significant pain and being unable to complete range of motion in the joint	F 697		

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F 697	Continued From page 10	F 697		

adding R2 "couldn't move it." RN-B explained he applied an as-needed topical pain cream and elevated the knee on a pillow to help reduce the pain in the moment, however, reiterated he did not seek physician input or assess the pain as "[his] understanding" was he "cannot call directly," so he passed the information to the oncoming nurse to be addressed. Further, since the incident, RN-B voiced nobody from the nursing home "addressed me on that yet," or provided any re-education on comprehensive pain assessment or seeking potential diagnostic care or treatments.

On 11/18/21 at 1:09 p.m., R2's hospice nurse was contacted via telephone with a request for a return call. However, no return call was received during the abbreviated survey.

On 11/18/21 at 2:11 p.m., the director of nursing (DON) was interviewed and verified she had reviewed R2's medical record. DON acknowledged the lack of a comprehensive pain assessment or timely diagnostic test despite the acute, newly identified pain and voiced the nurses who first handled and received the information "can't just pass it on in report" and need to act on the information. DON explained a comprehensive pain assessment would include the pain intensity, impact on function and current medication use to help ensure all areas are being reviewed and added the lack of documentation made her question how, or if, the pain was assessed or any rationale for not seeking immediate diagnostic imaging. DON verified R2 continued to use the mechanical standing lift for transfers from 10/26/21 until they verified a fracture had been sustained and she acknowledged, had they known sooner of the fracture, they could have

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F 697	Continued From page 11 adjusted his care plan and used a hoyer lift to help prevent further fracture and potentially reduce R2's pain levels. Further, DON voiced all staff, including the contracted nurses, were able to contact the physician and seek care or orders which was important to do as "we need to make him as comfortable as possible." A provided Pain Assessment and Management policy, dated 3/2018, identified a purpose to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs. The policy outlined several steps to help recognize pain in a resident which included, "Verbal expressions such as groaning, crying, screaming," and, "Facial expressions such as grimacing, frowning, clenching of the jaw ..." The policy continued and directed a comprehensive assessment would then include a review of the history of the pain, characteristics of the pain, impact on quality of life and factors which precipitate the pain or exacerbate the pain. The policy continued and directed "significant changes in the level of the resident's pain," and, "prolonged, unrelieved pain despite care plan interventions," should be reported to the physician.	F 697		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: TNGJ11

Dear Administrator:

The above facility was surveyed on November 18, 2021 through November 18, 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.

An equal opportunity employer.

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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	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 11/18/21, a survey was conducted by surveyors from the Minnesota Department of Health (MDH) to determine compliance for state licensure in conjunction with complaint investigation(s): H5359075C (MN78296), H5359076C (MN78114), H5359077C (MN78452), H5359078C (MN77392), H5359079C (MN78528)	2 000		

Minnesota Department of Health

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

Electronically Signed — 11/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1	2 000		

As a result, the following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota 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.

PLEASE DISREGARD THE HEADING OF THE

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure acute, severe complaints of knee pain were comprehensively assessed and diagnostics completed in a timely manner to provide comfort and reduce the risk of complications for 1 of 3 residents (R2) reviewed for change of condition. Findings include: R2's significant change Minimum Data Set	2 830	Corrected	12/1/21

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2 830	Continued From page 3	2 830		

(MDS), dated 9/9/21, identified R2 had cognitive impairment with demonstrated poor short-term memory and required extensive assistance with most of his activities of daily living (ADLs). Further, the MDS outlined R2 received both scheduled and as-needed (PRN) medication for pain relief, and voiced 'occasional' complaints of pain which was rated at "05" out of 10 (being the highest level).

R2's care plan, dated 10/29/21, identified R2 was at risk for pain related to his functional decline, dementia, and the sustained femoral metadiayphsis fracture (knee). The care plan listed a goal for R2 to not have an interruption in normal activities due to his pain along with several interventions to help R2 meet this goal; including evaluating the effectiveness of pain interventions, recording any pain characteristics, and monitoring for any changes in routines or patterns.

During observation on 11/18/21, at 9:38 a.m. R2 was laying in his bed with his eyes closed. R2 appeared comfortable at this time with no obvious grimacing or physical indication of pain present; however, did not respond to verbal stimulation or interact with the surveyor.

On 11/18/21, at 10:16 a.m. R2's family member (FM)-C was contacted for a telephone interview. FM-C was interviewed on 11/18/21 at 11:22 a.m. and stated R2 had resided at the nursing home for several years and had worsening dementia which, at times, lead to him self-transferring and falling. FM-C verified R2 had recently sustained a fracture in his right knee, and she explained, to her understanding, it occurred after R2 self-transferred to the toilet and when he went from a standing position to attempt to sit down,

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2 830	Continued From page 4	2 830		

R2's knee and leg made a motion which had caused it to fracture. FM-C expressed immediately following the incident, nobody from the nursing home had "said anything" about it happening; however, she recalled R2 contacting her repeatedly via telephone and voicing "he had pain" in his knee. FM-C reiterated R2 "kept calling me" and complaining of pain in his knee which was unusual and noticeably different than when he had complained of pain in the past. FM-C voiced this continued for another day or so until FM-C requested an x-ray be obtained of the knee. FM-C explained R2's hospice agency then expressed an x-ray was something they would not pay for, which resulted in another potential delay, however, R2 did finally get an x-ray completed on his knee which they found was fractured. As a result, R2 was then downgraded to a hoyer lift for transfers which caused him fear as R2 "was scared [of the hoyer lift] and didn't like it." FM-C expressed concern with the amount of time it took to get R2's acute knee pain to get x-rayed as R2 used a mechanical standing lift for transfers, even after the incident on 10/26/21, until they discovered the fracture on 10/29/21.

R2's progress note(s) were reviewed. The following recorded entries were identified:

On 10/26/21, "Nurse was informed by [nursing assistant] that resident twisted his right kneel [sic] why [sic] trying to set [sic] on the toilet. Resident complained of pain, administered Voltaren gel on right kneel [sic]." Later, on 10/26/21, R2 was provided as-needed oxycodone (a narcotic medication) for pain which he rated eight (8) out of 10. The note concluded, "Resident states the medication was initially effective, but currently pain is at 8/10. Writer placed call to hospice to notify and request orders for increased pain

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2 830	Continued From page 5	2 830		

relief." In addition, on 10/26/21 at 12:16 p.m. (approximately 7.5 hours after R2 was recorded as twisting his knee) another dose of as-needed oxycodone was administered for pain in his knee.

On 10/26/21, at 1:15 p.m. the record outlined, "New order from Moment's Hospice ... scheduled Oxycodone 2.5 mg [milligrams] by mouth twice daily for pain." The note included a bolded question which read, "Started Acute monitoring if needed[?]" which was answered by staff, "Yes. Acute pain monitoring starting for left [right] knee."

Later on 10/26/21, at 9:43 p.m. (approx. 17 hours after R2 twisted his knee) a note was completed by registered nurse (RN)-B which recorded, "Resident crying, unable to move right leg due to increased pain in right knee. Stated 'it hurt so bad I want to see the doctor." Oxycodone 0.5 mg given as needed for pain rate at 10 on a 0-10 scale, right leg elevated with pillow in bed. Resident sleeping at the time of this report [9:55 p.m.]."

On 10/28/21 (two days after R2 twisted his knee), R2's FM-C was recorded as asking if hospice would order an x-ray for R2's right knee "due to the increased pain lately and resident having rods and pins in that leg." The note concluded, "Writer stated that hospice would be contacted about this concern and would let wife know the answer." Later on 10/28/21, a note outlined, "Hospice nurse was contacted ... X ray was requested per [FM-C]. Nurse also updated on resident not eating/drinking and having increased pain on the overnight. Hospice nurse to be contacting [FM-C] and will be at the facility around 4 [p.m.] today to see resident." Further, on 10/28/21 at 5:46 p.m. an additional note was recorded which read,

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(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
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"Resident refused supper, continue to complained [sic] of right knee pain. Hospice nurse was at facility to see resident, received the following change in order ... Discontinued Oxycodone 2.5 mg [twice daily], start Oxycodone 2.5 mg [four times daily], and continue Oxycodone 2.5 mg [every six hours as-needed] ... Nurse spoke with hospice nurse concerning resident [FM-C] wanting x-ray on resident right kneel [sic], hospice nurse explained that she have called resident [FM-C] without success, left a voice[mail] for [FM-C] to call back."

On 10/29/21, R2 was recorded "complained of pain 10/10 this morning. Administered his scheduled oxycodone." Later, on 10/29/21, a note was recorded which read, "On 10/26/21 [NA] notified hall nurse resident twisted his knee during a toileting transfer. [R2] states he felt a 'pop' ... Hospice was notified and evaluated resident and gave orders for pain control ... [FM-C] wanted an xray of knee ... results were reviewed by writer at [4:15 p.m.] via fax from Mayo ... showing a new acute non-displaced fracture of the distal femoral metadiayphsis ... notified all parties ... review xray results with wife and hospice nurse who states she is reviewing with her medical team for next steps. Resident will be a hoyer lift with assist of [two] to keep non weight bearing status of [right leg] for the time being."

R2's medical record was reviewed and lacked evidence R2 had been comprehensively assessed for pain or physical injury until 10/28/21, despite having reported 'twisted' his knee two days prior on 10/26/21, with resulted increased complaints of right knee pain. Further, there was no evidence a diagnostic test (i.e., x-ray) had been sought, ordered, or obtained prior to

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	00148	A. BUILDING: ______ B. WING ______	C 11/18/2021

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10/29/21, despite these increased complaints of pain after a potential physical injury and family repeatedly requesting such diagnostic be obtained.

When interviewed on 11/18/21 at 10:53 a.m., licensed practical nurse (LPN)-B stated she recalled R2's knee fracture and described they felt it could have likely been a compression fracture as it "all the sudden" happened and did not result from a fall or other obvious traumatic injury to her knowledge. LPN-B voiced she recalled R2's complaints of knee pain describing the pain and complaints as being "new" for him. LPN-B reviewed R2's medical record, including the completed progress notes outlining the complaints of pain, and voiced if a resident starts complaining of newly identified pain, or worsening symptoms of pain, it should be assessed and recorded in the progress notes or "risk management" section of the record. LPN-B reviewed these areas of the medical record and verified it lacked evidence R2 had been comprehensively assessed for pain, or the need for potential prompt diagnostic (i.e., x-ray) of such until 10/29/21, which was three days after R2 reportedly 'twisted' his knee and started to complain of severe pain as a result. LPN-B stated the assessment, and corresponding diagnostic process, should have been completed "right away" for R2 and added she had not received any re-education or been alerted to any process changes to ensure a situation like R2's was addressed more timely in the future. LPN-B added, "We need a more clear policy on what to do."

During interview on 11/18/21 at 10:51 a.m., registered nurse (RN)-B verified he entered the progress note for R2 (dated 10/26/21) which

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identified R2 as crying and complaining of pain in his knee. RN-B stated he had heard "in report" R2 had "hit his knee and was having some problems" as a result. RN-B stated he did not pursue more immediate diagnostic intervention, or conduct a comprehensive assessment of the pain, as he had been instructed to talk to "people in the building" before seeking physician input since he was contracted and "from the pool." RN-B voiced he felt the knee pain was addressed "in the morning" of the following day but voiced he recalled R2 as having significant pain and being unable to complete range of motion in the joint adding R2 "couldn't move it." RN-B explained he applied an as-needed topical pain cream and elevated the knee on a pillow to help reduce the pain in the moment, however, reiterated he did not seek physician input or assess the pain as "[his] understanding" was he "cannot call directly," so he passed the information to the oncoming nurse to be addressed. Further, since the incident, RN-B voiced nobody from the nursing home "addressed me on that yet," or provided any re-education on comprehensive pain assessment or seeking potential diagnostic care or treatments.

On 11/18/21 at 1:09 p.m., R2's hospice nurse was contacted via telephone with a request for a return call. However, no return call was received during the abbreviated survey.

On 11/18/21 at 2:11 p.m., the director of nursing (DON) was interviewed and verified she had reviewed R2's medical record. DON acknowledged the lack of a comprehensive pain assessment or timely diagnostic test despite the acute, newly identified pain and voiced the nurses who first handled and received the information "can't just pass it on in report" and need to act on

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the information. DON explained a comprehensive pain assessment would include the pain intensity, impact on function and current medication use to help ensure all areas are being reviewed and added the lack of documentation made her question how, or if, the pain was assessed or any rationale for not seeking immediate diagnostic imaging. DON verified R2 continued to use the mechanical standing lift for transfers from 10/26/21 until they verified a fracture had been sustained and she acknowledged, had they known sooner of the fracture, they could have adjusted his care plan and used a hoyer lift to help prevent further fracture and potentially reduce R2's pain levels. Further, DON voiced all staff, including the contracted nurses, were able to contact the physician and seek care or orders which was important to do as "we need to make him as comfortable as possible."

A provided Pain Assessment and Management policy, dated 3/2018, identified a purpose to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs. The policy outlined several steps to help recognize pain in a resident which included, "Verbal expressions such as groaning, crying, screaming," and, "Facial expressions such as grimacing, frowning, clenching of the jaw ..." The policy continued and directed a comprehensive assessment would then include a review of the history of the pain, characteristics of the pain, impact on quality of life and factors which precipitate the pain or exacerbate the pain. The policy continued and directed "significant changes in the level of the resident's pain," and, "prolonged, unrelieved pain despite care plan interventions," should be reported to the physician.

Minnesota Department of Health

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2 830	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable polices and procedures pertaining to the timely assessment and evaluation of acute pain. Then inservice direct care staff on pain management and comprehensive assessment; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignified treatment for 1 of 3 residents (R3) reviewed for reported concerns related to staff treatment. Findings include: R3's annual Minimum Data Set (MDS), dated 11/5/21, indicated R3 was cognitively intact and had no hearing deficits. R3's Diagnosis Report dated 11/18/21 indicated R3's primary reason for admission was related to a right femur (upper leg bone) fracture.	21805	Corrected	12/1/21

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During interview on 11/18/21, at 10:51 a.m. R3 stated on 11/14/21 nursing assistant (NA)-A had helped her back into her bed after transferring her back from the bathroom and was helping her to get into bed. R3 stated she requested NA-A help her by putting a pillow under her head and NA-A stood over her and yelled at her stating, "Straighten you body out, of course it hurts, if you would just listen to me, you need to straighten out your body." R3 stated, "She was hollering at me and made me feel she wasn't listening to me."

During interview on 11/18/21, at 11:14 a.m. registered nurse (RN)-A stated on 11/14/21 she recalled the incident with R3, and stated she was in the room next door to R3 and could hear through the adjoining bathroom NA-A yelling at R3. RN-A stated she could hear NA-A yelling, "If you would just straighten out your body, of course it hurts. You need to just listen to me and straighten out your body." RN-A stated she entered R3's room and NA-A was standing over R3 yelling at her and R3 had her fingers in her ears and R3 stated to NA-A, "See, she hears you too," when R3 saw RN-A enter the room.

Review of NA-A's Pool Nursing Assistant Orientation competency checklist, dated 10/20/21, did not include training on resident rights or training on communication with residents. Review of the facility's orientation content for pool nursing assistants did not include content on resident rights.

During interview on 11/18/21, at 9:54 a.m. director of nursing (DON) stated the expectation with all staff is they should always treat residents with dignity and not raise their voices with resident's who have no difficulty with hearing. DON stated

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NA-A's communication with R3 did not meet those expectations.

During interview on 11/18/21, at 2:06 p.m. DON stated the facility did not have record of NA-A being trained in resident rights. In references to training on resident rights DON stated, "If it is not in the the orientation binder and not on their orientation checklist we don't have documentation that it happened."

Facility policy titled Resident Rights, dated December 2016, indicated "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a) a dignified existence;"

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON), or designee, could inservice direct care staff on professional and courteous treatment of the resident; then audit to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.