



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
April 10, 2022

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

RE: CCN: 245359  
Cycle Start Date: January 20, 2022

Dear Administrator:

On February 15, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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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Electronically delivered  
January 26, 2022

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

RE: CCN: 245359  
Cycle Start Date: January 20, 2022

Dear Administrator:

On January 20, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

#### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an E 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 20, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

Pine Haven Care Center Inc

January 26, 2022

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In addition, if substantial compliance with the regulations is not verified by July 20, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

#### INFORMAL DISPUTE RESOLUTION (IDR) / 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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](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.

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

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245359</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINE HAVEN CARE CENTER INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 NORTHWEST 3RD STREET</b> <b>PINE ISLAND, MN 55963</b>		
(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 1/19/22 and 1/20/22 an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  The following complaint was found to be unsubstantiated. H5359082C (MN79254)  The following complaint was found to be unsubstantiated. H5359083C (MN80240). However, as a result of the investigation a deficiency was identified at F656.  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.	F 000			
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	F 656		2/11/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/04/2022

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 656	<p>Continued From page 1</p> <p>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to develop a care plan for alcohol use and a safe plan for being out in the community while consuming alcohol for 1 of 1 resident (R2) reviewed for accidents.</p> <p>Findings include:</p> <p>R2's Admission Record indicated R2 was</p>	F 656	<p>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</p>		

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F 656	<p>Continued From page 2</p> <p>admitted to the facility on 1/21/21, with diagnoses that included alcoholic cirrhosis of liver without ascites and unspecified abnormalities of gait and mobility.</p> <p>R2 quarterly Minimum Data Set (MDS) dated 10/31/21, indicated R2 was cognitively intact, had unclear speech, had no behaviors and was able to understand and be understood.</p> <p>R26's care plan did not identify a plan of care for R2's risk for alcohol use, a safety plan for being out in the community while consuming alcohol, goals, and interventions for alcohol management.</p> <p>During an interview on 1/19/21, at 1:52 p.m. licensed social worker (LSW) stated, "when [R2] first came to the facility we knew [R2] had a history of drinking, he did have an order to have a drink here and he still has that order currently." LSW stated, "We did take the order to have a drink in the facility away because we did notice he was going out to get drinks." LSW stated for the winter the provider told R2 he could have the order back as it was winter, and he would not be going out as much from the facility and that seemed to be a good consensus between the provider and R2. LSW stated he was doing well with it until he had gone out of the facility and came back intoxicated. LSW stated this last fall, his blood alcohol level was beyond the level of being intoxicated. LSW stated R2 decided to stay at the facility as this was a safer plan than moving to an assisted living and the facility would be able to manage his alcohol use. LSW stated the provider had talked to R2 about his drinking numerous times. LSW stated there was not a care plan for his drinking and going out in the community to drink and stated the facility had not</p>	F 656	<p>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.</p> <p>1. Resident R2 care plan was updated to reflect resident's alcohol and linked to resident's Kardex including a safety plan, observation of stressors/triggers, and action if resident is unable to safely use scooter during an outing with a goal that resident will remain free of injury related to substance abuse; on 01/21/2022. Therapy evaluated this resident on 02/01/2022 for use of his electric wheel chair for safety.</p> <p>2. This has the potential to affect all 60 residents.</p> <p>3. All licensed staff were educated on our policy for comprehensive care plans, the use of alcohol in the facility and in the community, and safe plan for the resident while out in the community beginning on 02/03/2022 through 02/10/2022.</p> <p>4. Social services or designee will audit for alcohol use issues, care plan is updated and accurate, interventions are in place, and safe plan for residents while out in the community with history of alcohol abuse. Audits will be completed daily x 10, weekly x 6 and then monthly x1.</p>		

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F 656	<p>Continued From page 3 offered R2 substance abuse services.</p> <p>During an interview on 1/20/22, at 10:57 a.m. the director of nursing (DON) stated she did look and did not see alcohol use addressed in R2 care plan. The DON stated she would have expected alcohol use to be addressed in R2's psychosocial care plan. The DON stated the care plan should include R2's history of alcohol use, what the substance was that was being abused, interventions, supports and treatments. The Don stated she would have expected risk and benefits of alcohol use and going out in the community to be addressed with the resident and documented in the medical record and care plan. The DON stated he had been a heavy drinker for his whole life.</p> <p>The Care Plans, Comprehensive Person-Centered policy revised December 2016 included, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of completion of the resident comprehensive assessments (MDS).</p>	F 656			





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Electronically delivered  
January 26, 2022

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

Re: State Nursing Home Licensing Orders  
Event ID: WCI911

Dear Administrator:

The above facility was surveyed on January 19, 2022 through January 20, 2022 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](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.

Pine Haven Care Center Inc

January 26, 2022

Page 2

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:  <b>00148</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>01/20/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINE HAVEN CARE CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963</b>
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 1/19/22 and 1/20/22, 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.</p> <p>The following complaint was found to be</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  02/04/22
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00148</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2022</b>
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2 000	Continued From page 1 unsubstantiated. H5359082C (MN79254)  The following complaint was found to be unsubstantiated. H5359083C (MN80240). However, as a result of the investigation a deficiency was identified, and licensing orders were issued.  Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.  The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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 interview and document review, the facility failed to develop a care plan for alcohol use and a safe plan for being out in the community while consuming alcohol for 1 of 1 resident (R2) reviewed for accidents.  Findings include:  R2's Admission Record indicated R2 was	2 565	Corrected	2/11/22

Minnesota Department of Health

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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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2 565	<p>Continued From page 2</p> <p>admitted to the facility on 1/21/21, with diagnoses that included alcoholic cirrhosis of liver without ascites and unspecified abnormalities of gait and mobility.</p> <p>R2 quarterly Minimum Data Set (MDS) dated 10/31/21, indicated R2 was cognitively intact, had unclear speech, had no behaviors and was able to understand and be understood.</p> <p>R26's care plan did not identify a plan of care for R2's risk for alcohol use, a safety plan for being out in the community while consuming alcohol, goals, and interventions for alcohol management.</p> <p>During an interview on 1/19/21, at 1:52 p.m. licensed social worker (LSW) stated, "when [R2] first came to the facility we knew [R2] had a history of drinking, he did have an order to have a drink here and he still has that order currently." LSW stated, "We did take the order to have a drink in the facility away because we did notice he was going out to get drinks." LSW stated for the winter the provider told R2 he could have the order back as it was winter, and he would not be going out as much from the facility and that seemed to be a good consensus between the provider and R2. LSW stated he was doing well with it until he had gone out of the facility and came back intoxicated. LSW stated this last fall, his blood alcohol level was beyond the level of being intoxicated. LSW stated R2 decided to stay at the facility as this was a safer plan than moving to an assisted living and the facility would be able to manage his alcohol use. LSW stated the provider had talked to R2 about his drinking numerous times. LSW stated there was not a care plan for his drinking and going out in the community to drink and stated the facility had not offered R2 substance abuse services.</p>	2 565		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00148</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINE HAVEN CARE CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963</b>
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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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2 565	<p>Continued From page 3</p> <p>During an interview on 1/20/22, at 10:57 a.m. the director of nursing (DON) stated she did look and did not see alcohol use addressed in R2 care plan. The DON stated she would have expected alcohol use to be addressed in R2's psychosocial care plan. The DON stated the care plan should include R2's history of alcohol use, what the substance was that was being abused, interventions, supports and treatments. The Don stated she would have expected risk and benefits of alcohol use and going out in the community to be addressed with the resident and documented in the medical record and care plan. The DON stated he had been a heavy drinker for his whole life.</p> <p>The Care Plans, Comprehensive Person-Centered policy revised December 2016 included, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of completion of the resident comprehensive assessments (MDS).</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing could re-educate staff to ensure care plans are developed for identified areas of concern for residents and could develop a system to audit and monitor for compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 565		
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