Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 11, 2025

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

RE: CCN: 245359
Cycle Start Date: December 24, 2024

Dear Administrator:

On February 3, 2025, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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February 11, 2025

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

Re: Reinspection Results
Event ID: L8FF12

Dear Administrator:

On February 3, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
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625 Robert Street North
St. Paul, MN 55155
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January 6, 2025

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

RE: CCN: 245359
Cycle Start Date: December 24, 2024

Dear Administrator:

On December 24, 2024, a survey was completed at your facility by the Minnesota Department of Health, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 March 24, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by June 24, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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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 12/24/2024

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 12/23/24 and 12/24/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H53593181C (MN109223) with a deficiency cited at (F609 and F684). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		1/31/25

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

Electronically Signed | 01/09/2025

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 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure allegations of staff to resident physical abuse were immediately reported to the State Agency (SA) no later than 2 hours after the knowledge of the allegation of abuse, for 1 of 1 residents (R1) reviewed for abuse. Findings include: Facility reported incident (FRI) submitted on 12/18/24 at 9:27 p.m., identified that on 12/18/24 at 4:10 p.m., the facility was notified by registered nurse (RN)-D that R1 stated her leg was sore because someone had kicked her in the leg and pinched her in the groin area. Two finger sized bruises noted to inner thigh. In addition, R1 stated she had been slapped in the cheek and her glasses were knocked off of her face. R1 identified it was a staff member from 2 weeks ago and had not seen staff member since.	F 609	• Abuse allegation reported by R1 was reported and investigated. • All residents have the potential to be affected by the deficient practice. • Provided education to RN-D on 12-26-2024 regarding the need to report abuse immediately. • Alleged perpetrator has been termed and has not worked in the facility since incident was reported. • Provided education to all nursing staff per written and signed for memo 0n 12-19-2024. • ABUSE, NEGLECT, MISTREATMENT AND MISAPPROPRIATION OF RESIDENT PROPERTY policy was reviewed and no changes made. • Provided reeducation on Abuse policy and reporting procedure at Nursing Department meeting on 1-14-2025 and	

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F 609	Continued From page 2 R1's quarterly, Minimum Data Set (MDS), dated 11/13/24, indicated R1's cognition was moderately impaired. R1's diagnoses included dementia. R1's progress note dated 12/18/24 at 6:12 p.m., identified R1 made an accusation of abuse that happened 'a couple weeks ago'. R1 stated it was a female and it happened in the morning. R1 stated the caregiver slapped her on the cheek, knocking her glasses off. The person purposely kicked her in the left leg and pinched at the left inner thigh. At 6:17 p.m., identified R1 had relayed the abuse accusation at 6:05 p.m. Writer called the on-call manager phone at 6:10 p.m., and 6:15 p.m., without connecting to anyone in person. Writer left a voice message describing the basic situation and left a phone number to call back. At 6:22 p.m., R1 was unable to identify her accuser. During an interview on 12/23/24 at 3:29 p.m., RN-D (agency nurse) stated on 12/18/24, at around 6:00 p.m. R1 reported a nurse aide kicked her in the left ankle and pinched her inner thigh a few weeks prior. Shortly after he called the DON, but she did not answer the phone, so he left a message. RN-D could not recall the exact time he had left the message. RN-D stated at 7:00 p.m., the DON called back with the instructions to obtain more information and get a description of the nursing assistant involved. RN-D stated at 7:45 p.m., he spoke with DON to inform her of the description that R1 gave. RN-D thought allegations were reported within 2 hours; RN-D asked surveyor "Does this mean the 2-hour timeframe would be from 2 hours of being reported by the resident or would it be 2 hours when we report it to management?"	F 609	follow up with any staff unable to attend in person by 1-31-2025. • Social Services will track each abuse allegation made by documenting the time it is first reported by the resident/resident representative and the time that it is reported to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law, for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the monthly QAPI committee for trends and determination of areas for improvement. The next QAPI meeting is scheduled for 1-23-25. The committee will provide recommendations if indicated. • Responsible party: Administrator • Date of compliance: 1-31-25	

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F 609	Continued From page 3 During an interview on 12/24/24 at 11:06 a.m., director of nursing (DON) indicated on 12/18/24, RN-D called her phone at 6:13 p.m. and left a voice message. DON had missed the call and did not get the message. At 8:14 p.m. she talked to RN-D, had him collect more information, then reported to the SA. DON indicated RN-D had told her R1 had reported the allegation to him at 4:10 p.m. however was documented in the record a little after 6:00 p.m. When asked what the time period of reporting abuse to the SA was, DON stated, immediately but within 24-hours. DON verified R1's allegation of abuse was reported to the SA on 12/18/24, at 9:27 p.m. which was more than 2-hours of when the allegation was made by R1. During an interview on 12/24/24 at 1:19 p.m., director of social services (DOS)-A stated all abuse allegations should be reported to the SA no later than 2 hours. DOS-A stated she provides all staff upon hire during orientation and staff were required to do abuse training annually. DOS-A indicated she does not educate agency staff of abuse reporting. During an interview on 12/24/24 at 1:47 p.m., administrator stated all allegations of abuse should be reported to the SA no later than 2-hours and verified R1's abuse allegation was reported late. Administrator indicated when the DON had called her on 12/18/24, she had informed the DON allegations of abuse needed to be reported to the SA immediately. During an email correspondance on 12/27/24, at 12:03 p.m., DON indicated she had made an error in the reporting time and stated she had put	F 609		

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F 609	Continued From page 4 4:10 p.m., for the initial report in error and should have been 6:12 p.m. On 12/30/24 at 8:45 a.m., via phone DON stated the report would still be late. Facility policy, "ABUSE, NEGLECT, MISTREATMENT AND MISAPPROPRIATION OF RESIDENT PROPERTY," policy revised 1/2021 identified it is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation...The Nursing Home Administrator or designee will report "abuse" to the state agency per State and Federal requirements ...It is the policy of this facility that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 5 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess and monitor non-pressure related skin injury (bruises) for changes until resolved for 1 of 1 resident (R1), reviewed for abuse. Findings include: R1's admission, Minimum Data Set (MDS), dated 11/13/24, indicated R1's cognition was moderately impaired. R1's care plan dated 4/9/24, identified a focus of R1 had history of potential for/actual impairment to skin integrity however did not identify and/or direct a monitoring plan for the potential or actual impairment. R1's progress note dated 12/17/24 at 10:31 p.m., included R1's skin issues on arms and back still present. Facility reported incident (FRI) submitted on 12/18/24 at 9:27 p.m., identified that on 12/18/24 at 4:10 p.m., the facility was notified by registered nurse (RN)-D that R1 reported allegations of physical abuse. Two finger sized bruises noted to inner thigh. R1's record was reviewed between 12/18/24 through 12/24/24, and did not include a comprehensive skin assessment and monitoring of the bruises identified in the FRI dated 12/18/24.	F 684	• Measuring and monitoring of bruise on left thigh of R1 was completed and added to care plan and TAR or R1 on 12/23/2024. Bruise has resolved/healed. • All residents have the potential to be affected by the deficient practice. All residents will have N ADV skin only evaluation completed. • Policy and procedure for the Prevention and Treatment of Skin Breakdown was revised. • Process change from weekly skin check progress note to N ADV skin only evaluation. • Education on the above policy revisions was provided to all nursing staff on 1-14-2025 and education will be provided to any staff unable to attend in person by 1-31-2025. • Weekly skin inspections audit will be completed weekly x4 weeks and then monthly x 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the monthly QAPI committee for trends and determination of areas for improvement. The next QAPI meeting is scheduled for 1-23-25. The committee will provide recommendations if indicated. • Responsible party: DON or designee • Date of compliance: 1-31-2025	

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F 684	Continued From page 6 During an interview on 12/23/24 at 3:29 p.m., RN-D stated R1 informed him on 12/18/24 of being pinched on inner thigh and kicked on her leg. RN-D indicated he had observed two small bruises on R1's left inner thigh that were about 1/2 inch in diameter and dark purple in color but he did not measure or record the information into R1's medical record. During an observation and interview on 12/23/24 at 12:10 p.m., R1 indicated a staff member had pinched her leaving bruises. She lifted the blanket to show her left inner thigh where there was two purple oval bruises in proximity to each other. The two bruises were each approximately 1.0 cm in diameter. During an interview on 12/23/24 at 1:28 p.m., nursing assistant (NA)-A stated she cared for R1 today and stated around 11:30 a.m., the director of nursing was in R1's room with her looking at R1's two bruises to her inner thigh. NA-A indicated she was not aware of where the bruises came from or how long they had been there. During an interview on 12/24/24 at 8:29 a.m., registered nurse (RN)-C indicated she was the nurse responsible for R1. RN-C explained she was aware R1 had two bruises on her inner thigh becasue someone told her two days ago (12/22/24). RN-C reviewed R1's record and reported there was nothing that identified R1 had bruises or that directed monitoring. RN-C stated she was agency staff and was unaware of the facility process for documenting skin impairments such as bruises. At 11:51 a.m RN-C stated she had just obtained measurements of R1's bruises on left inner thigh today. Measurements were	F 684		

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F 684	Continued From page 7 1.25 cm x 1.25 cm (purple/maroon in color) and 1.5 cm x 1.25 cm purple/maroon in color. During an interview on 12/24/24 at 11:06 a.m., director of nursing (DON) stated RN-D initially found R1's two bruises on her left inner thigh on 12/18/24. DON further stated that no comprehensive skin assessment or monitoring of R1's bruises for healing were in R1's medical record and there should be. A follow-up email correspondance sent by the DON on 12/27/24, at 12:03 p.m., included a a skin ulcer policy. On 12/30/24 at 8:45 a.m., via phone DON indicated the facility did not have a non pressure skin policy, however the skin ulcer policy did direct monitoring of residents skin integrity. Facility policy, "Skin Ulcers," reviewed 7/2022, identified..D.Monitor Skin Integrity: Skin will be observed daily during cares done by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits on the bath/shower day will be performed by the Licensed Nurse. The Care Plan for Skin Integrity is to be evaluated and revised by Nurse Manager based on response, outcomes, and needs of the resident. E.Identified risk factors and problems will be care planned... Review of Skin ulcer Policy did not address the facility process for monitoring and assessing for non-pressure skin integrity concerns.	F 684		

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Electronically delivered
January 6, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: L8FF11

Dear Administrator:

The above facility was surveyed on December 23, 2024, through December 24, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	12/24/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/23/24 and 12/24/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53593181C (MN109223) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	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 assess and monitor non-pressure related skin injury (bruises) for changes until resolved for 1 of 1 resident (R1), reviewed for abuse. Findings include: R1's admission, Minimum Data Set (MDS), dated 11/13/24, indicated R1's cognition was moderately impaired.	2 830	• Measuring and monitoring of bruise on left thigh of R1 was completed and added to care plan and TAR or R1 on 12/23/2024. Bruise has resolved/healed. • All residents have the potential to be affected by the deficient practice. All residents will have N ADV skin only evaluation completed. • Policy and procedure for the Prevention and Treatment of Skin Breakdown was revised. • Process change from weekly skin	1/31/25

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2 830	Continued From page 3 R1's care plan dated 4/9/24, identified a focus of R1 had history of potential for/actual impairment to skin integrity however did not identify and/or direct a monitoring plan for the potential or actual impairment. R1's progress note dated 12/17/24 at 10:31 p.m., included R1's skin issues on arms and back still present. Facility reported incident (FRI) submitted on 12/18/24 at 9:27 p.m., identified that on 12/18/24 at 4:10 p.m., the facility was notified by registered nurse (RN)-D that R1 reported allegations of physical abuse. Two finger sized bruises noted to inner thigh. R1's record was reviewed between 12/18/24 through 12/24/24, and did not include a comprehensive skin assessment and monitoring of the bruises identified in the FRI dated 12/18/24. During an interview on 12/23/24 at 3:29 p.m., RN-D stated R1 informed him on 12/18/24 of being pinched on inner thigh and kicked on her leg. RN-D indicated he had observed two small bruises on R1's left inner thigh that were about 1/2 inch in diameter and dark purple in color but he did not measure or record the information into R1's medical record. During an observation and interview on 12/23/24 at 12:10 p.m., R1 indicated a staff member had pinched her leaving bruises. She lifted the blanket to show her left inner thigh where there was two purple oval bruises in proximity to each other. The two bruises were each approximately 1.0 cm in diameter.	2 830	check progress note to N ADV skin only evaluation. • Education on the above policy revisions was provided to all nursing staff on 1-14-2025 and education will be provided to any staff unable to attend in person by 1-31-2025. • Weekly skin inspections audit will be completed weekly x4 weeks and then monthly x 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the monthly QAPI committee for trends and determination of areas for improvement. The next QAPI meeting is scheduled for 1-23-25. The committee will provide recommendations if indicated. • Responsible party: DON or designee • Date of compliance: 1-31-2025	

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2 830	Continued From page 4 During an interview on 12/23/24 at 1:28 p.m., nursing assistant (NA)-A stated she cared for R1 today and stated around 11:30 a.m., the director of nursing was in R1's room with her looking at R1's two bruises to her inner thigh. NA-A indicated she was not aware of where the bruises came from or how long they had been there. During an interview on 12/24/24 at 8:29 a.m., registered nurse (RN)-C indicated she was the nurse responsible for R1. RN-C explained she was aware R1 had two bruises on her inner thigh becasue someone told her two days ago (12/22/24). RN-C reviewed R1's record and reported there was nothing that identified R1 had bruises or that directed monitoring. RN-C stated she was agency staff and was unaware of the facility process for documenting skin impairments such as bruises. At 11:51 a.m RN-C stated she had just obtained measurements of R1's bruises on left inner thigh today. Measurements were 1.25 cm x 1.25 cm (purple/maroon in color) and 1.5 cm x 1.25 cm purple/maroon in color. During an interview on 12/24/24 at 11:06 a.m., director of nursing (DON) stated RN-D initially found R1's two bruises on her left inner thigh on 12/18/24. DON further stated that no comprehensive skin assessment or monitoring of R1's bruises for healing were in R1's medical record and there should be. A follow-up email correspondance sent by the DON on 12/27/24, at 12:03 p.m., included a a skin ulcer policy. On 12/30/24 at 8:45 a.m., via phone DON indicated the facility did not have a non pressure skin policy, however the skin ulcer policy did direct monitoring of residents skin integrity.	2 830		

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2 830	Continued From page 5 Facility policy, "Skin Ulcers," reviewed 7/2022, identified..D.Monitor Skin Integrity: Skin will be observed daily during cares done by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits on the bath/shower day will be performed by the Licensed Nurse. The Care Plan for Skin Integrity is to be evaluated and revised by Nurse Manager based on response, outcomes, and needs of the resident. E.Identified risk factors and problems will be care planned... Review of Skin ulcer Policy did not address the facility process for monitoring and assessing for non-pressure skin integrity concerns. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents with skin alterations to include bruising to assure they are receiving the necessary treatment/services to prevent bruising and to promote healing of bruising. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for skin alteration development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		