Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 2, 2024

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

RE: CCN: 245359
Cycle Start Date: October 3, 2024

Dear Administrator:

On November 18, 2024, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2024

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

Re: Reinspection Results
Event ID: XV0512

Dear Administrator:

On November 18, 2024, 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 October 3, 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
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2024

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

RE: CCN: 245359
Cycle Start Date: October 3, 2024

Dear Administrator:

On October 3, 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 January 3, 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 April 3, 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) / 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 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

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, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 10/03/2024

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 10/3/24, 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 complaints were reviewed H53596229C (MN105145) and H53599121C (MN107022) with a deficiency cited at F695 and F880. 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 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		11/8/24

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

Electronically Signed | 10/16/2024

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.

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 10/03/2024

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 695	Continued From page 1 Based on observation, interview and document review the facility failed to ensure a physician order for oxygen was transcribed accurately to ensure adequate monitoring and oxygen administration and further failed to deliver oxygen as ordered for 1 of 1 residents (R5) reviewed for oxygen use. Findings include: R5's significant change Minimum Data Set (MDS) dated 8/20/24, indicated R5's cognition was intact, had diagnoses of respiratory failure, obstructive sleep apnea, and had oxygen therapy. MDS did not identify if oxygen therapy was intermittent or continuous. R5's care plan dated 7/26/24, identified a focus that R5 had oxygen therapy related to obstructive sleep apnea (OSA), 2 liters (L) bled into BIPAP at bedtime. Interventions included: monitor for signs and symptoms of respiratory distress and report to medical doctor (MD) PRN (as needed): respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy, confusion, atelectasis (collapse of lung that cause shortness of breath), hemoptysis (coughing up blood), cough pleuritic (lining of lung) pain, accessory muscle usage, skin color, and oxygen settings: O2 (oxygen) via Bilevel Positive Airway Pressure (BIPAP) at bedtime, 2 liters bled into continuous positive airway pressure (CPAP). R5's progress note dated 9/17/24 at 2:06 p.m., R5 was transferred to shower chair, noted to be on oxygen at the time of transfer. After bathing cares oxygen level checked on room air noted to be 82%. Standing House Orders (SHO) for	F 695	1. R5 oxygen order was clarified with provider and updated on 10-3-2024. 2. All residents receiving oxygen have the potential for being affected. 3. All residents receiving Oxygen had their orders reviewed and updated if indicated. 4. Policy and procedure for Oxygen Administration was reviewed. 5. Education for nursing staff on Oxygen Administration and cleaning of O2 equipment policy, specific to Physician initiated Oxygen orders including verification that the physician's order for oxygen includes liter flow, frequency and route and verification that the EMAR in PCC includes monitoring of O2 saturation every shift and weekly change of oxygen tubing, nasal cannula/mask. 6. Oxygen audits on all residents with O2 orders will be completed weekly X 4 weeks, then monthly 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 QAA/QAPI Committee for trends and determination of areas of improvement. The next meeting scheduled for 10/31/24 The Committee will provide recommendations if indicated. 7. Responsible party: Director of Nursing or Designee 8. Date of Compliance: 11/8/2024	

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 10/03/2024

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 695	Continued From page 2	F 695		

hypoxia initiated, respiratory assessment completed, SBAR (communication tool) faxed to the provider.

R5's progress note dated 9/18/24 at 4:49 a.m., O2 2L bled into BIPAP, several warm fingers tried with same answer SPO2 = 74% on 2L.

R5's Treatment Administration Record (TAR) dated September 2024, included the order dated 9/17/24, at 2:30 p.m. that directed to initiate and titrate supplemental O2 at 2L per minute (LPM) via nasal cannula (NC) every shift for dyspnea, hypoxia, O2 sats less than 88%, or acute angina (chest pain). If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in the ER.
-Recorded documentation on 9/17/24 at 2:30 p.m. R5's O2 sats were 90%, no oxygen used, and pulse was not recorded.
-Recorded documentation on 9/17/24 at 11:30 p.m. included a chart code of '9' indicating to see progress note. R5's record did not include a corresponding progress note.
-Recorded documentation on 9/18/24 at 6:00 a.m., R5's O2 sats were 90% on 2 LPM and pulse was 77.

R5's record did not specify if oxygen supplementation was continuous or as needed (PRN) and/or how often R5's O2 saturations should be monitored to ensure saturations were over 88% outside of "every shift".

R5's MD order dated 9/18/24 at 11:59 a.m., included an order for oxygen administration however did not identify if oxygen was supposed to be administered continuously or as needed (PRN). The order directed if persistent hypoxia

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 10/03/2024

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 695	Continued From page 3 (low levels of oxygen in the body) despite 2L nasal canula (NC) oxygen supplementation or if R5 developed tachycardia (pulse of more than 100 beats per minute), or symptoms of somnolence(drowsiness), R5 should be promptly evaluated in the emergency room (ER) given her history of hypercapnia (when carbon dioxide (CO2) levels in the blood increase above 45), anemia, congestive heart failure (CHF) and high risk for venous thromboembolism (VTA) due to immobility. R5's TAR included the aforementioned physician order; the order was discontinued on 9/24/24. Recorded entries on 9/22/24 and 9/23/24 at 6:00 a.m., O2 was not used and O2 sats were 90% and 96% respectively. No entries were recorded on 9/22/24 and 9/23/24 for the 2:30 p.m. and 11:30 p.m. shift entries. Between 9/18/24 through 9/24/24, R5's oxygen levels ranged from 89% to 93% on 2 LPM per NC. R5's advanced practice registered nurse (APRN) recertification visit dated 9/24/24, identified R5 was seen by a provider last week for hypoxia with oxygen levels in the 70's at times overnight and in the early morning. R5 was placed on oxygen on 9/17/24 at 2L per NC which improved her oxygen levels to 94%. R5 was educated on being compliant with her BIPAP. Today nurse reported R5 continued to be on oxygen. Nurse was instructed to get R5 up for breakfast and check O2 saturations. O2 saturations were 87% on room air (RA). New order to continue oxygen 1-2 L to keep O2 above 90% (did not identify if oxygen was to be administered continuously and/or PRN). R5's transcribed physician orders for oxygen	F 695		

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 10/03/2024

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 695	Continued From page 4 administration dated 9/24/24, were inconsistent with the direction in the physician note; the order included "Initiate and titrate supplemental O2 at 2 liters per minute via nasal cannula. As needed for with exertion or continuously for SpO2 less than 90% If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in ER. AND every shift for with exertion or continuously for Spo2 less than 90% If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in ER." R5's TAR included the aforementioned physician order. From 9/25/24 to 9/30/24 R5 was on 2L of oxygen and O2 sats were checked each shift and ranged from 90% to 96%. R5's progress note dated 9/30/24 at 10:48 a.m., identified R5 was on room air, O2 level checked was 84%, started 2L of supplemental O2, rechecked and currently at 93%. R5 APRN follow up visit dated 10/1/24 identified R5 had a diagnosis of oxygen dependent and acute and chronic respiratory failure with hypercapnia. No new oxygen orders identified. R5's TAR dated October 2024 indicated from 10/1/24 to 10/3/24, R5 was on 2L of O2 per NC every shift and oxygen saturations ranged from 91 to 96%. R5's Kardex dated 10/4/24, identified oxygen with exertion or continuously for SPO2 less than 90%, discontinue if SPO2 is greater than 94%. During an observation and interview on 10/3/24 at 10:26 a.m., R5 stated when she woke up at 8:45	F 695		

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 10/03/2024

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 695	Continued From page 5 a.m. the staff took her CPAP off and never put her oxygen back on. R5 indicated she had been without oxygen for the last two hours and stated, I guess I should put my call light to have someone put it back on me since I can't reach it. R5's oxygen concentrator was running at 1.5 liters and a green hose came from the concentrator that was hooked to the CPAP machine on her bedside table that was out of R5's reach. R5 turned her call light on. R5 stated she was supposed to have her oxygen on at all times and received oxygen through her CPAP at night. During an observation and interview on 10/3/24 at 10:37 a.m., nursing assistant (NA)-C walked into R5's room to answer the call light. R5 told NA-C that she needed her oxygen put back on. NA-C placed the pulse oximeter on R5's left index finger which read 87%. NA-C turned the oxygen concentrator off and disconnected the green oxygen tubing from the CPAP machine and hooked the nasal canula to the green tubing, handed R5 the nasal cannula, and R5 put it on. NA-C then turned the oxygen concentrator back on. At 10:39 a.m. NA-C checked R5 oxygen saturations again which read 84%. NA-C directed R5 to take some deep breaths through her nose which R5 complied with. At 10:39 a.m. oxygen saturations were checked and read 91%. NA-C stated sometimes staff forget to put R5's oxygen back on and R5 would put the call light on to have the oxygen put on. During an observation and interview on 10/3/24 at 10:46 a.m., licensed practical nurse (LPN)-B stated she was told that no one put R5's oxygen on this morning and her oxygen levels had dropped to 84%. LPN-B checked R5's oxygen levels which read 96% on 1.5 L of oxygen. LPN-B	F 695		

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 10/03/2024

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 695	Continued From page 6 asked R5 how many liters of oxygen she should be on and R5 replied usually 1.5 to 2 liters. LPN-B then turned the rate of flow up to 2 liters and assessed R5's respiratory status. LPN-B stated R5 had no shortness of breath, difficulty breathing, oxygen and pulse was within normal limits. R5 stated she didn't feel any different from when she had the oxygen off. LPN-B stated she thought R5 was supposed to have her oxygen on continuously but would have to look into it. During an interview on 10/3/24 at 3:04 p.m., registered nurse (RN)-B stated she put the oxygen order in for R5 on 9/24/24. RN-B indicated she had not transcribed the oxygen order as per the physician visit note dated 9/24/24. RN-B stated she had a different understanding of what the doctor said that day and verified she did not call a provider to clarify R5's oxygen orders. RN-B put the orders in per her discussion with the provider and did not fill out a verbal order for the provider to sign. During an interview on 10/3/24 at 4:24 p.m., director of nursing (DON) stated when a provider puts a new oxygen order in for a resident the nurse transcribing it should enter it as the provider ordered. DON further stated if there were questions about the order the provider would have to be called for clarification. DON indicated R5's oxygen order was entered incorrectly on 9/24/24 and the provider was not notified. DON stated R5 oxygen order should have been to ensure R5 was receiving 1- 2 liters to keep sats above 90%. DON indicated when R5's CPAP was removed in the AM a respiratory assessment should be completed and oxygen orders should be implemented as ordered.	F 695		

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 10/03/2024

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 695	Continued From page 7 Facility policy, "Oxygen Administration and cleaning of O2 equipment," revised 9/16/21 identified the purpose was to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues ... Routine if Physician initiated 02 orders. 1. Review physician order for the number of liters and frequency. 2. Gather supplies as above: Concentrator, tubing, nasal cannula and 02 signs. 3. Label MAR for recording 02 sats q shift. 4. Document in nurses notes and notify family. Facility policy, "Medication and Treatment Orders," dated 12/2017, identified Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. 4. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. 5. The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used. 6. The staff and practitioner shall use only approved abbreviations and symbols when ordering and/or charting medications. 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. 8. Verbal orders must be signed by the prescriber at	F 695		

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 10/03/2024

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 695	Continued From page 8 his or her next visit. 9. Orders for medications must include: a.Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.). 10. Only authorized personnel shall call in orders for prescribed medications to the pharmacy. 11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. 12. Orders not specifying the number of doses, or duration of medication, shall be subject to automatic stop orders. a. Drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. b. One (1) day prior to the date the stop order is to become effective, the nurse supervisor/charge nurse on duty must contact the prescriber or attending physician to determine if the medication is to be continued. 13. Orders for withholding food prior to a test or treatment ("NPO") shall be made by the attending physician as necessary. a. Nursing will use a diet change notification form to inform the food services staff when it is necessary to hold the resident's food tray, and when the tray delivery can resume. b. Nursing staff will review the overall situation for a resident for whom one or more meals is to be held to ensure that any related issues are addressed (e.g., adjustment of insulin doses, maintenance of adequate hydration). 14. Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring. a.	F 695		

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 10/03/2024

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 695	Continued From page 9 The attending physician must periodically record in the progress notes the results of the laboratory monitoring and the review for potential complications.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		11/8/24

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 10/03/2024

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 880	Continued From page 10 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP) were implemented for management of wound care to reduce the risk of infection to others for 1 of 1 resident (R6) who	F 880	1. R6 dressing change was divided into a 2-part procedure on 10-3-2024. One part on AM shift and one part on PM shift to limit amount of time staff are donned in PPE. Coaching was completed with LPN	

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 10/03/2024

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 880	Continued From page 11 was reviewed for infection control and prevention. Findings include: R6's diagnosis list printed on 10/3/24 included; bullous pemphigoid (rare skin condition causing large, fluid filled blisters that appear on the abdomen, chest, upper and lower extremities, groin, and/or axillary region), chronic venous hypertension with ulcer of bilateral lower extremities, non-pressure chronic ulcer of left calf with unspecified severity, non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin, and subacute osteomyelitis of the right ankle and foot. R6's admission minimum data set (MDS) dated 8/16/24 indicated R6 had a brief interview for mental status (BIMS) of 15 (score of 13-15 indicates individual is cognitively intact), 2 diabetic foot ulcers, and open lesions that required pressure reducing devices in bed, in the chair, application of ointments/medications, application of nonsurgical dressings, and application of dressings to feet. R6's admission care plan dated 8/9/24 indicated R6 had actual impairment to skin integrity of the left heel, bilateral lower extremities, and groin related to neuropathic diabetic ulcer, venous ulcers, bullous pemphigoid, and moisture-associated skin damage (MASD). Interventions included, encourage good nutrition/hydration and to follow facility protocols for treatment of injury. R6's active physician orders as of 10/3/24, directed the following wound care treatment: -Bullous pemphigoid wound care: cleanse with	F 880	A regarding the need for PPE during the entire procedure along with a discussion about barriers to achieve this. 2. All residents on EBP have the potential to be affected. 3. EBP Policy and Procedure was reviewed and revised to include: • If staff are not tolerating PPE (too warm, etc.) they are encouraged to doff the PPE and take a break from the cares/procedure being performed if safe to do so. Then don clean PPE and resume the cares/procedure. • When appropriate procedures/cares will be scheduled to be performed in increments less than 60 min. 4. Education for staff on revised EBP Policy and Procedure and donning and doffing of PPE. 5. EBP and PPE audits will be completed daily for 2 weeks (Monday-Friday), then weekly X 4weeks, then monthly 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 QAA/QAPI Committee for trends and determination of areas of improvement. The next meeting scheduled for 10/31/24. The Committee will provide recommendations if indicated. 6. Responsible party: Director of Nursing or Designee 7. Date of Compliance: 11/8/2024	

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 10/03/2024

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 880	Continued From page 12 acetic acid, pat dry, apply Clobetasol 0.05% cream to wound bed, apply hydrogel gauze over cream in wound bed and cover with an army battle dressing (ABD-type of gauze to treat large heavy draining wounds) on day shift Monday, Wednesday, and Friday. -Complete weekly skin inspection progress note for resident skin check. Check skin every Monday evening shift. -Neuropathic heel wound care: cleanse the area with Vashe wound cleanser, pat dry, apply Iodosorb to the entire wound bed. Do not apply to intact skin, cover with ABD pad with hole cut around the ulcer and cover with another ABD pad. Change daily and as needed. Apply Prevalon boots on day shift. -Venous ulcers on bilateral legs, cleanse with acetic acid only to wound beds, gently pat dry, apply Aquacel Ag+ ribbon to wound beds only, and cover with ABD and secure with Kerlix on day shift. R6's provider note dated 9/23/24 indicated R6 has extensive wounds throughout 90 percent of his body, including his back. Wound care was discussed with the facility nurse and facility nurse to apply collagen to his legs, covered with calcium alginate with silver, and secured with absorbent gauze dressing or Opti Lock if obtained. For R6's bilateral hip area, would like to utilize impregnated gauze so these will stay moist and prevent sticking to skin. Wound care is quite extensive and takes 60-120 minutes. R6's Kardex (reference document that provides a brief overview of each resident) printed on 10/3/24 indicated that R6 is on EBP due to a PEG tube site, bilateral nephrology tubes, and wounds.	F 880		

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 10/03/2024

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 880	Continued From page 13 R6's treatment administration record dated 10/1/24-10/31/24 identified R6's wound care was completed per provider orders. During observation on 10/3/24 at 10:51 a.m., upon entrance to R6's room, there was an orange sign taped to the wall with two stop sign icons in the top right and left corner of the sign. The sign indicated Enhanced Barrier Precautions, everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff must also: wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, and tracheostomy. Wound care: any skin opening requiring a dressing. Upon entering R6's room, licensed practical nurse (LPN)-A was in the process of changing R6's left lower extremity dressings. LPN-A applied Vaseline, ABD pads, and a compression wrap to R6's left lower extremity per the wound care orders. LPN-A was not wearing a gown as directed by the EBP sign outside R6's door and the facilities infection prevention policy, only gloves were worn. On 10/3/24 at 2:58 p.m., nursing assistant (NA)-A stated appropriate indications when staff are to use personal protectice equipment (PPE) and the donning/doffing process for using PPE. NA-A stated the order of donning PPE starting with the mask, gown, then gloves. NA-A stated PPE is donned before entering and doffed in the room before exiting. Hands to be washed before entering and after exiting the room.	F 880		

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 10/03/2024

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 880	Continued From page 14 10/3/24 at 3:00 p.m., NA-A stated training was done by in-services and online education. Once completed, staff were to sign a paper document that indicated the content was reviewed. During interview on 10/3/24 at 12:43 p.m., LPN-A stated the gown was removed while providing care to R6 since it "got hot" in R6's room. Further, LPN-A stated EBP precautions were in place to prevent the spread of infection. LPN-A discussed how to don and doff PPE appropriately and stated EBP training was completed online. LPN-A indicated that a resident on EBP would have a sign outside their door and an isolation cart with PPE outside the resident's room indicating the necessary precautions. During interview on 10/3/24 at 1:16 p.m., registered nurse (RN)-A stated staff received EBP and TBP training at the time of hire by online education, Educare (education platform), and facility/staff meetings/in-services. RN-A indicated that the most recent EBP content was provided to staff after the 2024 recertification survey as part of the plan of correction (POC) that was approved. RN-A also stated in some situations on the spot training for staff was completed. On 10/3/24 at 1:21 p.m., RN-A stated staff were expected to be able to know why EBP was in place for any resident, be aware of the signage for EBP, and how to don and doff PPE appropriately. On 10/3/24 at 4:29 p.m., DON stated staff were made aware of residents on EBP with signage on or near the resident's door, PPE cart, and the Kardex. DON stated staff were expected to wear gowns, gloves, masks, and eye protection if	F 880		

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 10/03/2024

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 880	Continued From page 15 necessary. DON also stated the purpose of EBP and expected staff to follow the policy. Facility policy named Infection Control Transmission/Isolation Precautions revised on 3/2024 indicated: Enhanced Barrier Isolation Precautions: Example; Multidrug-Resistant Organisms (MDRO), Methicillin-resistant staphylococcus aureus (MRSA) Vancomycin-resistant Enterococcus (VRE) Carbapenem-resistant Enterobacteriaceae (CRE). Enhanced Barrier Precautions expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Face protection may also be needed if performing activity with risk of splash or spray. Enhanced Barrier Precautions apply to residents with any of the following: - Infection or colonization with a novel or targeted MDRO when Contact Precautions do not apply. - Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. Wounds include chronic wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing, do not require EBP. Examples of high-contact resident care activities requiring gown and glove use for Enhanced	F 880		

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 10/03/2024

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 880	Continued From page 16 Barrier Precautions include: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. Gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: XV0511

Dear Administrator:

The above facility was surveyed on October 3, 2024 through October 3, 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	10/03/2024

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 10/3/24, 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 and	2 000		

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 _____	10/03/2024

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	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53596229C (MN105145) and H53599121C (MN107022) with a licensing order issued at 0830 and 1380. 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	2 000		

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 _____	10/03/2024

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	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	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 a physician order for oxygen was transcribed accurately to ensure adequate monitoring and oxygen administration and further failed to deliver oxygen as ordered for 1 of 1 residents (R5) reviewed for oxygen use. Findings include: R5's significant change Minimum Data Set (MDS)	2 830	corrected	11/8/24

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 _____	10/03/2024

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
2 830	Continued From page 3 dated 8/20/24, indicated R5's cognition was intact, had diagnoses of respiratory failure, obstructive sleep apnea, and had oxygen therapy. MDS did not identify if oxygen therapy was intermittent or continuous. R5's care plan dated 7/26/24, identified a focus that R5 had oxygen therapy related to obstructive sleep apnea (OSA), 2 liters (L) bled into BIPAP at bedtime. Interventions included: monitor for signs and symptoms of respiratory distress and report to medical doctor (MD) PRN (as needed): respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy, confusion, atelectasis (collapse of lung that cause shortness of breath), hemoptysis (coughing up blood), cough pleuritic (lining of lung) pain, accessory muscle usage, skin color, and oxygen settings: O2 (oxygen) via Bilevel Positive Airway Pressure (BIPAP) at bedtime, 2 liters bled into continuous positive airway pressure (CPAP). R5's progress note dated 9/17/24 at 2:06 p.m., R5 was transferred to shower chair, noted to be on oxygen at the time of transfer. After bathing cares oxygen level checked on room air noted to be 82%. Standing House Orders (SHO) for hypoxia initiated, respiratory assessment completed, SBAR (communication tool) faxed to the provider. R5's progress note dated 9/18/24 at 4:49 a.m., O2 2L bled into BIPAP, several warm fingers tried with same answer SPO2 = 74% on 2L. R5's Treatment Administration Record (TAR) dated September 2024, included the order dated 9/17/24, at 2:30 p.m. that directed to initiate and titrate supplemental O2 at 2L per minute (LPM)	2 830		

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 _____	10/03/2024

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
2 830	Continued From page 4 via nasal cannula (NC) every shift for dyspnea, hypoxia, O2 sats less than 88%, or acute angina (chest pain). If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in the ER. -Recorded documentation on 9/17/24 at 2:30 p.m. R5's O2 sats were 90%, no oxygen used, and pulse was not recorded. -Recorded documentation on 9/17/24 at 11:30 p.m. included a chart code of '9' indicating to see progress note. R5's record did not include a corresponding progress note. -Recorded documentation on 9/18/24 at 6:00 a.m., R5's O2 sats were 90% on 2 LPM and pulse was 77. R5's record did not specify if oxygen supplementation was continuous or as needed (PRN) and/or how often R5's O2 saturations should be monitored to ensure saturations were over 88% outside of "every shift". R5's MD order dated 9/18/24 at 11:59 a.m., included an order for oxygen administration however did not identify if oxygen was supposed to be administered continuously or as needed (PRN). The order directed if persistent hypoxia (low levels of oxygen in the body) despite 2L nasal canula (NC) oxygen supplementation or if R5 developed tachycardia (pulse of more than 100 beats per minute), or symptoms of somnolence(drowsiness), R5 should be promptly evaluated in the emergency room (ER) given her history of hypercapnia (when carbon dioxide (CO2) levels in the blood increase above 45), anemia, congestive heart failure (CHF) and high risk for venous thromboembolism (VTA) due to immobility. R5's TAR included the aforementioned physician	2 830		

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 _____	10/03/2024

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
2 830	Continued From page 5 order; the order was discontinued on 9/24/24. Recorded entries on 9/22/24 and 9/23/24 at 6:00 a.m., O2 was not used and O2 sats were 90% and 96% respectively. No entries were recorded on 9/22/24 and 9/23/24 for the 2:30 p.m. and 11:30 p.m. shift entries. Between 9/18/24 through 9/24/24, R5's oxygen levels ranged from 89% to 93% on 2 LPM per NC. R5's advanced practice registered nurse (APRN) recertification visit dated 9/24/24, identified R5 was seen by a provider last week for hypoxia with oxygen levels in the 70's at times overnight and in the early morning. R5 was placed on oxygen on 9/17/24 at 2L per NC which improved her oxygen levels to 94%. R5 was educated on being compliant with her BIPAP. Today nurse reported R5 continued to be on oxygen. Nurse was instructed to get R5 up for breakfast and check O2 saturations. O2 saturations were 87% on room air (RA). New order to continue oxygen 1-2 L to keep O2 above 90% (did not identify if oxygen was to be administered continuously and/or PRN). R5's transcribed physician orders for oxygen administration dated 9/24/24, were inconsistent with the direction in the physician note; the order included "Initiate and titrate supplemental O2 at 2 liters per minute via nasal cannula. As needed for with exertion or continuously for SpO2 less than 90% If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in ER. AND every shift for with exertion or continuously for Spo2 less than 90% If persistent hypoxia despite 2L NC oxygen, tachycardia, or somnolence patient should be promptly evaluated in ER." R5's TAR included the aforementioned physician	2 830		

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 _____	10/03/2024

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
2 830	Continued From page 6 order. From 9/25/24 to 9/30/24 R5 was on 2L of oxygen and O2 sats were checked each shift and ranged from 90% to 96%. R5's progress note dated 9/30/24 at 10:48 a.m., identified R5 was on room air, O2 level checked was 84%, started 2L of supplemental O2, rechecked and currently at 93%. R5 APRN follow up visit dated 10/1/24 identified R5 had a diagnosis of oxygen dependent and acute and chronic respiratory failure with hypercapnia. No new oxygen orders identified. R5's TAR dated October 2024 indicated from 10/1/24 to 10/3/24, R5 was on 2L of O2 per NC every shift and oxygen saturations ranged from 91 to 96%. R5's Kardex dated 10/4/24, identified oxygen with exertion or continuously for SPO2 less than 90%, discontinue if SPO2 is greater than 94%. During an observation and interview on 10/3/24 at 10:26 a.m., R5 stated when she woke up at 8:45 a.m. the staff took her CPAP off and never put her oxygen back on. R5 indicated she had been without oxygen for the last two hours and stated, I guess I should put my call light to have someone put it back on me since I can't reach it. R5's oxygen concentrator was running at 1.5 liters and a green hose came from the concentrator that was hooked to the CPAP machine on her bedside table that was out of R5's reach. R5 turned her call light on. R5 stated she was supposed to have her oxygen on at all times and received oxygen through her CPAP at night. During an observation and interview on 10/3/24 at 10:37 a.m., nursing assistant (NA)-C walked into	2 830		

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 _____	10/03/2024

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
2 830	Continued From page 7 R5's room to answer the call light. R5 told NA-C that she needed her oxygen put back on. NA-C placed the pulse oximeter on R5's left index finger which read 87%. NA-C turned the oxygen concentrator off and disconnected the green oxygen tubing from the CPAP machine and hooked the nasal canula to the green tubing, handed R5 the nasal cannula, and R5 put it on. NA-C then turned the oxygen concentrator back on. At 10:39 a.m. NA-C checked R5 oxygen saturations again which read 84%. NA-C directed R5 to take some deep breaths through her nose which R5 complied with. At 10:39 a.m. oxygen saturations were checked and read 91%. NA-C stated sometimes staff forget to put R5's oxygen back on and R5 would put the call light on to have the oxygen put on. During an observation and interview on 10/3/24 at 10:46 a.m., licensed practical nurse (LPN)-B stated she was told that no one put R5's oxygen on this morning and her oxygen levels had dropped to 84%. LPN-B checked R5's oxygen levels which read 96% on 1.5 L of oxygen. LPN-B asked R5 how many liters of oxygen she should be on and R5 replied usually 1.5 to 2 liters. LPN-B then turned the rate of flow up to 2 liters and assessed R5's respiratory status. LPN-B stated R5 had no shortness of breath, difficulty breathing, oxygen and pulse was within normal limits. R5 stated she didn't feel any different from when she had the oxygen off. LPN-B stated she thought R5 was supposed to have her oxygen on continuously but would have to look into it. During an interview on 10/3/24 at 3:04 p.m., registered nurse (RN)-B stated she put the oxygen order in for R5 on 9/24/24. RN-B indicated she had not transcribed the oxygen order as per the physician visit note dated	2 830		

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 _____	10/03/2024

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
2 830	Continued From page 8 9/24/24. RN-B stated she had a different understanding of what the doctor said that day and verified she did not call a provider to clarify R5's oxygen orders. RN-B put the orders in per her discussion with the provider and did not fill out a verbal order for the provider to sign. During an interview on 10/3/24 at 4:24 p.m., director of nursing (DON) stated when a provider puts a new oxygen order in for a resident the nurse transcribing it should enter it as the provider ordered. DON further stated if there were questions about the order the provider would have to be called for clarification. DON indicated R5's oxygen order was entered incorrectly on 9/24/24 and the provider was not notified. DON stated R5 oxygen order should have been to ensure R5 was receiving 1- 2 liters to keep sats above 90%. DON indicated when R5's CPAP was removed in the AM a respiratory assessment should be completed and oxygen orders should be implemented as ordered. Facility policy, "Oxygen Administration and cleaning of O2 equipment," revised 9/16/21 identified the purpose was to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues ... Routine if Physician initiated 02 orders. 1. Review physician order for the number of liters and frequency. 2. Gather supplies as above: Concentrator, tubing, nasal cannula and 02 signs. 3. Label MAR for recording 02 sats q shift. 4. Document in nurses notes and notify family. Facility policy, "Medication and Treatment Orders," dated 12/2017, identified Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon	2 830		

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 _____	10/03/2024

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
2 830	Continued From page 9 the written order of a person duly licensed and authorized to prescribe such medications in this state. 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. 4. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. 5. The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used. 6. The staff and practitioner shall use only approved abbreviations and symbols when ordering and/or charting medications. 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. 8. Verbal orders must be signed by the prescriber at his or her next visit. 9. Orders for medications must include: a.Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.). 10. Only authorized personnel shall call in orders for prescribed medications to the pharmacy. 11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. 12. Orders not specifying the number of doses, or duration of medication, shall be subject	2 830		

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 _____	10/03/2024

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
2 830	Continued From page 10 to automatic stop orders. a. Drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. b. One (1) day prior to the date the stop order is to become effective, the nurse supervisor/charge nurse on duty must contact the prescriber or attending physician to determine if the medication is to be continued. 13. Orders for withholding food prior to a test or treatment ("NPO") shall be made by the attending physician as necessary. a. Nursing will use a diet change notification form to inform the food services staff when it is necessary to hold the resident's food tray, and when the tray delivery can resume. b. Nursing staff will review the overall situation for a resident for whom one or more meals is to be held to ensure that any related issues are addressed (e.g., adjustment of insulin doses, maintenance of adequate hydration). 14. Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring. a. The attending physician must periodically record in the progress notes the results of the laboratory monitoring and the review for potential complications. Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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 _____	10/03/2024

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
21380	Continued From page 11	21380		
21380	MN Rule 4658.0800 Subp. 2 Infection Control; Direction of Program Subp. 2. Direction of program. A nursing home must assign one person, either a registered nurse or a physician, the responsibility of directing infection control activities in the nursing home. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP) were implemented for management of wound care to reduce the risk of infection to others for 1 of 1 resident (R6) who was reviewed for infection control and prevention. Findings include: R6's diagnosis list printed on 10/3/24 included; bullous pemphigoid (rare skin condition causing large, fluid filled blisters that appear on the abdomen, chest, upper and lower extremities, groin, and/or axillary region), chronic venous hypertension with ulcer of bilateral lower extremities, non-pressure chronic ulcer of left calf with unspecified severity, non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin, and subacute osteomyelitis of the right ankle and foot. R6's admission minimum data set (MDS) dated 8/16/24 indicated R6 had a brief interview for mental status (BIMS) of 15 (score of 13-15 indicates individual is cognitively intact), 2 diabetic foot ulcers, and open lesions that required pressure reducing devices in bed, in the chair, application of ointments/medications, application	21380	corrected	11/8/24

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 _____	10/03/2024

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
21380	Continued From page 12 of nonsurgical dressings, and application of dressings to feet. R6's admission care plan dated 8/9/24 indicated R6 had actual impairment to skin integrity of the left heel, bilateral lower extremities, and groin related to neuropathic diabetic ulcer, venous ulcers, bullous pemphigoid, and moisture-associated skin damage (MASD). Interventions included, encourage good nutrition/hydration and to follow facility protocols for treatment of injury. R6's active physician orders as of 10/3/24, directed the following wound care treatment: -Bullous pemphigoid wound care: cleanse with acetic acid, pat dry, apply Clobetasol 0.05% cream to wound bed, apply hydrogel gauze over cream in wound bed and cover with an army battle dressing (ABD-type of gauze to treat large heavy draining wounds) on day shift Monday, Wednesday, and Friday. -Complete weekly skin inspection progress note for resident skin check. Check skin every Monday evening shift. -Neuropathic heel wound care: cleanse the area with Vashe wound cleanser, pat dry, apply Iodosorb to the entire wound bed. Do not apply to intact skin, cover with ABD pad with hole cut around the ulcer and cover with another ABD pad. Change daily and as needed. Apply Prevalon boots on day shift. -Venous ulcers on bilateral legs, cleanse with acetic acid only to wound beds, gently pat dry, apply Aquacel Ag+ ribbon to wound beds only, and cover with ABD and secure with Kerlix on day shift. R6's provider note dated 9/23/24 indicated R6	21380		

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 _____	10/03/2024

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
21380	Continued From page 13 has extensive wounds throughout 90 percent of his body, including his back. Wound care was discussed with the facility nurse and facility nurse to apply collagen to his legs, covered with calcium alginate with silver, and secured with absorbent gauze dressing or Opti Lock if obtained. For R6's bilateral hip area, would like to utilize impregnated gauze so these will stay moist and prevent sticking to skin. Wound care is quite extensive and takes 60-120 minutes. R6's Kardex (reference document that provides a brief overview of each resident) printed on 10/3/24 indicated that R6 is on EBP due to a PEG tube site, bilateral nephrology tubes, and wounds. R6's treatment administration record dated 10/1/24-10/31/24 identified R6's wound care was completed per provider orders. During observation on 10/3/24 at 10:51 a.m., upon entrance to R6's room, there was an orange sign taped to the wall with two stop sign icons in the top right and left corner of the sign. The sign indicated Enhanced Barrier Precautions, everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff must also: wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, and tracheostomy. Wound care: any skin opening requiring a dressing. Upon entering R6's room, licensed practical nurse (LPN)-A was in the process of changing R6's left lower extremity dressings. LPN-A applied Vaseline, ABD pads, and a compression wrap to R6's left lower extremity per the wound care orders. LPN-A was	21380		

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 _____	10/03/2024

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
21380	Continued From page 14 not wearing a gown as directed by the EBP sign outside R6's door and the facilities infection prevention policy, only gloves were worn. On 10/3/24 at 2:58 p.m., nursing assistant (NA)-A stated appropriate indications when staff are to use personal protectice equipment (PPE) and the donning/doffing process for using PPE. NA-A stated the order of donning PPE starting with the mask, gown, then gloves. NA-A stated PPE is donned before entering and doffed in the room before exiting. Hands to be washed before entering and after exiting the room. 10/3/24 at 3:00 p.m., NA-A stated training was done by in-services and online education. Once completed, staff were to sign a paper document that indicated the content was reviewed. During interview on 10/3/24 at 12:43 p.m., LPN-A stated the gown was removed while providing care to R6 since it "got hot" in R6's room. Further, LPN-A stated EBP precautions were in place to prevent the spread of infection. LPN-A discussed how to don and doff PPE appropriately and stated EBP training was completed online. LPN-A indicated that a resident on EBP would have a sign outside their door and an isolation cart with PPE outside the resident's room indicating the necessary precautions. During interview on 10/3/24 at 1:16 p.m., registered nurse (RN)-A stated staff received EBP and TBP training at the time of hire by online education, Educare (education platform), and facility/staff meetings/in-services. RN-A indicated that the most recent EBP content was provided to staff after the 2024 recertification survey as part of the plan of correction (POC) that was approved. RN-A also stated in some situations on	21380		

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 _____	10/03/2024

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
21380	Continued From page 15 the spot training for staff was completed. On 10/3/24 at 1:21 p.m., RN-A stated staff were expected to be able to know why EBP was in place for any resident, be aware of the signage for EBP, and how to don and doff PPE appropriately. On 10/3/24 at 4:29 p.m., DON stated staff were made aware of residents on EBP with signage on or near the resident's door, PPE cart, and the Kardex. DON stated staff were expected to wear gowns, gloves, masks, and eye protection if necessary. DON also stated the purpose of EBP and expected staff to follow the policy. Facility policy named Infection Control Transmission/Isolation Precautions revised on 3/2024 indicated: Enhanced Barrier Isolation Precautions: Example; Multidrug-Resistant Organisms (MDRO), Methicillin-resistant staphylococcus aureus (MRSA) Vancomycin-resistant Enterococcus (VRE) Carbapenem-resistant Enterobacteriaceae (CRE). Enhanced Barrier Precautions expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Face protection may also be needed if performing activity with risk of splash or spray. Enhanced Barrier Precautions apply to residents with any of the following: - Infection or colonization with a novel or targeted MDRO when Contact Precautions do not apply. - Wounds and/or indwelling medical devices (e.g.,	21380		

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 _____	10/03/2024

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
21380	Continued From page 16 central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. Wounds include chronic wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing, do not require EBP. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. Gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI	21380		

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 _____	10/03/2024

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
21380	Continued From page 17 committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21380		