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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C3YS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245359**

2.STATE VENDOR OR MEDICAID NO.
(L2) **664240300**

3. NAME AND ADDRESS OF FACILITY
(L3) **PINE HAVEN CARE CENTER INC**
(L4) **210 NORTHWEST 3RD STREET**
(L5) **PINE ISLAND, MN** (L6) **55963**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **7/3/2019** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, Unit Supervisor 7/10/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 7/10/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245359

July 10, 2019

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 24, 2019 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2019

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

RE: Project Number S5359030

Dear Administrator:

On July 3, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 24, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C3YS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00148

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245359**
2.STATE VENDOR OR MEDICAID NO.
(L2) **664240300**

3. NAME AND ADDRESS OF FACILITY
(L3) **PINE HAVEN CARE CENTER INC**
(L4) **210 NORTHWEST 3RD STREET**
(L5) **PINE ISLAND, MN** (L6) **55963**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/16/2019** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 06/21/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/27/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 3, 2019

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

RE: Project Numbers S5359030, H5359023C, H5359024C, H5359025C

Dear Administrator:

On May 16, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the May 16, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint numbers H5359023C, H5359024C, H5359025C that were found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is June 25, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 August 16, 2019 (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 November 16, 2019 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 05/16/2019

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
E 000	Initial Comments A survey with CMS Appendix Z, Emergency Preparedness Requirements, was conducted 5/13 through 5/16/19, during a recertification survey. The facility is NOT in compliance with the Appendix Z, Emergency Preparedness Requirements.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address patient/client population including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in in their emergency preparedness plan. This had the potential to affect all 55 residents residing at the facility. Findings include:	E 007	Pine Haven Care Center has developed and implemented emergency preparedness policies and procedures that are reviewed and updated at least annually. The policies have been revised to address the resident/client population including persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	6/24/19

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

Electronically Signed | 06/12/2019

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 05/16/2019

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
E 007	Continued From page 1 On 5/16/19, at 10:12 a.m. the maintenance director was interviewed regarding the facility's emergency plan. The maintenance director verified the facility did not have an emergency plan that included persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	E 007	Pine Haven Care Center provides services to residents who live at the facility for short rehabilitation stays and those who reside at the facility long term. Residents have unique vulnerabilities and may need may need additional accommodations in case of emergency due to mobility, cognitive, sensory, and communication impairments as well as behavioral symptoms negatively affecting others. A significant number of residents have pharmacological dependencies and need additional response assistance due to physical and mental disabilities. The facility has sufficient number of wheelchairs and staff to provide safe transport for all residents who cannot independently evacuate the building. Each resident□s personal care plan is accessible to the direct care staff and instructs the staff on the mobility needs and limitations of the resident. The facility exits are well marked and evacuation procedures are reviewed at the time of routine fire drills. In case of a community emergency, the facility would be able to provide food, shelter, and basic first aid care on a limited basis. The emergency plan has been updated to identify which staff would assume specific roles in another□s absence through delegation of authority and succession planning. There is a person who is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility.	

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 05/16/2019

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
E 007	Continued From page 2	E 007	During the mandatory meeting June 18, 2019, all staff will be reminded of how to access the facility□s emergency preparedness plan and that the plan addresses the client/resident population, including persons at-risk; the type of services the facility could offer in an emergency; and the delegations of authority and succession plans. The administrator will monitor compliance through review of the facility□s plan to ensure the content of the plan is consistent with the requirements in 483.73(a)(3) (Tag E-007). The plan will be reviewed at least annually to ensure ongoing compliance. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness	E 013		6/24/19

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 05/16/2019

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
E 013	Continued From page 3 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness (EP) plan addressed details should the facility need to shelter in place, the use of volunteers in an emergency, or other emergency staffing strategies. In addition, the EP did not have arrangements and/or an agreement with other facilities to receive patients in the event the facility is not able to care for them during an emergency, and the facility failed to develop	E 013	Pine Haven Care Center has developed and implemented emergency preparedness policies and procedures based on the emergency plan that align with the hazards that are identified in the facility- and community-based risk assessment and communication plan. An all-hazards approach is utilized. The emergency policies and procedures are reviewed at least annually and updated as	

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 05/16/2019

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
E 013	Continued From page 4 policies and procedures in the emergency plan describing the facility's role in providing care and treatment at alternate care sites under the section 1135 act waiver. This had the potential to affect all 55 residents residing at the facility, as well as staff, visitors and volunteers. Finding include: The facility's Emergency Preparedness Plan (EPP) revised 3/25/19, was reviewed. During an interview on 5/16/19, at 10:12 a.m. the maintenance director verified the shelter in place policy did not have criteria for determining which patients and staff that would be sheltered in place. In addition, the maintenance director verified the EP plan did not include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency and lacked arrangements with other facilities to receive residents as needed during an emergency. In addition he stated the facility had a policy on providing care at alternative sites. The maintenance director verified the policy did not address the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.	E 013	needed. The emergency preparedness policies and procedures will be revised to include criteria for identifying who should shelter in place and maximizing safety of residents, staff, and volunteers should they need to shelter in place (such as during a tornado). Policies will also address the emergent use of volunteers and other staffing resources/strategies including integration of State and Federally designated health care professionals to address surge needs during an emergency. In the event of an evacuation, agreements are in place with other area nursing facilities to house residents under the section 1135 act waiver. Procedures outline how current staff would be allocated to assist in caring for residents at alternate sites. During the mandatory meeting June 18, 2019, all staff will be reminded of how to access the facility's emergency preparedness plan and reminded that the plan which is based on the facility and community risk assessment uses an all-hazards approach in the development of policies and procedures. Sheltering in place, evacuation/relocation of residents, reassignment of staff, and use of additional resident care resources will be addressed. The administrator will monitor compliance through review of the facility's plan to ensure the content of the plan is consistent with the requirements in	

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 05/16/2019

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
E 013	Continued From page 5	E 013	483.73(b)(Tag E-013). The plan will be reviewed at least annually to ensure ongoing compliance. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by:	E 031		6/24/19

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 05/16/2019

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
E 031	Continued From page 6 Based on interview and document review, the facility failed to ensure their emergency preparedness (EP) plan included contact information for federal emergency preparedness staff and the office of state long- term care ombudsman. This had the potential to affect all 55 residents who currently resided in the facility. Findings include: On 5/16/19, at 11:02 a.m. the facility's EP plan was reviewed with the maintenance director who confirmed the findings. The plan-included components of an EP communication plan however, lacked documentation of contact information for federal emergency preparedness staff and the office of state long-term care ombudsman.	E 031	Pine Haven Care Center has developed and implemented an emergency preparedness plan which includes contact information for the following: 1. Federal, State, and local emergency preparedness staff. 2. The State Licensing and Certification Agency. 3. The Office of the State Long-Term Care Ombudsman. 4. Other sources of assistance as appropriate. The contact information is readily available and accessible to leadership during an emergency event. All contact information is reviewed annually and updated as necessary. During the mandatory meeting June 18, 2019, all staff will be reminded that the emergency preparedness plan includes the components of an emergency communication plan and important contact numbers. The administrator will monitor compliance through review of the facility's plan to ensure the content of the plan is consistent with the requirements in 483.73(c)(2)(Tag E-031). The plan will be reviewed at least annually to ensure ongoing compliance. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)	E 035		6/24/19

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 05/16/2019

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
E 035	Continued From page 7 [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their emergency preparedness (EP) communication plan included a method for sharing information the facility has determined appropriate, with residents and their families or representatives. This had the potential to affect all 55 residents residing in the facility and their families/representatives. Findings include: During an interview on 5/16/19, at 11:05 a.m. the maintenance director stated the admission book provided to residents upon admission included, "Pine Haven has an emergency preparedness plan. It is available upon request." The maintenance director verified the facility had not determined the information deemed appropriate to share with residents, and their families/representatives, if a request for information was made.	E 035	Pine Haven Care Center has established and maintains an emergency preparedness program that complies with applicable Federal, State and local emergency preparedness requirements. The emergency preparedness program describes the facility's comprehensive approach to meeting the health, safety, and security needs of the staff and resident population during an emergency or disaster situation. The program addresses how the facility will coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The comprehensive plan encompasses the elements for emergency preparedness based on the “all-hazards” definition and specific to the location of the facility with the goal to meet the health, safety, and security needs of the staff and of the resident population. The emergency preparedness program is	

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 05/16/2019

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
E 035	Continued From page 8	E 035	reviewed annually. The emergency preparedness plan will be revised to include a communication method for sharing appropriate information about the plan with residents and their families or representatives. A flyer informing the residents of the location of information about the emergency preparedness plan will be distributed to all residents during the wee of June 16, 2019 and information will also be enclosed with the monthly billing statement. The emergency preparedness plan will be an agenda topic during the June Resident Council meeting and an announcement will be made prior to other activity events such as Bingo and social hour. Plans are to put a link to the emergency preparedness plan on the facility's website. Information about the emergency preparedness plan will be included with information provided to residents at the time of admission. During the June 18, 2019 meeting, the staff will be reminded that information about the facility's comprehensive emergency preparedness plan is available to residents and their families/legal representatives. The administrator will monitor compliance for the next three months through review of the appropriateness of the emergency preparedness plan content that is shared with families/representative and the method for disseminating the information.	

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 05/16/2019

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
E 035	Continued From page 9	E 035	If noncompliance is noted, additional staff training will be done. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness	E 037		6/24/19

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 05/16/2019

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
E 037	Continued From page 10 policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually.	E 037		

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 05/16/2019

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
E 037	Continued From page 11 (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		

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 05/16/2019

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
E 037	Continued From page 12 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct annual training of the emergency preparedness (EP) plan with staff. This had the potential to affect all 55 residents and staff. Findings include: During an interview on 5/16/19, at 11:09 a.m. the maintenance director confirmed initial EP training was completed upon hire however, lacked documentation to indicate the facility had on going annual training based on the emergency plan and risk assessment completed by the facility. The maintenance director verified annual EP training had not been completed in the last year.	E 037	Pine Haven Care Center has developed and implemented an emergency preparedness plan. The facility provides for staff/volunteer training as follows: 1. Initial training in emergency preparedness policies and procedures to all new staff, volunteers, and individuals providing services under arrangement. 2. Provide emergency preparedness training at least annually. 3. Maintain documentation of the training. 4. Demonstrate staff knowledge of emergency procedures. During the June 18, 2019 meeting, staff will be reminded of the location of the emergency manual, informed of the requirement for annual training, and	

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 05/16/2019

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
E 037	Continued From page 13	E 037	informed of the arrangements for mandatory emergency preparedness training on June 20 and 21, 2019. The administrator will monitor compliance through review of the facility's plan to ensure the content of the plan is consistent with the requirements in 483.73(c)(2)(Tag E-031). The plan will be reviewed at least annually to ensure ongoing compliance. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
F 000	INITIAL COMMENTS On 5/13 through 5/16/19, a standard survey was completed at your facility by the Minnesota Department of Health. Complaint investigations were also conducted. Pine Haven was found not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint(s) were found unsubstantiated: #H5359025C, however associated deficiencies were identifeid at F609 and F610; other unsubstantiated complaints included: #H5359024C and #H5359023C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipts of an acceptable electronic POC,	F 000		

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 05/16/2019

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	Continued From page 14 an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		6/24/19

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 05/16/2019

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 550	Continued From page 15 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure a dignified dining experience for residents (R13, R31, R32, R42) observed while being assisted with their meal. In addition, facility failed to treat 2 of 2 residents (R23 and R17) with dignity who expressed feelings of not being treated with dignity. Findings include: On 5/15/19, at 8:46 a.m. nursing assistant (NA) -B joined NA-C and NA-D at the breakfast table to assist resident R 13, R31, R32, R42 who were no longer independently able to feed themselves. NA-B and NA-C sat with R32 between them and began to discuss their workload for the day, specifically how many baths there were to give and a plan to complete their work. NA-C named a resident, not at the table, who was to receive a bath that day. Then NA-C told NA-B how to provide cares to that resident, including how to transfer her and with a directive to "make sure you check her pants." The conversation was loud enough to be heard across the room. Neither NA-B nor NA-C were observed to attempt to converse with the residents at the table. Neither NA-B nor NA-C were observed to attempt to assist R32 with her meal. NA-C attempted to	F 550	Pine Haven Care Center staff treat residents with dignity and care for each resident in a manner that enhances his or her quality of life. The staff provide resident-centered care with recognition and respect for each resident's preferences and individuality. The facility has policies and procedures that protect and promote the rights of all residents. The staff routinely interact with residents and provide care and services that support and enhance their self-esteem and self-worth including needed assistance with activities of daily living (grooming, dressing, bathing, eating, and toileting) as identified in their comprehensive assessment and outlined in their plan of care. The facility policy addressing dignity and quality of life were reviewed and found appropriate. During the June 18, 2019 mandatory meetings, the nursing staff will be 1) reinstructed on feeding assistance procedures, techniques, and interactions that foster a positive dining experience for the resident 2) reminded of the residents' right to dignified and respectful	

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 05/16/2019

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 550	Continued From page 16 draw NA-D into the discussion about bathing residents and NA-D got up and left the table. NA-C then talked with NA-B about what they should do in order to get their breaks in for the day. According to an interview 5/15/19, at 8:58 a.m. NA-B stated she had been trained to attempt to keep residents engaged in conversation when assisting with dining. NA-B said conversations at the dining table should be talking "with the residents, not about them. I guess that wasn't good." During an interview 5/15/19, at 9:00 a.m. NA-C stated residents at the dining table should be included in conversations and should be spoken to in order for them to be prepared for bites being offered by staff. NA-C confirmed that the conversation at the table had not been resident centered, but stated they had five baths to give and had to figure out their strategy. NA-C said, "it probably was not the best setting but this is where we are all together." According to an interview 5/15/19, at 9:15 a.m. NA-D stated conversation in the dining room should be centered on the residents being cared for. NA-D said the discussion about bathing other residents had not provided a dignified experience for the residents and should have taken place in a private area. NA-D stated a reluctance to intervene due to a concern that other staff would perceive the actions to be intimidating. When interviewed on 5/15/19, at 11:13 a.m. the director of nursing (DON) stated they had been working on developing a dignified dining experience for the facility residents. They have	F 550	conversational responses and 3) reeducated on the need to respect the residents' preferences for evening and bedtime schedules. Respecting a resident's right to dignified care and treatment will continue to be addressed during annual staff training and new employee orientation. The care plans for residents number 13, 31, 32, and 42 were reviewed and found to appropriately address the residents' eating dependencies. The plans of care will continue to be reviewed and revised at least quarterly and with changes in condition. The care plans for residents number 17 and 23 were updated to reflect the residents' preference to choose their bedtime schedule. During the investigation of the incident it was found that only one nursing assistant was alleged to speak to residents number 17 and 23 in an undignified manner. The nursing assistant did not feel the conversation was undignified or disrespectful toward the residents. The nursing assistant was counseled regarding the residents' interpretation of the situation and counseled to be sensitive to residents' perceptions and to avoid words and tones of voice that can be misunderstood or misconstrued, especially by residents with hearing deficits. Residents number 17 and 23 were interviewed by the Director of Nursing on June 7, 2019 and both stated that they had no further concerns about	

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 05/16/2019

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 550	Continued From page 17 been providing education to staff on what dignity during dining means and how to provide it. DON confirmed that discussions at the dining table that do not include residents, and those about specifics of how to provide care to named residents, or staff concerns about break time did not conform to facility expectations for dignified dining. A facility policy on dignified dining was requested. A document titled Dignity, originally dated 12/2017 and revised 3/2018 was provided. The document included the following policy statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Furthermore, the policy indicated that residents were to be treated with dignity and respect at all times and that verbal "staff-to-staff communication (e.g. change of shift reports) shall be conducted outside the hearing range of residents and the public." R23's admission minimum data set (MDS) assessment, dated 12/11/18, identified R23 to have intact cognition. R23's quarterly, MDS assessment, dated 3/13/19, identified R23 to lack any behavioral problems and was independent with most activities of daily living (ADL)'s. R23's Admission Record, identified an admit date of 12/4/18, and diagnoses of peripheral vascular disease, heart failure, and disorientation. R23's care plan, dated 12/4/18, identified a focus: Potential for susceptibility and vulnerability related to placement in skilled nursing facility and	F 550	interactions with staff. The social worker will continue to meet periodically with the residents to monitor their satisfaction with cares; satisfaction with cares and services will continue to be addressed during their quarterly interdisciplinary care conferences. The Director of Nursing/designee will monitor compliance with a dignified dining experience by random observations of staff assisting residents with eating for three weeks. If noncompliance is observed, additional auditing and staff training will be done. A nurse or social worker will randomly interview residents for three weeks to determine their satisfaction with staff care and treatment. If concerns are noted, additional auditing and staff training will be done. Within 90 days all residents will have been asked about their satisfaction with cares/treatments. Residents will continue to be invited to discuss concerns with cares and services during their quarterly interdisciplinary care conferences and during the Resident Council meetings. Compliance will be reviewed at the July 2019 Quality Assurance Committee meeting and ongoing.	

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 05/16/2019

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 550	Continued From page 18	F 550		

Interventions: inform family of personal needs, social service intervention as needed, staff need to be aware of vulnerability.

During observation and interview on 5/13/19, at 7:21 p.m. R23 was sitting in her recliner and when asked if staff treat her with respect R23 recalled last night [5/12/19] there were three aides that had brown uniforms on, not sure if they were in training or what they were, but they told me to go to my room and go to bed, it was sometime after 6:30 p.m. R23 have never seen the aides here before. R23 told the staff last night what they. R23 told the aides, I don't have to go to my room and go to bed,. They also told R17 the same thing.

R17's Quarterly, minimum data set (MDS) assessment, dated, 3/5/19, identified R17 to have intact cognition, and to be independent with most ADL's.

R17's Admission Record, identified an admit date of 6/22/16, and diagnoses of macular degeneration, peripheral vascular disease, and hypertension.

R17's care plan dated 6/22/16, identified a focus: Potential for susceptibility and vulnerability related to placement in skilled nursing facility and Interventions: inform family of personal needs, social service intervention as needed, staff need to be aware of vulnerability.

During interview on 5/16/19, at 10:53 a.m. nursing assistant (NA)-K stated, R17 told me on Sunday that one of the aides here told her and R23 to go to bed now. This happened on Saturday night. I reported this to my registered

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 05/16/2019

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 550	Continued From page 19	F 550		

nurse (RN)-B on Sunday. NA-K said was not sure what RN-B did about it, but they need to treat these residents here a little nicer. This could be your mother or father.

During interview on 5/16/19, at 11:04 a.m. licensed practical nurse (LPN)-D stated, R23 told me about the situation on Monday when I was working. R23 told me the aide put R6 in her room and R23 and R17 went to go visit with R6. R17 told me it was NA-A that told her it was none of her business and to go to her room and go to bed. I reported this to the DON right away. I told the DON they needed to not have her work down here because R17 and R23 are pretty mad at her, so they switched her to work on the 600 unit instead.

During interview on 5/16/19, at 1:17 p.m. LPN-B verified she is the unit manager for this unit. LPN-B stated she heard over the weekend that NA-A told R17 and R23 to go to their rooms and go to bed, and I know it was reported to the DON. That is not treating a person with respect and dignity. My expectation would be that all residents should be treated with respect and dignity.

During interview on 5/16/19, at 1:46 p.m. R23 said, we (R23 and R17)were both in the middle of the hallway and then the aide told us, go to your rooms and go to bed. I told her, you don't talk to us like that, we will go to bed when we are damn good and ready.

During interview on 5/16/19, at 1:46 p.m. R17 stated, It was Saturday night, NA-A told both of us (R17 and R23) to go to our rooms. Certainly, they were disrespectful the way she talked to 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 05/16/2019

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 550	Continued From page 20	F 550		

Then R17 stated, I worked here as an aide for 10 years, you would never talk to anyone like that. I felt like a piece of trash when she said that to me, you just don't talk to people like that. I feel like NA-A is safe to work with the other residents here, she just has a bad attitude and needs to learn to treat people with respect. We know the LPN-A heard that NA-A say that to us. When I trained people in as an aide I would tell them this could be your mother or your father, or this could be you someday, so you always treat people with respect.

During interview on 5/16/19, at 2:58 p.m. the director of nurses (DON) stated, I was notified on 5/13/19, in the morning about the incident with R23 and R17 being treated with disrespect from NA-A on 5/11/19. I notified social services (SS)-A today so she can follow up with the residents. I learned this when you guys [surveyors] walked through the door so I didn't let SS-A know until today. My expectation is, I expect all staff to be treating residents with respect and dignity at all times.

During interview on 5/16/19, at 3:16 p.m. the Administrator stated, I was notified about the situation with the residents being treated with disrespect from Saturday and we are investigating this now. We need to have all of our staff to be treating residents with respect and dignity.

Facility policy entitled, "Dignity," dated 12/2017, revised 3/2018, identified each resident will be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents shall be treated with respect and dignity at all times. 2. "Treated with

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 05/16/2019

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 550	Continued From page 21 dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 7. Staff shall speak respectfully to all residents at all times, including addressing resident by their name of choice and not labeling or referring to the resident by his room number, diagnosis, or care needs. 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: c. allowing resident unrestricted access to common areas open to the public, unless this poses a safety risk for the resident.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		6/24/19

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 05/16/2019

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 561	Continued From page 22 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing preferences for 1 of 1 residents (R24), reviewed for choices. Findings include: R24's admission Minimum Data Set (MDS) assessment dated 3/14/19, identified R24 had severe cognitive impairment, needed one person extensive assist with activities of daily living (ADLs), and identified R24 as always incontinent of urine and frequently incontinent of bowel. R24's Admission Record identified an admission date of 6/8/18, with diagnoses including: anxiety disorder, major depressive disorder, and unspecified urinary incontinence. R24's Admission Temporary Resident Care Plan indicated R24 needed one person assist with bathing and shower schedule daily in the early morning. R24's care plan dated 6/8/18, included: Requires assist of 1 with bathing related to deconditioning. Goal: He will continue to bath himself with staff assistance through next review. Intervention: one person assist with bathing and prefers shower. Review of care plan lacks frequency of bathing.	F 561	Pine Haven staff respect the residents' right to self-determination and support residents in 1) choosing activities, schedules, and health care that is consistent with their interests, assessments, and plans of care and 2) making choices about the aspects of their life that are significant to them. The facility staff embrace the concept of resident-centered care and the right of the residents and their representatives to make informed choices about care and treatments including the right to determine bathing schedules (time of day), frequency, and type of bath (tub/shower/sponge/bed bath). The residents are encouraged to participate to the greatest extent possible in the care planning process. The staff assist the residents in exercising their rights by discussing with them (or their representative) the resident's condition and care needs, treatment options, personal preferences, and potential consequences of declining recommended cares and treatments. The facility's polices and procedure for determining the residents' bathing preferences were reviewed and found appropriate. The residents are asked	

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 05/16/2019

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 561	Continued From page 23 Review of R24's Body Audit Forms, identified R24 received a bath 13 times since 2/3/19. During interview on 5/13/19, at 2:55 p.m. R24 stated, "Before coming to the facility I showered every day, I miss that very much." R24 stated the facility had told him on admission how many showers/baths he would get and added, "I am one of these guys who feels dirty if I don't take a shower every morning. Now I have a situation where I urinate myself and sometimes I poop the bed. I can't help that, but would just like a bath more often." During interview on 5/16/19, at 10:46 a.m. nursing assistant (NA)-K stated, the admission nurse asks the resident when they first get here how many baths they want a week. NA-K verified R24 was incontinent of bowel and bladder and stated, R24 was scheduled to get a shower twice a week, on Wednesday and Saturday mornings. During interview on 5/16/19, at 1:06 p.m. licensed practical nurse (LPN)-B stated, "I am the clinical manager for this unit. Upon admission we do the assessments and we have a form that asks how many bath/showers per week a resident would prefer. We do have people that have a shower every day here. I am not sure if we reassess to see if the residents are happy with their bathing frequency. I do know [R24] gets a shower twice a week on Wednesday and Saturday mornings. My expectation in regards to bathing is, if a resident wants a shower every day they should be getting one every day." During interview on 5/16/19, at 2:51 p.m. the director of nursing (DON) verified R24's admission temporary care plan identified that R24	F 561	about their bathing preferences at the time of admission. As part of the ongoing assessment process (at least quarterly) the residents are asked about their preferred bathing schedule and frequency as well as type of bath. The residents are also asked about the importance of choosing what to wear, having snacks available, security of personal belongings, choosing arise/bedtime, having access to reading material, listening to favorite music, keeping up with the news, participating in religious services/practices, etc. The residents' preferences are included in their plan of care and the staff attempts to follow their preferences to the greatest extent possible. The resident and/or their legal representative are routinely asked about satisfaction with cares/services during the quarterly care conferences, with significant condition changes, and more often, if indicated. During the mandatory meetings June 18, 2019, the staff will be reminded of the residents' right to make choices regarding health care services and the need to provide care consistent with their interests and assessed needs including the need to respect their bathing preferences. The facility's policies and procedures for determining and communicating the residents' preferences for personal cares will be reviewed with the staff. The Director of Nursing met with resident number 24 on June 7, 2019 to discuss his bathing preferences. He prefers a tub	

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 05/16/2019

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 561	Continued From page 24 would like a shower daily but R24 is currently scheduled to get two showers per week. The DON acknowledged her expectation would be for residents who want a shower every day, they should get one every day. A policy for bathing frequency was requested and not received.	F 561	bath or shower every other day and will inform the staff of the type of bath he prefers. The resident's care plan and the nursing assistants' pocket care plan have been updated accordingly. His satisfaction with cares will be discussed during one-on-one visits with the social worker; the resident's bathing preferences will continue to be reviewed at his quarterly interdisciplinary care conferences. To monitor compliance, a nurse/designee will conduct random resident interviews for three weeks to verify that the residents' bathing regimen is consistent with their preferences. The residents will be asked about their satisfaction with bathing schedules, frequency, and type of bath. If noncompliance is noted, additional resident interviews and staff training will be done. The residents' care preferences will continue to be routinely addressed and the care plan updated as necessary during the quarterly interdisciplinary care conferences. Respect for the residents' right to self-determine and participate in health care decisions as well as their satisfaction with cares, including bathing, will be monitored ongoing by the Social Worker during one-on-one interviews and through feedback from the Resident Council meetings. Any care concerns will be communicated to the appropriate department manager/supervisor. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		6/24/19

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 05/16/2019

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 584 SS=D	Continued From page 25 CFR(s): 483.10(i)(1)-(7)	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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 05/16/2019

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 584	Continued From page 26 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to follow up on concerns of missing personal items for 1 of 1 resident (R14) reviewed for personal property. Findings include: R14's quarterly minimum data set (MDS) assessment dated 2/21/19, indicated R14 was cognitively intact with diagnoses that included: depression, anxiety disorder and psychotic disorder. R14's care plan included potential for mood and behavior indicators related to: diagnoses of depression, anxiety and delusional disorder. Target behaviors included; self-reporting sadness, delusions, and paranoid thoughts about personal items being missing or being stolen. On 5/14/19, at 9:14 a.m. when asked if she had any missing items R14 stated, "I lose blouses and don't get them back. Then I tell the people over at the desk." R14 stated, "I got new shoes yesterday and I might have to hide them, people like to steal things here. I tell the kids not to buy me anything because someone will steal them anyway." R14's medical record review revealed a hand written note with a list of five missing clothing items dated 2-14-19 and an additional list of nine missing clothing items dated 3-19-19 in the social service section of the chart. R14's missing item report dated 3-25-19 had a list of thirteen missing	F 584	Pine Haven provides a homelike environment for residents which allows them to use their personal belongings to the greatest extent possible. The facility exercises reasonable care for the protection of the resident's property from loss or theft. The policies and procedures for identifying and following up on missing resident property were reviewed and found appropriate. A Missing Item Report form is used to track the search process. During the mandatory meetings June 18, 2019, the staff will be reminded of the procedures for identifying, notifying, and following up on missing items. On June 6, 2019, resident number 14 was interviewed regarding her concerns about missing clothing items. She states that she has had concerns in the past about missing items, but has had no recent missing items. She was encouraged to immediately report missing items to the staff. To monitor compliance with facility policy and procedures addressing missing resident belongings, the Environmental Services Manager/designee will review all Missing Item Reports for the next three months to determine whether there was appropriate documentation and follow up	

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 05/16/2019

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 584	Continued From page 27 clothing items resident had reported. On 5/14/19, at 1:04 p.m. the social services (SS) staff stated she was aware R14 had reported missing items in the past. The SS staff stated she should have been made aware of the hand written note in R14's chart about missing items. On 5/14/19, at 1:16 p.m. the SS staff stated the hand written list of missing items from R14's chart was a totally different list than she had seen before. The SS staff stated there had been a missing item form completed on 3/25/19, and stated she had planned to talk to R14 when she completed her assessment. However the SS staff stated she had not completed the form. The SS staff stated, "According to policy we try to find missing items within 10 days, I am not really sure what happened here. I wish I had seen this long list." The SS staff stated she would call R14's family. The SS staff said she did'nt know what had happened with the missing item form filled out on 3/25/19, and said she would follow up on the missing items "today." On 5/16/19, at 1:14 p.m. the director of nursing (DON) stated missing items are reported to SS and SS filled out the missing item forms. The DON stated, "Everybody can look for the missing items. We usually look the next business day and get back to the resident and family." The facility's 3/2016 Missing Item Report policy, indicated: "Will make every effort to maintain a secure environment for resident, visitor and staff belongings. When items are reported missing the following steps will be taken. The first person aware of missing item will do the following: -Fill out Missing Items Report form	F 584	related to the lost items. If noncompliant trends are noted, additional auditing will be done and related systems will be investigated to identify opportunities for process improvements. Residents will continue to be asked during their quarterly interdisciplinary care conferences whether they have any concerns about their care and services at the facility. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 584	Continued From page 28 -Document dates and areas searched (lost and found, resident room, laundry) -Notify social worker or environmental services of missing item via verbal communication (phone/face to face conversation) or written notice -Environmental Services Manager/Social Worker will then search for the missing item. -Completed form will be retained in social services supervisor office. -Follow up action will be documented on the form."	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		6/24/19

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 05/16/2019

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 585	Continued From page 29	F 585		

of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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 05/16/2019

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 585	Continued From page 30 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a grievance was followed up on timely for 2 of 2 residents (R23 and R17) reviewed for expressed concerns with not being treated with dignity and respect. Findings include: R23's admission minimum data set (MDS)	F 585	Pine Haven policies address the residents' right to voice grievances to the facility staff or other agencies/entities that hear grievances without fear of discrimination or reprisal. The staff respect and support each resident's right to express grievances such as those about treatment, care, management of funds, lost items, violation of rights,	

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 05/16/2019

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 585	Continued From page 31	F 585		

assessment dated 12/11/18, identified R23 to have intact cognition.

R23's care plan dated 12/4/18, identified a focus area of: Potential for susceptibility and vulnerability related to placement in skilled nursing facility. Interventions included: inform family of personal needs, social service intervention as needed, staff need to be aware of vulnerability.

R17's quarterly MDS dated 3/5/19, identified R17 to have intact cognition, and as independent with most activities of daily living (ADL's).

R17's care plan dated 6/22/16, also identified a focus area of: Potential for susceptibility and vulnerability related to placement in skilled nursing facility. Interventions included: inform family of personal needs, social service intervention as needed, staff need to be aware of vulnerability.

During observation and interview on 5/13/19 at 7:21 p.m., R23 was observed sitting in her recliner. When asked if staff treated her with respect and dignity, R23 stated three staff, who she was unsure whether they were in training or not, had told her recently to "go to my room and go to bed." R23 stated she'd reported this to the staff working "last night." R23 further said she'd told those three staff, "I don't have to go to my room and go to bed." R23 stated she'd heard those same staff tell R17 the same thing.

During interview on 5/16/19, at 10:53 a.m. nursing assistant (NA)-K stated, "[R17] told me on Sunday that one of the aides here had told her and [R23] to 'go to bed now'. This happened on

behavior of staff and other residents, as well as any other concerns regarding their stay at the facility.

The facility provides instructions to the resident for filing a grievance or complaint and informs them that it can be done anonymously. The facility policy requires that the grievance be promptly addressed and that the resident is apprised of progress toward resolution. When requested, a copy of the grievance policy is made available to the resident.

The facility's grievance policy was reviewed and found appropriate. During the June 18, 2019 mandatory meetings, the nursing staff will be 1) reinstructed on the facilities grievance policies and completion of the Problem Resolution Form 2) reminded of the residents' right to dignified and respectful conversational responses and 3) reeducated on the need to respect the residents' preferences for evening and bedtime schedules. Respecting residents' rights to voice grievances and receive dignified care and treatment will continue to be addressed during annual staff training and new employee orientation.

The care plans for residents number 17 and 23 were updated to reflect the resident's preference to choose their bedtime schedule. During the investigation of the incident it was found that only one nursing assistant was alleged to speak to residents number 17 and 23 in an undignified manner. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 05/16/2019

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 585	Continued From page 32 Saturday night. I reported this to my registered nurse (RN)-B on Sunday." NA-K said she wasn't sure what RN-B had done about it. During interview on 5/16/19, at 11:04 a.m. licensed practical nurse (LPN)-D stated, "[R23] told me about the situation on Monday when I was working. I reported this to the director of nursing (DON) right away. I told the DON they needed to not have that aide work down here because [R17] and [R23] are mad at her, so they switched her to work on a different unit instead." During interview on 5/16/19, at 1:17 p.m. LPN-B verified she was the unit manager for the unit. LPN-B stated she'd heard over the weekend that NA-A had told R17 and R23 to go to their rooms and to go to bed. LPN-B said, "I know it was reported to the DON. That was not treating a person with respect and dignity. All residents should be treated with respect and dignity." During interview on 5/16/19, at 2:58 p.m. the DON stated, "I was notified on 5/13/19, in the morning about the incident with [R23] and [R17] being treated with disrespect from NA-A on 5/11/19. I notified social services (SS)-A today so she can follow up with the residents. I first learned this when you surveyors walked through the door, so I did not let SS-A know until today. I expect all staff to be treating residents with respect and dignity at all times. Any time there is a complaint, a grievance should be filled out right away, and the grievance official should be notified so it can be investigated timely." During interview on 5/16/19, at 3:13 p.m. social services (SS)-A stated, "I just found out about the incident from Saturday and I am investigating it	F 585	nursing assistant did not feel the conversation was undignified or disrespectful toward the residents. The nursing assistant was counseled regarding the residents' interpretation of the situation and counseled to be sensitive to residents' perceptions and to avoid words and tones of voice that can be misunderstood or misconstrued, especially by residents with hearing deficits. Residents number 17 and 23 were interviewed by the Director of Nursing on June 7, 2019 and both stated that they had no further concerns about interactions with staff. The social worker will continue to meet periodically with the residents to monitor their satisfaction with cares; satisfaction with cares and services will continue to be addressed during their quarterly interdisciplinary care conferences. Any concerns will have a timely response by the staff. To monitor compliance, for three months the Director of Nurses/designee will audit the Problem Resolution Forms for timely follow up to concerns expressed by residents. If the responses/resolutions are not addressed in a timely manner, additional auditing and staff training will be done. Residents will continue to be invited to discuss concerns with cares, treatment, and services during their quarterly interdisciplinary care conferences. Compliance will be reviewed during the 2019 July Quality Assurance Committee meeting and ongoing.	

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 05/16/2019

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 585	Continued From page 33	F 585		

now. I am the grievance official here. The nurses did not fill out the grievance timely."

During interview on 5/16/19, at 3:16 p.m. the administrator stated, "I was notified about the situation with the residents being treated with disrespect from Saturday and we are investigating this now. We expect all of our staff to treat residents with respect and dignity."

The facility's Grievance/Concern Policy revised 6/2018, included: "It is the policy of this facility that each resident has the right to voice grievances to the facility, or other agency or entity, that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. The facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed throughout the investigation and resolution process. The facility grievance process will be overseen by a designated Grievance Officer. They will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations, maintaining confidentiality of all information associated with grievances, and communicate with residents throughout the process to find a resolution. 2. Grievances can be filed verbally or in writing, using the grievance concern form. The forms are to be provided at admission and upon request and are located adjacent to the Bill of Rights posting located throughout the community and included in the admission packet. Grievances

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 05/16/2019

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 585	Continued From page 34 can be anonymously and placed in the suggestion/payment box located in each dining room. 3. Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and their authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility grievance official. 5. Grievances will be responded to within 72 hours for non-emergency concerns. The facility will notify the complainant to provide updates on resolution for the complaint. Additionally, complainants have the right to a written decision regarding a grievance. 7. All communications will be documented on the grievance/Concern form ...8. The manager responsible for investigating and resolving the grievance will complete the grievance/concern form, including a plan for resolution."	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency	F 609		6/24/19

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 35 and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of physical abuse within 2 hours for 1 of 1 resident (R21) who reported an allegation of physical abuse. In addition, the facility failed to report allegations of drug diversion to the SA for 1 of 1 resident (R28) reviewed for drug diversion. Findings include: R21's Admission Record identified diagnoses that included vascular dementia without behavioral disturbance and cerebral infarction due to embolism of right middle cerebral artery. R21's annual Minimum Data Set (MDS) assessment dated 3/11/19, identified R21 had long and short term memory problems, had modified independence in decision making in new situations and delusions. The MDS further identified R21 required extensive assistance of one staff with all activities of daily living (ADL). A vulnerable adult report regarding R21, submitted to the SA on 4/17/19 at 11:30 p.m.,	F 609	Pine Haven Care Center requires that all alleged resident mistreatment, neglect, abuse, and misappropriation of resident property be 1) reported immediately to the administrator and other appropriate officials and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action is taken. The facility intervenes to prevent further potential abuse while the investigation is in process. The facility's vulnerable adult policies and procedures for identifying, reporting and internally investigating incidents were reviewed and revised to clarify that diversion of a resident's medications is considered exploitation of resident property. During the mandatory meetings on June 18, 2019, the staff will be reinstructed on the requirements for documenting, investigating and reporting	

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 36 included: "Reported from off going shift that incident was reported by resident that day shift aide had slapped his hand and was rough with him during cares. No injuries have been reported." The corresponding investigative summary submitted to the SA on 4/22/19, at 5:38 p.m. included: 1. This writer interviewed the nursing assistant (NA)-L (4-22-19), alleged perpetrator, who was [R21's] aide during day shift. NA-L stated [R21] had been upset all day since she first started her shift. NA-L stated that he [R21] was fixated on bowel medications (which NA-L had reported to the nurse). [R21] was stating that he was having loose stools, which, he was not. When NA-L told [R21] that he was not having loose stools, he became more upset and showed verbal behaviors. NA-L stated that she was laying him down for awhile, which he needed to do once or twice a day because he has a sore on his bottom that needs to heal. When she went to lay him down, [R21] attempted to grab her breast, which she did not like. NA-L stated that she reacted by pushing his hand away from her breast, not slapping it away. NA-L stated [R21] then got upset with her when she pushed his hand away. NA-L stated she did not know if he knew where he was grabbing or not. NA-L stated as soon as he was in bed he had fallen asleep. She stated she reported his behaviors and mood to the nurse and passed it along in report. 2. This writer interviewed registered nurse (RN)-D (4-22-19), who was the RN who reported the incident. RN-D stated she heard about the incident during shift change. RN-D stated she did not know much about the incident other than that it had happened on the day shift. RN-D stated she had looked at R21 and there were no injuries.	F 609	alleged resident mistreatment. The staff will also be instructed that diversion of a resident's medication is considered misappropriation of his/her property and must be reported to the state agency. The staff are reeducated on vulnerable adult issues at least annually and vulnerable adult reporting/investigation is addressed as part of the new employee orientation process. Resident number 21 – The investigation and reporting of the inappropriate touching of the care giver by resident number 21 and the care giver's response were reviewed as part of the facility's ongoing quality assurance performance improvement process. The resident admitted that he grabbed the staff member in the "wrong place", that everyone treats him right and good, and that he is satisfied with cares and has no concerns. The resident was not injured and resident abuse was not substantiated. The resident's vulnerability care plan was reviewed and revised to reflect a history of inappropriate touching. Staff counseling on the importance of timely reporting of alleged abuse and neglect was provided. Resident number 28 – The required state reporting of the diversion of the resident's drugs was reviewed as part of the facility's ongoing quality assurance performance improvement process. According to the revised facility policy, diversion of resident drugs is considered misappropriation of their property and will be reported to law enforcement and the appropriate state	

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 37 RN-D said she had heard in report during shift change, that R21 was stating the aide who was helping him had slapped his hand. 3. This writer interviewed R21 on 4/22/19. R21 stated the aide did slap his hand but not in a "bad way". R21 stated the aide did that because he was grabbing in the wrong place, not how he was supposed to. R21 stated that everyone here treats him right and good. R21 stated that he is satisfied with cares. R21 stated he was not sure why everyone was asking him about this, including the sheriff. R21 stated the sheriff told him he (R21) reported that the aide had slapped his hand. R21 stated he had never reported this and it was taken out of context. R21 stated he had no concerns. The report further indicated the facility's policies and procedures were followed. On 5/16/19, at 5:21 p.m. the director of nursing (DON) stated she did not get notified of this incident until 11:00 p.m. on 4/17/19, when RN-D had called her. The DON stated, "RN-D and licensed practical nurse (LPN)-A, should have reported it to us right away. When I found out what happened I told RN-D to report it." On 5/16/19, at 5:36 p.m. social serves (SS) staff stated the incident had happened around 1:30 p.m. on 4/17/19, when NA-L was laying R21 down after lunch. The SS staff confirmed the incident was not reported right away and stated the facility policy was to report abuse within two hours. The SS staff verified a report had been made to the SA at 11:30 p.m. on 4/17/19. On 5/16/19, at 6:48 p.m. the administrator stated he was unsure whether the allegation of abuse was reported immediately to him. The administrator stated the first person R21	F 609	agencies. Compliance will be monitored by the Director of Nursing/designee by auditing all Vulnerable Adult Reports for one month to ensure they are submitted to the State Agency within the required facility policy and state time frame parameters. The Administrator/designee will monitor compliance of appropriate reporting of the diversion of residents' medication for three months. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 38	F 609		

mentioned this allegation to, should have reported it right then and there to the supervisor. The administrator stated the supervisor was suppose to notify the DON and administrator at the time an allegation was made, after ensuring the safety of the resident. The administrator stated their abuse policy was to report abuse within two hours to the SA.

The facility's Abuse Prevention Plan/Vulnerable Adult policy dated 3-2018 included; "Investigative Procedure: Any person with the knowledge or suspicion of suspected violations shall report immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours is events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials ..."

During interview on 5/15/19, at 1:12 p.m. the director of nursing (DON) stated, "We had a drug diversion back in February, the facility identified the alleged perpetrator (AP) and terminated the AP." Further, the DON said she immediately implemented a count of all tramadol shift to shift which they had not previously been doing. The DON also stated she'd notified the police, the pharmacist, and the medical director. However when asked, the DON verified she had not filed a vulnerable adult report with the SA because she didn't know she had to.

During interview on 5/15/19, at 4:22 p.m. the administrator stated, "I was notified of the drug diversion on 2/8/19." The administrator further verified this incident should have been reported to

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 39 the SA. During interview on 5/16/19, at 6:09 p.m. the DON stated, "I looked at the other residents getting tramadol to make sure none of there medications were missing. I did not assess all residents who have pain or who received pain pills, I only checked to see if any tramadol was missing, not all pain pills. I did not interview any other staff in regards to whether there was any suspicion of drug diversion." The DON verified the medication diversion had been identified on 2/8/19. They had verified LPN-E was the AP 2/14/19, and had fired LPN-E the same day. The facility's Abuse Prevention Plan/Vulnerable Adult policy dated 3-2018 included: ..."Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a resident's belongings without the resident's consent."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610		6/24/19

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 40 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and respond to an allegation of abuse, maintain documentation of the investigation, and prevent further abuse while the investigation was in progress for 1 of 1 residents (R21) reviewed for an alleged incident of physical abuse. Findings include: A vulnerable adult report regarding R21, submitted to the SA on 4/17/19 at 11:30 p.m., included: "Reported from off going shift that incident was reported by resident that day shift aide had slapped his hand and was rough with him during cares. No injuries have been reported." The corresponding investigative summary submitted to the SA on 4/22/19, at 5:38 p.m. included: 1. This writer interviewed the nursing assistant (NA)-L (4-22-19), alleged perpetrator, who was [R21's] aide during day shift. NA-L stated [R21] had been upset all day since she first started her shift. NA-L stated that he [R21] was fixated on bowel medications (which NA-L had reported to the nurse). [R21] was stating that he was having loose stools, which, he was not. When NA-L told [R21] that he was not having loose stools, he became more upset and showed verbal behaviors. NA-L stated that she was laying him down for awhile, which he needed to do once	F 610	In response to any allegations of resident abuse, neglect, exploitation, or mistreatment, Pine Haven Care Center has policies and procedures that require that all alleged violations are thoroughly investigated. The policies have measures to prevent further potential abuse, neglect, exploitation, and mistreatment while the investigation is in progress. The policies instruct staff to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken. The goal will be to improve investigative methods including more extensive interviewing of staff, residents, and visitors, if appropriate. Options to adjust the work assignments of alleged perpetrators and/or remove alleged perpetrators from the schedule or facility were reviewed. Depending upon the type of allegation reported, the investigation would address the following: 1) Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where	

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 41 or twice a day because he has a sore on his bottom that needs to heal. When she went to lay him down, [R21] attempted to grab her breast, which she did not like. NA-L stated that she reacted by pushing his hand away from her breast, not slapping it away. NA-L stated [R21] then got upset with her when she pushed his hand away. NA-L stated she did not know if he knew where he was grabbing or not. NA-L stated as soon as he was in bed he had fallen asleep. She stated she reported his behaviors and mood to the nurse and passed it along in report. 2. This writer interviewed registered nurse (RN)-D (4-22-19), who was the RN who reported the incident. RN-D stated she heard about the incident during shift change. RN-D stated she did not know much about the incident other than that it had happened on the day shift. RN-D stated she had looked at R21 and there were no injuries. RN-D said she had heard in report during shift change, that R21 was stating the aide who was helping him had slapped his hand. 3. This writer interviewed R21 on 4/22/19. R21 stated the aide did slap his hand but not in a "bad way". R21 stated the aide did that because he was grabbing in the wrong place, not how he was supposed to. R21 stated that everyone here treats him right and good. R21 stated that he is satisfied with cares. R21 stated he was not sure why everyone was asking him about this, including the sheriff. R21 stated the sheriff told him he (R21) reported that the aide had slapped his hand. R21 stated he had never reported this and it was taken out of context. R21 stated he had no concerns. The report further indicated the facility's policies and procedures were followed. Review of internal investigation documents on file from the allegation did not include documentation	F 610	the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between a resident to other residents; 2) Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, practitioner, interviews with personnel from outside agencies such as other investigatory agencies, and hospital or emergency room personnel; 3) Conducting record review for pertinent information related to the alleged violation, as appropriate, such as interdisciplinary progress notes, financial records, risk management reports, hospital/emergency room records, laboratory or x-ray reports, medication administration records, photographic evidence, and reports from other investigatory agencies. During the mandatory meetings June 18, 2019 the staff will be reinstructed on the facility's policies and the regulatory requirements for 1) investigating alleged abuse, neglect, exploitation, and mistreatment and 2) reporting allegations and 3) preventing further abuse, neglect, exploitation, or mistreatment while the investigation is in process. As part of the facility's quality assurance and performance improvement process, the investigation of the alleged mistreatment of resident number 21 was reviewed by the administrative/supervisory	

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 42 of interviews with other staff or other residents. R21's annual Minimum Data Set (MDS) assessment dated 3/11/19, identified R21 had long and short term memory problems, had modified independence in decision making in new situations and delusions. The MDS further identified R21 required extensive assistance of one staff with all activities of daily living (ADL). On 5/16/19, at 5:21 p.m. the director of nursing (DON) stated NA-L was not removed from the schedule. The DON stated normally we pull the person off the schedule until the investigation was completed or pull off that area, but it depends on what type of investigation it is. On 5/16/19, at 5:36 p.m. social services (SS) stated the incident happened around 1:30 p.m. when NA-L was laying R21 down after lunch. SS verified she had only interviewed the alleged perpetrator (AP), the nurse who reported the incident and the resident. SS stated that constituted her complete investigation. SS verified she did not interview any other residents or staff. SS also verified the AP was not removed from the schedule but stated the AP was not working with R21 on that wing during the investigation. SS stated she completed the investigation the next day after it was submitted. SS stated, "To be honest I did not think of protecting other residents during the investigation." SS stated I know when I interviewed the AP she was working on the 200 wing. SS verified the AP was working with residents during the investigative process and had not been removed from the schedule. SS verified the information provided was the complete investigation. SS stated there was	F 610	staff. The resident will continue to be asked about his satisfaction with cares and services during one-to-one visits with the social worker and during the quarterly interdisciplinary care conferences. Compliance will be monitored by the Administrator/designee by tracking vulnerable adult reports for three months to ensure appropriate actions such as staff/resident interviews, report completion, schedule adjustments, staff suspensions, safety interventions, staff education/counseling, etc. are enacted during the investigation process. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the July 2019 Quality Assurance Committee meeting and ongoing.	

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 43	F 610		

nothing put into place to monitor/audit the AP interactions with residents. SS stated she did not have any documentation from the aides that were working that day or evening regarding the incident.

On 5/16/19, at 6:05 p.m. trained medication assistant (TMA)-B stated nursing assistant NA-M had reported that R21 had stated NA-L had slapped his hand. TMA-B stated she wrote her accounting on a piece of scrap paper and either gave it to registered nurse (RN)-D (the night nurse), or had put it in the social service box.

On 5/16/19, at 6:15 p. m. NA-M stated, "When I went to toilet [R21], he was talking and said that [NA-L] had slapped his hand because he let go of the handle on the easy stand." NA-M stated she was not aware of this allegation until R21 told her during cares, and said, "I told him that was not right that she did that." NA-M stated, 'I finished toileting him took him to the supper table and reported to the nurse. NA-M also stated, "I did write it out on a scratch piece of paper and gave the information to the nurse."

On 5/16/19, at 6:26 p.m. RN-D stated she turned the scratch pieces of paper that were given to her into the social worker mailbox.

On 5/16/19, at 6:48 p.m. the administrator stated the first person that R21 mentioned this to, right then and there should have reported it to the supervisor. The administrator stated the supervisor was to notify the DON and administrator at that time after ensuring the safety of the resident. The administrator verified the AP was not removed from the facility and continued to provide cares to the residents on that wing for

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 05/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 44 the rest of the shift. The administrator stated the AP should have been excused from working until completion of the investigation. The administrator stated the investigation should have included interviews with other residents and staff members and stated these interviews should be documented as a part of the investigation on interview forms. The Abuse Prevention Plan/Vulnerable Adult policy dated 3-2018 included, "Investigative Procedure: Any person with the knowledge or suspicion of suspected violations shall report immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours is events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials ...5-Day follow-up report: 1. After the MDH report has been made, the Vulnerable Adult committee, which consists of the Administrator, Director of Nursing, Social Services and the clinical nurse will thoroughly, investigate the incident determining whether it is true or false or not possible to substantiate or disprove through interviews and examination with involved parties ...Protection: Residents shall be protected from harm during an investigation. If needed room or staffing changes to protect the resident from the alleged perpetrator ..."	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		6/24/19

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 05/16/2019

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 625	Continued From page 45 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident, or legal representative, was informed of bed hold rights at the time of hospitalization for 1 of 2 residents (R4) reviewed for hospitalizations. Findings include: During an interview on 5/13/19, at 4:22 p.m. R4 stated she had recently been in the hospital for pneumonia. She was unable to remember if she had been provided any document about her bed	F 625	Pine Haven Care Center provides the resident or the resident's representative information regarding the facility's bed hold policy at the time of admission and when a resident is transferred to the hospital or goes on a therapeutic leave. The notice explains the facility's policies regarding bed-hold periods and addresses the duration of the bed-hold and the reserve bed allowance provided by state Medical Assistance Plan.	

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 05/16/2019

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 625	Continued From page 46 hold rights. According to a progress note in R4's electronic health record (EHR), on 5/7/19 at 8:48 p.m., R4 had a temperature of 99 degrees Fahrenheit, was confused and sleepy, and had crackles in her lungs. She was taken to St. Mary's hospital emergency department. The progress note did not include any statement about the provision of a bed hold notice. According to the EHR, R4 was readmitted to the facility on 5/8/19 at 2:41 p.m. with a new diagnosis of pneumonia. According to a progress note dated 5/10/19 at 2:32 a.m., R4 was again readmitted back from the hospital. A corresponding transfer to the hospital note was not found, nor was any bed hold documentation found. According to an interview 5/16/19, 10:14 a.m. social worker (SW)-A stated she was unable to locate a completed/signed bed hold document for either date R4 had been to the hospital. SW-A stated she was unaware she should have provided this because R4 had been admitted both times for "observation." However, SW-A confirmed she did not know prior to either transfer whether R4 would be in an observation bed, or admitted as an inpatient to the hospital. Furthermore, SW-A said that residents and families were often confused about their rights about any payments needed to hold a bed. SW-A stated, "I have had families asking me about that, worried, asking 'how much will this cost me?' I think I will just have anyone sign this whether an admission is for observation or not."	F 625	The Pine Haven Care Center policy addressing bed hold notification was reviewed and revised. Documentation that the resident/legal representative received a copy of the bed hold notice at the time of transfer to the hospital or therapeutic leave will now be made in the nurses' notes. During the mandatory June 18, 2019 meetings, the nursing staff will be reminded of the requirement to provide bed hold notices to residents and/or their representatives upon transfer to the hospital or when going on therapeutic leave. The procedures for providing bed hold policy notices are included in the orientation of new nursing staff. The bed hold notification and related documentation for resident number 4 were reviewed as part of the facility's ongoing quality assurance improvement process. The resident was uneventfully readmitted to the facility after the hospitalizations on May 8, 2019 and May 10, 2019. Appropriate and timely bed hold notices will be provided for any future hospitalizations or leave of absences for this and all other residents. To monitor compliance, for three weeks the Director of Nursing/designee will audit the records of residents transferred to the hospital or on therapeutic leave to verify that they were provided a copy of the bed hold notice. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nail care was provided to 1 of 3 residents (R2) reviewed for activities of daily living (ADL's) who were dependent on staff for assistance with ADL care. Findings include: R2's significant change minimum data set (MDS) assessment dated 5/2/19, indicated R2 had a severe cognitive deficit and required one person extensive assist with personal hygiene. R2's undated Admission Record, identified diagnosis of cerebral infarction, dysarthria (difficult articulation of speech), and anxiety disorder. During observation and interview on 5/13/19 at 2:47 p.m., R2 was observed sitting on the edge of her bed, barefooted. R2's toenails on both feet were observed to be long and thick. R2 stated, "When they are long like this my socks catch on them, and then my shoes don't fit right." R2 stated she couldn't clip them herself because she needed help and was not sure who would help her. R2's care plan dated 2/13/16, identified a focus area including: Required assistance with bathing related to past CVA (stroke), impaired mobility.	F 677	Pine Haven Care Center provides the necessary services to maintain good nutrition and personal care for residents who are unable to carry out activities of daily living independently. Based on the comprehensive resident assessment, the staff provides cares which assist the resident to maintain and enhance his/her self-esteem and self-worth. Assistance with nail care is provided in accordance with resident/representative preferences. The resident's need for assistance with grooming is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary. The facility's personal hygiene policies were reviewed and found appropriate. During the mandatory meetings on June 18, 2019, the staff will be instructed on the cares that are to be routinely provided as part of the bathing process, including nail care. Criteria for referring a resident to the podiatrist for toenail care were reviewed. On May 16, 2019, resident number two was asked by a staff member if it would be permissible to cut her toenails and the resident replied, "No, they are fine." Later	6/24/19

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 05/16/2019

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 677	Continued From page 48 Goal: continue to participate in the bathing process through the next review. Interventions included: Nail care as needed. R2's progress note dated 3/14/19 indicated [R2] had received a tub bath. "Nails are cleaned and do not need to be trimmed. Toes were done at podiatry on Wednesday." Further record review indicated that was the last time toe nail care had been documented as provided. During interview on 5/16/19 at 10:37 a.m., nursing assistant (NA)-K verified R2's toe nails were long and needed to be clipped. NA-K stated, "They should have been clipped this morning when she had her bath." During interview on 5/16/19, at 10:33 a.m. NA-F stated, "I did [R2's] bath this morning. Yes, I think [R2's] toenails did look long today, I did not clip them though. I will get that done." During observation and interview on 5/16/19, at 2:01 p.m. R2 appeared well dressed and was sitting in her wheelchair at the nurses' station. R2 stated, "I am waiting to get my toenails clipped." During interview on 5/16/19, at 2:18 p.m. the director of nursing (DON) stated, "Toenail care should be done on bath days, if they don't clip them every time because they do not need it, they should at least be assessing it." The facility's 12/2017 policy Care of Fingernails/Toenails (revised 1/2019), included: "The purpose of this procedure is to clean the nail bed, to keep the nails trimmed, and to prevent infections. Preparation: 1. review the resident's care plan to assess for any special needs of the	F 677	in the day the resident did allow a staff member to cut her nails. The resident frequently refuses nail care. The toenails of resident number two were checked by a registered nurse June 7, 2019 and were an acceptable length. The resident's toenails will continue to be monitored during the bathing process. The resident has one very thick toenail; a referral to the podiatrist will be made. The resident's care plan was reviewed to reflect frequent refusal of toenail care and the need for podiatry services. To monitor compliance, for three weeks a licensed nurse will check the length of the residents' toenails as part of the bathing process. If toenails are observed to need trimming, additional monitoring and staff training will be done. Compliance will be reviewed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 677	Continued From page 49 resident. General Guidelines: Nail care includes daily cleaning and regular trimming. 6. Stop and report to the supervisor if there is evidence of ingrown toenails, infections, pain, or if nails are too hard or too thick to cut with ease. Documentation: Any problems or complaints made by the resident with his/her hands or feet or any complaints related to the procedure."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow physician orders to notify the physician of weight gain, and failed to monitor and assess edema, for 1 of 2 residents (R54) reviewed for edema. Findings include: R54's annual Minimum Data Set (MDS) assessment dated 2/11/19, included R54's diagnosis of congestive heart failure, and indicated R54 had moderate cognitive impairment. The MDS also indicated R54 received diuretic medication during the assessment period.	F 684	Pine Haven Care Center staff believe that quality of care is a fundamental principle that applies to all services provided to the residents. Based on the resident's comprehensive assessment, the facility ensures that each resident receives treatment and care in accordance with professional practice standards. Priority is placed on developing a plan of care for each resident that focuses on person-centered care and reflects individual choices, preferences, and goals, as well as the resident's concerns and needs. The plan describes the services, including management of symptoms, that assist in attaining and	6/24/19

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 05/16/2019

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 684	Continued From page 50 R54's Diagnosis report dated 5/16/19, included diagnoses of: heart failure, chronic atrial fibrillation, and chronic kidney disease stage 3. R54's care plan printed and provided by the facility on 5/16/19, included; potential for alteration for cardiovascular status related to diagnosis of atrial fibrillation, hypertension, and congestive heart failure (CHF). The care plan directed staff to administer medication as ordered and observe for adverse side effects, and observe for signs and symptoms of increased edema, and significant weight changes. R54's skin care plan directed staff to apply compression stocking or ace wraps in the morning and remove at night. R54's physician orders included the following: -Daily weights. Notify the provider if weight gain of 3 pounds (lbs.) in 24 hours or 5 lbs. in a week (start date 3/16/19) -low stretch wraps or compression socks on in the morning and off at bedtime (start date 11/1/2017). -Lasix (diuretic medication) 60 milligrams by mouth in the morning for CHF (start date 5/6/18). R54's record was reviewed from 3/15/19, through 5/3/19, the record lacked evidence of ongoing edema monitoring as directed by the care plan and lacked evidence the physician was notified when there was a weight increase according to physician orders. R54's physician progress note dated 3/15/19, indicated reason for visit was hypertension, congestive heart failure and mental status changes. The note indicated R54 had 3+ pitting edema to both legs. The plan was to increase	F 684	maintaining the resident's highest practicable physical, mental and psychosocial well-being. The policies and procedures for identifying, reporting, monitoring and communicating symptoms were reviewed. The interdisciplinary care team assesses each resident's needs for care and services when a resident moves in, quarterly, with significant changes in condition, and more often as the resident's condition indicates. In recognition that managing symptoms can improve the resident's quality of life, the goal is to ensure that effective management is provided and that the resident's care is consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. An individualized plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on continuing resident assessments. If the resident exhibits symptoms such as excessive edema or weight gain, the attending physician is notified. During the mandatory meetings June 18, 2019, the staff will be instructed on 1) the need to be aware of changes in condition for all residents and to report changes to the nurse/physician as appropriate 2) the need to observe for edema when the resident has acute congestive heart failure and to monitor changes 3) the need to follow medical providers' orders	

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 05/16/2019

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 684	Continued From page 51 diuretic medication for five days. R54's weight record indicated a 6 lb. weight increase between 4/16/19, and 4/18/19. -4/16/19, 161.2 lbs. -4/17/19, 162.8 lbs. -4/18/19, 168.8 lbs. -4/19/19, 168.0 lbs. -4/20/19, 170.2 lbs. -4/21/19, 167.4 lbs. -4/22/19, 167.6 lbs. -4/23/19, 165.4 lbs. -4/24/19, 167.6 lbs. -4/25/19, 167.6 lbs. -4/26/19, 167.8 lbs. R54's record indicated the physician was not notified of the weight increase until 4/26/19. R54's progress note dated 4/26/19, indicated the physician was notified related to weight gain and swelling in lower extremities. R54's physician visit note dated 4/26/19, indicated the reason for visit was for routine recertification. The note included, "New Concerns: Nursing staff report fluctuations in her weight lately. She has been as high as 170 lb. and is 165 lb. yesterday morning [4/25/19]. This is up from her baseline of around 159 lb. Staff have noted some increase in leg edema as well. On visiting with her, she notes some lower extremity edema." The physical exam indicated R54 had 1+ pitting edema to both lower extremities with compression wraps on. The visit note included a plan to continue daily weights, increase R54's diuretic by 20 mg daily, and follow-up visit on 4/30/19. The note further indicated if R54's weight improved but edema continued, R54's amlodipine (cardiac medication) would be reviewed.	F 684	for notification of weight gain/loss. The Medical Director from Mayo Medical Center (provides services to most of the facility's residents) has discussed plans to provide a protocol to facilitate monitoring residents with congestive heart failure; tracking weights will be included in the protocol. The nursing staff will be educated on the protocol when it becomes available. Resident number 54 died at the facility on May 4, 2019. Her record has been reviewed by the nursing management staff as part of the facility's quality assurance and performance improvement process. To monitor compliance, for three weeks the Nurse Managers will audit the records of residents who have orders to contact the medical provider with weight gain/loss to ensure appropriate notifications are made. If noncompliance is noted, additional auditing and staff education will be completed. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 684	Continued From page 52	F 684		

R54's record lacked evidence of edema monitoring after the physician visit that indicated medication regimen change if edema did not improve.

R54's follow-up physician visit note dated 4/30/19, indicated at time of visit R54's weight was 164.4 lbs. after increased diuretic for five days, and indicated R54's legs had 1+ pitting edema. The note indicated R54's diuretic was changed related to lack of effectiveness of the original diuretic. The note also indicated the plan was to review blood pressures and weights on 5/3/19, and make adjustments to medications if warranted.

R54's record continued to lack evidence of ongoing edema monitoring and/or assessment.

R54's follow-up physician visit note dated 5/3/19, indicated R54's weight had decreased by 2.2 lbs. with change in diuretic, continued to have 1+ pitting edema in her legs, and directed to continue the diuretic as prescribed.

A progress note dated 5/4/19, indicated R54 was wheeling herself back from the dining room, stopped in her usual location in hallway at 6:40 p.m. and at 6:50 p.m. when staff were going to assist R54 back to her room, she was noted to have passed away.

During an interview on 5/16/19, at 12:45 p.m. the medical director confirmed he was R54's physician and was familiar with R54's medical history. The medical director stated he had not been notified of the six pound weight increase and/or the sustained weight increase between 4/17 and 4/26/19. The medical director stated

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 05/16/2019

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 684	Continued From page 53 although R54's death was not related to the facility's failure to notify the physician timely of her weight gain, he expected facility nursing staff to follow the physician's orders. The medical director further stated the facility had a new protocol for monitoring edema but it had not yet been implemented. The medical director stated the edema should be monitored and assessed based on the individual resident's medical history in order to identify when there is a change that may require a change in medications or treatment by the physician. During an interview on 5/16/19, at 1:21 p.m. the director of nursing (DON) reviewed R54's record and verified the record lacked evidence of edema monitoring and verified the physician orders were not followed when R54 had an increase in weight. DON stated edema assessments/monitoring should be documented in the record at least weekly during skin inspections on bath days and more often depending on the resident's clinical status. The facility's policy was requested and not received.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to	F 685		6/24/19

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 05/16/2019

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 685	Continued From page 54 and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance to ensure hearing aids were available to maintain hearing/communication needs for 1 of 1 resident (R2) reviewed for hearing. Findings include: R2's significant change Minimum Data Set (MDS) assessment indicated R2 had severe cognitive impairment, was admitted 2/1/16, and used a hearing aid or other hearing appliance with minimal difficulty hearing when the hearing aid/appliance was used. R2's Personal Inventory form dated 2/1/16, identified a hearing aide for the right ear. R2's care plan dated 2/13/16, included a focus area of: hearing aids. Goal: communication will be maintained, Interventions: Staff to assist resident with hearing aids as needed, such as placing in resident's ear, taking out and storing, check batteries daily and replace as needed, clean hearing aids with dry soft cloth or stiff brush as needed. R2's treatment administration record (TAR) dated May 2019, identified R2 to have hearing aids in every AM (morning): take out at bedtime and keep in the med cart with a start date of 8/9/18. During observation and interview on 5/13/19, at	F 685	Pine Haven Care Center ensures that residents receive proper treatment and assistive devices to maintain vision and hearing abilities. The facility staff assists the resident if necessary to make appointments and arrange for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairments. The facility assists the residents and their representatives in locating and utilizing any available resources (e.g., Medicare or Medicaid program payment, local health organizations offering items and services which are available free to the community) for the provision of the services. In situations where the resident has lost their device, the facility assists residents and their representatives in locating resources, as well as in making appointments, and arranging for transportation to replace the lost devices. Hearing aids will be inventoried at the time of admission and the families/legal representatives will be requested to notify the social worker or charge nurse if they take the hearing aids from the facility. The facility procedure is to secure the hearing aids overnight in the locked medication cart. If the resident prefers to store their hearing aids in their room overnight, they	

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 05/16/2019

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 685	Continued From page 55 2:36 p.m. R2 was sitting in her room and was noted to have a hearing aid in her left ear. R2 stated she was pretty deaf and had 2 hearing aids at one time. R2 said the hearing aids were $2000 a piece. R2 said she was missing her right hearing aid and was unsure when it had gone missing. R2 said she was mad when it went missing and continues to look for it everyday. During a phone interview on 5/15/19 at 5:25 p.m., family member (FM)-A verified they'd bought R2 new hearing aids and the facility had both of them. During interview on 5/16/19 at 10:37 a.m., nursing assistant (NA)-K stated R2's hearing aides were kept in the nurses' cart each night and stated R2 had her right hearing aid. Upon observation of R2 NA-K stated, "I guess she has her left hearing aid." During interview on 5/16/19, at 11:14 a.m. trained medication aide (TMA)-C stated, "A few months ago [R2's] right hearing aid was broken and her family has the right one. [R2] still has her left hearing aid." During interview on 5/16/19, at 11:15 a.m. licensed practical nurse (LPN)-D verified R2 has not had her right hearing aid here for a while. After reviewing the progress notes LPN-D stated, "In August of 2018, [R2's] left hearing aid broke and it was given to the family to fix, and in November of 2018, the right hearing aid was broken and given to the family to fix." LPN-D stated she was not sure if the family was aware of the missing right hearing aid or not. During interview on 5/16/19, at 12:50 p.m.	F 685	will be asked to sign a form attesting that they are aware of the increased risk of misplacement of the devices. During the mandatory meetings June 18, 2019, the staff will be reminded of the procedures for assisting the residents in securing/storing their hearing aids. The staff will be instructed to be alert to the placement and safe handling of the hearing aids due to their small size, expensive replacement cost, and impact of the device on the resident's quality of life. When the Director of Nurses interviewed resident number two on June 7, 2019, the resident was not wearing her hearing aids. When asked about her hearing aids, the resident stated she does not want to wear them because she "wants her ears to be free." According to the registered nurse note, "she does have functional hearing and was able to understand the conversation with no trouble." The care plan will be updated accordingly and the resident's preference for hearing aid use will be addressed during the quarterly interdisciplinary care conference. To monitor compliance 1) the hearing aid use and storage preferences for all residents will be readdressed within the next 90 days and their care plans will be updated as necessary and 2) the Environmental Services Manager/designee will review all Missing Item Reports for the next three months to determine whether there was appropriate	

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 05/16/2019

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 685	Continued From page 56 licensed practical nurse (LPN)-B stated, she was the clinical manager of this R2's unit and was unaware that R2 was missing a hearing aide. LPN-B further stated, "When there is a broken or missing hearing aid the wing nurse should let LPN-B or social services know." LPN-B said she was not sure where the other hearing aid went. During interview on 5/16/19, at 2:24 p.m. the director of nursing (DON) stated, "[R2's] hearing aides have been an issue. We need to get this figured out. [R2] should have both of her hearing aids." During interview on 5/16/19, at 3:12 p.m. social services (SS)-A, state she was aware of issues with R2's hearing aids and stated, "I will dig into it and let you know." At 6:15 p.m. on 5/16/19, SS-A stated she had looked in the med cart and R2's hearing aid was not there. "Since the staff here did not know [R2] was missing the hearing aide, they are not checking this daily." SS-A said she had guessed R2's son had come and picked up the hearing aid, took it to fix it, brought it back, and then it went missing again. SS-A said she would ask housekeeping to help search R2's room and added, "If we find it, we will call her son, so he can get it fixed. Then we will educate the staff that they need to be checking her ears to make sure she has her hearing aids in." The facility's policy Care of Hearing Aids dated 12/2017 (revised 1/2019), identified the purpose of caring for a hearing aid was to maintain the resident's hearing at the highest attainable level. "Storage of the hearing aid: 1. turn the hearing aid off when not in use. 2. Remove the battery	F 685	follow up and documentation related to lost hearing aids. If noncompliant trends are noted, related systems will be investigated to identify opportunities for process improvements. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 685	Continued From page 57 from the battery case when the unit is not in use. Leave the case open. 3. be sure the hearing aid container is clearly labeled with the resident's name and room number. Reporting: 1. Notify the supervisor if hearing aid is damaged or needs to be sent to the dealer for cleaning. 2. Notify the supervisor if the resident complains of problems related to hearing and/or hearing aid or has wax build up in the ear. 3. Report other information in accordance with facility policy and professional standards of practice."	F 685		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a reduction in range of motion (ROM) or provide services to maintain range of motion (ROM) of extremities for	F 688	Pine Haven Care Center provides comprehensive care and services to attain or maintain the highest practicable physical, mental and psychosocial	6/24/19

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 05/16/2019

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 688	Continued From page 58 1 of 1 (R32) resident reviewed for ROM. Findings include: R32's significant change Minimum Data Set (MDS) assessment dated 4/4/19, indicated R32 had an on-going decline in condition and had been admitted to hospice services. The documentation within the MDS indicated R32 had no limitation in ROM. According to R32's admission record, R32 had a diagnosis Alzheimer's disease, osteoarthritis (a degenerative disease of the joints which can reduce range of motion and produce pain with movement). R32's care plan dated 12/12/14, included the following problem area: Requires assistance for mobility, positioning and locomotion related to deconditioning and dementia. The listed problem did not include an identified risk for decreased ROM nor did it include any provision of interventions that would reduce R32's risk for contractures (a condition where soft tissues such as muscles and tendons become rigid and joints may become deformed and immobile). During an observation on 5/13/19, at 7:26 p.m. R32's right hand was pulled tightly into a fist with the thumb pulled in tightly across the fingers. Knuckles of the hand observed to be swollen in appearance. Tendons were prominent. R32 made no effort to move the hand or fingers and was unable to follow direction to open the hand. On 5/15/19, at 7:06 a.m. R32 was seated in a wheel-chair in the lobby of the building with right hand pulled tightly into a fist with the thumb under	F 688	well-being of all residents. The goal of Pine Haven Care Center staff is to ensure that residents who enter the facility without limited range of motion do not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction is unavoidable. Based on the initial comprehensive assessment and routine subsequent reassessments, a resident with limited range of motion receives appropriate treatment and services to increase range of motion capability to the highest possible level and/or prevent further limitation in range of motion. The policies and procedures for assessing a resident's range of motion were reviewed and found appropriate. The range of motion component of the resident-centered plan of care is based on the physical and occupational therapist recommendations, a nursing assessment of the resident's functional status, and the resident's rehabilitative/restorative goals and participation preferences. Appropriate referrals to the physician and/or therapist are made if there is a decline in functional status. The policies and procedures for implementing therapy recommendations were reviewed and revised. During the mandatory meetings June 18 2019, the nursing staff will be instructed on the procedures for assessing the resident for contractures and providing range of motion exercises.	

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 05/16/2019

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 688	Continued From page 59 the fingers. According to an interview on 5/16/19, at 3:00 p.m. nursing assistant (NA)-G and trained medication aide (TMA)-B stated a person with reduced ROM should receive cares such as ROM exercises to prevent contractures and/or something to position or support the joint. TMA-B said the nurse should be notified if a resident had reduced ROM and it should be documented in the resident chart. During an observation and interview on 5/16/19, at 4:29 p.m. licensed practical nurse (LPN)-A confirmed R32 was unable to open her right hand independently. LPN-A attempted to assist R32 with opening her hand. With assist, R32 was able to straighten the first two joints of each finger except for the thumb. R32 was not able to straighten the thumb. LPN-A was unable to fully extend any of the fingers at the third knuckle joint where the fingers meet the hand. The fingers remained in a bent position, flexed down, in relation to the hand. Furthermore, LPN-A confirmed that R32's fingers could not be fully spread open even with assistance nor could the thumb be positioned away from the palm of the hand. LPN-A stated she could see a red area of pressure at the first knuckle of the thumb where it had been pushing against the palm of the hand, and several red areas on the palm where LPN-A thought fingers had been pushing against the skin. R32 stated it was painful when LPN-A attempted to open her hand. According to LPN-A this was a definite change in R32's condition and should have been reported. According to an interview on 5/16/19, at 3:44 p.m. the director of nursing (DON) stated she was unaware of R32's reduced ROM. The DON	F 688	Two licensed nurses reassessed the range of motion of the right hand of resident number 32 on June 9, 2019 at 9:00 a.m.. The resident was able to extend her fingers and thumb to a functional level with no verbal or nonverbal indications of pain. The resident's hand muscles contract more at night and the hand is more difficult to open upon first awakening; the order for a rolled wash cloth in the right hand during the day (which has been falling from the resident's hand due to the voluntary extension of her fingers) will be changed to placement of a rolled wash cloth in the right hand at night as the resident tolerates. The resident's care plan was reviewed and revised accordingly. During the next two weeks, a licensed nurse will reassess the upper extremity range of motion of the long term care unit residents. If undocumented range of motion limitations are observed, interventions will be implemented as appropriate and additional range of motion assessments and staff training will be done. The range of motion of new admissions will be evaluated during the minimum data set assessment process. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 688	Continued From page 60 stated, "Any resident with a reduction in ROM, or at risk for contractures, should be assessed." The DON stated the expectation would be to consult a provider and perhaps get recommendations from physical therapy for the resident's care. In addition, the DON confirmed R32 was at risk for contractures if unable to move her hand independently and if not receiving assistance with movement and positioning. A policy related to range of motion was requested. The facility provided a document titled Resident Mobility and Range of Motion, originally dated 12/2017 and revised 2/2019. The policy statement included the following: "Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in ROM." The policy interpretation and implementation portion of the policy included the following: 1. As part of the resident's comprehensive assessment, the nurse will identify the resident's a. Current range of motion of his or her joints ... The policy also stated: 4. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		6/24/19

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 05/16/2019

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 689	Continued From page 61 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a portable oxygen tank was properly secured in a portable oxygen tank cylinder cart for 1 of 1 resident (R1) observed to be ambulating with an the oxygen tank placed into the basket of her walker. Findings Include: R1 was observed on 5/14/19, at 2:41 p.m. to be walking in the hallway of the rehab unit with a portable cylinder oxygen tank and tubing placed in the basket of her walker. R1 sat down on a chair in the hallway and licensed practical nurse (LPN)-A checked her oxygen levels. LPN-A escorted R1 back to her room with the oxygen placed in the walker basket. On 5/14/19, at 2:51 p.m. LPN-A verified R1 had the oxygen placed in the basket of her walker. LPN-A stated, "Yes, I would think this would be a safety concern." On 5/14/19, at 3:00 p.m. registered nurse (RN)-A stated oxygen should not be in the basket of a walker, it could have easily tipped out. RN-A stated the oxygen should be placed in a stand that R1 can use to pull when she walking. RN-A verified the oxygen that had been placed on the walker basket was a large oxygen tank.	F 689	Pine Island Care Center has policies and procedures to ensure that the residents' environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a safety plan of care. The interdisciplinary care team comprehensively assesses each resident at the time of admission to identify safety risks and develops a resident-centered plan of care with interventions that enhance and promote safety. The resident's safety needs/risks are reassessed quarterly and whenever there is a change in the resident's behavior, physical condition, and/or cognition that impact safety and functional status. The care plan is modified as necessary with the goal to attain maximum function with minimal risk of injury. The resident's safety interventions are communicated to the direct care staff during shift reports and through routinely updated care plans. The policies and procedures related to oxygen storage and transport were	

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 05/16/2019

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 689	Continued From page 62 On 5/15/19, at 8:23 a.m. the director of nursing (DON) stated oxygen must be upright and not laying in the basket. The DON stated it was really not safe to have the oxygen placed in the walker basket. The DON stated I am sure staff put it (oxygen tank) in the basket of the walker and stated R1 could not do it. On 5/15/19, at 3:31 p.m. nursing assistant (NA)-A stated it was not safe to have the oxygen tank in the basket of the walker. NA-A stated I saw it (R1's oxygen) in there (the walker basket) once yesterday and stated usually in the cart. The facility's Oxygen Administration and cleaning of O2 equipment policy revised 3/15/18, included: "Oxygen Safety: ...3. Oxygen must be secured in a portable oxygen carrier."	F 689	reviewed and found appropriate. During the mandatory meetings June 18, 2019, the nursing staff will be reinstructed on the safe transport of oxygen cylinders. Resident number 1 was discharged home on May 29, 2019. After a fall at home, she was readmitted to the facility from the hospital on June 4, 2019 with the goal to discharge home after completing therapy. She has an order for supplemental oxygen with walking/exertion. A portable oxygen cylinder holder will be used to securely restrain the resident's oxygen cylinder to the walker/wheelchair during transport between locations within the facility. The resident's interdisciplinary care plan will address oxygen use. Compliance will be monitored by the Activity Director/designee who will randomly observe for secure mounting of oxygen cylinders to the walker or wheelchair during resident transport to meals, activities and other locations throughout the facility. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the July 2019 Quality Assurance Committee meeting.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		6/24/19

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 05/16/2019

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 690	Continued From page 63 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess a change in urinary and bowel continence status for 1 of 1 resident (R8) reviewed who had a change in continence status. Findings include:	F 690	Bowel and bladder function is considered an important part of the resident's comprehensive assessment and is recognized as having a significant impact on the residents' quality of life. The goal of Pine Island Care Center staff is that a resident who is continent of bladder and bowel on admission receives services and	

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 05/16/2019

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 690	Continued From page 64 R8's annual Minimum Data Set (MDS) assessment dated 11/13/18, indicated R8 was frequently incontinent (this was a decline for R8) of urine, was occasionally incontinent of Bowel (this was a decline for R8) was not on a toileting program and was independent with toileting and required set up help only. In addition, the MDS indicated that a toileting program was not being used to manage urinary or bowel incontinence. However, the quarterly MDS dated 8/14/18, indicated R8 was occasionally incontinent of urine, was continent of bowel and was not on a toileting program. R8's Bowel/Bladder Assessment dated 8/13/18 indicated R8 was mildly incontinent of bladder and continent of bowel. Treatment Plan: 1. Scheduled/Habit toileting: schedule toileting at regular intervals on planned basis (reduces episodes of incontinence) cognitively impaired; functionally disabled; caregiver dependent. Was answered yes. Plan to maintain current level of continence. R8's Bowel/Bladder Assessment dated 11/13/18 indicated R8 was frequently incontinent of bladder and continent of bowel. Treatment Plan: 1. Scheduled/Habit toileting: schedule toileting at regular intervals on planned basis (reduces episodes of incontinence) cognitively impaired; functionally disabled; caregiver dependent. Was answered yes. Plan to maintain current level of continence. R8's care plan included, "Requires assistance for the physical process of TOILETING related to: Cog. (cognitive) deficit, deconditioning, and use of diuretics. R8 has noted URGE and FUNCTIONAL bladder incontinence r/t (related	F 690	assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. Based on the resident's comprehensive assessment, the Pine Island Care Center staff ensures that a resident who is incontinent of bowel and/or bladder is identified and assessed with the subsequent development of an individualized plan of care that includes interventions to achieve or maintain as much normal bowel and bladder function as possible. The policies and procedures for assessing urinary/bowel function and incontinence were reviewed and found appropriate. During the mandatory educational meetings June 18, 2018, the licensed nursing staff will be instructed on the importance of 1) conducting a comprehensive, accurate assessment of bowel and bladder function 2) ongoing monitoring and tracking of voiding patterns and episodes of incontinence and 3) developing and implementing interventions to promote continence, manage incontinence and prevent infections. The direct care staff will be instructed on the importance of following the resident's bowel/bladder management plan of care. The bowel/bladder function of resident number 8 is being reassessed. The resident's voiding pattern is being monitored for six days after which the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 05/16/2019

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 690	Continued From page 65 to) back pain." Interventions included, "Toilet resident upon rising, after breakfast, before and after lunch and supper meals, hs (hour of sleep) and prn (as needed). TOILETING - One person constant supervision and phys (physical) assist for safety ie. adjust clothing, wash hands, pericare. TOILETING required. Uses incontinent products check and change q2-3h, and as needed. Pericare with each incontinence, protective barrier product as needed." R8's nursing assistant care plan directed staff to toilet R8 every two hours and as needed. R8 was interviewed on 5/13/19, at 3:27 p.m. and stated, "Once in a awhile, I have problems with urgency. This has been a problem for about a year and the facility has not discussed this with me. I still take myself to the bathroom." On 5/15/19, at 1:38 p.m. nursing assistant (NA)-I stated R8 takes herself to the bathroom. NA-I stated R8 was not on a toileting schedule and stated R8 did not ask for help to go to the bathroom. On 5/15/19, at 2:16 p.m. NA-J stated R8 was independent with going to the bathroom. NA-J stated R8's nursing assistant care plan indicated R8 was incontinent and stated every two hours we are to offer to toilet her and as needed. NA-J stated R8 normally takes herself. NA-J stated if I catch her doing it herself, I will go in and assist her. NA-J stated R8 did not put her call light on to go to the bathroom and stated I think the only time R8 puts on her call light was by accident. NA-J stated I will offer to help her (with toileting) but she refuses.	F 690	data will be analyzed by a registered nurse. The care plan will then be reviewed by the nurse and staff interventions will be revised as necessary to promote continence and manage incontinence. Maintaining independence in toileting is important to the resident and the goal will be to maximize her ability to self manage her bowel/bladder program to the greatest extent possible. The resident's toileting plan of care has been updated and will be revised as needed based on the ongoing bowel/bladder assessment. The certified nursing assistant's care worksheets were reviewed for accuracy. To monitor compliance, the MDS Coordinator will conduct a three-month audit for any decline in urinary continence identified during the minimum data set assessments. If a decline is noted, the clinical manager will determine whether the resident's toileting plan was appropriately reevaluated. The residents' bowel/bladder function and toileting needs will continue to be assessed quarterly and reviewed during the quarterly interdisciplinary care conferences with the resident's plan of care revised as needed. Compliance will be reviewed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 690	Continued From page 66	F 690		

On 5/15/19, at 4:25 p.m. licensed practical nurse (LPN)-B stated R8 was independent with toileting and stated R8 can ring if she was incontinent and needed help with toileting. LPN-B stated staff do not check on her for toileting issues. LPN-A reviewed R8's toileting care plan and verified the care plan had three different conflicting toileting interventions that included a toileting schedule, indicated R8 required supervision and assistance and had check and change every 2 to 3 hours. LPN-B stated the care plan needed to be updated. LPN-B stated the care plan should be updated to R8 was independent with toileting and will alert staff if she needed help with incontinence. LPN-B stated R8 does not ask for much help and stated if R8 needed the help she definitely asked for it and stated she will let us know. LPN-B verified the nursing assistant care plan directed staff to toilet R8 every two hours and as needed.

On 5/15/19, at 4:52 p.m. the director of nursing (DON) stated, "We have not done a bowel and bladder program with her [R8] is a tough one to get to do things." The DON added, "That does not mean we should not try." The DON stated R8 was one of those residents who was independent, but probably should not be. The DON also stated R8 probably needed assistance with toileting, but does not want to give up the independence. The DON verified R8 had experienced a decline in bladder and bowel continence from the 8/13/18 quarterly MDS to the 11/14/18 annual MDS and verified R8 had not been reassessed to determine interventions to restore or prevent further loss of continence.

On 5/15/19, at 5:17 p.m. registered nurse (RN)-C stated, "We usually review a decline in bowel and

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 05/16/2019

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 690	Continued From page 67	F 690		

bladder in the IDT (Interdisciplinary team) meeting in mornings. We should try to find out the reason for the change in bowel and bladder and update the care plan." RN-C also stated staff should attempt to restore bowel and bladder to previous level of function when there was a decline in continence.

On 5/16/19, at 12:03 p.m. RN-C stated, "I did not see where the facility did anything to attempt to restore [R8's] incontinence for bowel and bladder after she displayed a decline in continence. The facility should have reviewed a bowel and bladder screening three-day void documentation and then attempted to implement a toileting plan around the times she was incontinent."

The facility's Functional Impairment policy revised 3/2018, indicated: "Staff will identify individuals with a significant decline in function, including ability to perform activities of daily living (ADLs). Cause Identification: As appropriate, the physician and other staff will identify and evaluate the individual's co-morbidities, conditions causing functional decline, symptoms, risks, impairments and disabilities, and investigate their causes."

The Bowel and Bladder Protocol policy revised 3/2018 included Purpose: The purpose of this is to gather information on urinary and bowel incontinence, bowel training program, and bowel patterns. Each resident who may be incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments, and/or devices) and services to achieve or maintain as normal elimination function as possible. Procedure: 1. Bowel and bladder assessments and 3 Day

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 05/16/2019

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 690	Continued From page 68 Bowel and Bladder Screenings will be completed on all residents upon admission, with all quarterly, significant change, and annual MDS's, and with hospital returns. 2. The clinical manager or designee will initiate the 3-day bowel and bladder-screening tool. The Screening Form needs to be completely filled in for each hour for each shift for the full 72 hours. Each shift, the nurse on that wing needs to initial the sheet and any comments. 3. At the end of the 72-hour screening, the RN will review the bowel and bladder assessment based on the data gathered. 4. Implement the care plan based upon the assessment of the resident's unique toileting pattern.	F 690		
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: Based on observation, interview and document review, the facility failed to maintain clean and sanitary equipment for 1 of 1 resident (R4) reviewed for respiratory care. Findings include: R4's admission record indicated R4 had a diagnosis of dementia. A progress note dated	F 695	Pine Island Care Center ensures that a resident who needs respiratory care and services, including supplemental oxygen, is provided such care/services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	6/24/19

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 05/16/2019

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 69 5/9/19, at 2:41 p.m. indicated R4 had been readmitted from a short hospital stay with a new diagnosis of pneumonia. During interview and observation on 5/13/19 at 3:51 p.m., R4 stated she had been in the hospital recently and was told she had pneumonia. She said she wasn't sure where or how she had caught it. She was observed to be receiving oxygen (O2) supplied by a concentrator machine given through a nasal cannula. The tubing did not have a date indicating when it had been applied or when fresh tubing should be supplied. A review of R4's record failed to include a physician's order for oxygen until 5/15/19, and there were no directions for changing the tubing or care of oxygen supplies found in the medication or treatment administration records. A review of R4's care plan did not find interventions related to oxygen use or care of the equipment. On 5/15/19, at 8:15 a.m. R4 was observed to be in the dining room, utilizing O2 from a tank attached to her wheelchair. In her room the O2 tubing from concentrator was observed to be laying on the floor. On 5/15/19, at 9:39 a.m. R4 had not returned to her room and the O2 tubing was observed to remain on the floor. According to an interview 5/15/19 at 9:42 a.m., trained medication aide (TMA)-B confirmed the tubing was laying on the floor and said, "Oh, that should be wrapped up and not on the floor. Ideally, we would have some baggies to keep that off the floor." TMA-B was observed to pick up the tubing and place it on top of the concentrator.	F 695	Resident number 4 is occasionally short of breath and has an order for supplemental oxygen to keep her oxygen saturation levels above 90%. When oxygen is not in use the oxygen tubing is stored in a bag attached to her oxygen concentrator. The oxygen tubing is changed every Thursday according to facility policy. The care plan has been updated accordingly. To monitor compliance, the records of all residents using oxygen will be reviewed to ensure that there are current orders for oxygen use and for frequency of changing of oxygen tubing. The Environmental Services Director/Designee will randomly check the rooms of residents receiving oxygen therapy for two weeks to ensure there is no oxygen tubing on the floor while the resident is out of the room. If noncompliance is noted, additional auditing and staff education will be completed. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 70 TMA-B did not replace the tubing with clean supplies. On 5/16/19, 8:40 a.m. R4's room was observed. R4 was not in the room, and the O2 tubing attached to the concentrator was draped up over the concentrator with the tip hanging over the back of the machine touching the floor. The director of nursing (DON) came to room and confirmed the tubing was laying so the tip of the tubing was touching the floor. The DON confirmed this was an infection control issue and that R4 was at high risk for infection, having recently been diagnosed with pneumonia. The DON stated they had recently provided training to the staff related to care of oxygen equipment. The DON also stated care of the equipment and tubing changes should be documented in the resident's treatment administration record. The DON removed the soiled tubing from R4's concentrator and replaced it with clean. A facility policy related to the care and cleaning of oxygen equipment was requested. The facility policy Cleaning and Disinfection of Resident-Care Items and Equipment, revised 3/2019, included: "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard." The policy did not include information about the specific care, cleaning or storage of oxygen equipment.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		6/24/19

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 05/16/2019

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 755	Continued From page 71 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff had the knowledge of proper disposal of fentanyl patches (an opioid patch delivery system), to prevent potential diversion. This had the potential to affect all 55 residents who resided in the facility. Findings include:	F 755	Pine Island Care Center provides pharmaceutical services to meet the needs of each resident. The facility has a contract with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of related procedures to	

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 05/16/2019

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 755	Continued From page 72 During medication storage review, of licensed nursing staff (LPN) were interviewed, with the following being reported, as to how used fentanyl patches were to be disposed of: During an interview on 5/15/19, at 8:27 a.m. (LPN)-D, when asked how fentanyl patches were destroyed after use, LPN-D stated, we just throw them in the garbage. During an interview on 5/15/19, at 9:55 a.m. director of nursing (DON) stated, for fentanyl patch destruction 2 licensed staff flush down the toilet that is our policy. During phone interview on 5/16/19, at 9:49 a.m. Pharmacist (P) stated, in regards to fentanyl patch destruction (Centers for Medicare & Medicaid Services) CMS recommends to flush in the sewer system. Sterling pharmacy recommends to check with your solid waste provider first, then either put the fentanyl patch in drug buster or the sewer system. Sterling pharmacy strongly discourages putting fentanyl patches in the garbage or Sharps containers. Fentanyl Package insert, Disposing of Fentanyl Patch transdermal System, indicated to fold the used Fentanyl patch transdermal system in half so the sticky side touches itself. Flush the used Fentanyl patch transdermal system down the toilet right away. A used fentanyl transdermal system can be very dangerous and lead to death in babies, children, pets and adults who have not been prescribed fentanyl transdermal system. In review of a facility policy, entitled: Destruction of Fentanyl Patches, dated 2/2019. To be	F 755	ensure the accurate acquiring, receiving, dispensing, storing, administering, and disposing of all drugs and biologicals. In accordance with State and Federal laws, the facility stores all drugs and biologicals in locked compartments under proper temperature controls, and permits only authorized personnel to have access to the keys. Controlled substances are stored in a separate double locked, permanently affixed compartments. The facility has policy and procedures addressing safe disposal of controlled substances. The facility policy for disposal of controlled medications was revised to require that the nurse removing a fentanyl patch sign the narcotic book verifying proper disposal of the patch. During the meetings June 18, 2019, the licensed nurses will be informed of the policy changes. To monitor compliance, the Director of Nursing/designee will review the narcotic book for two weeks to verify documentation of fentanyl patch disposal. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 755	Continued From page 73 completed in the presence of 2 licensed staff, with both staff witnessing the removal of the old patch and the destruction of the old patch. 1. Identify the location on the body of the patch. 2. Remove the old patch form the body. 3. Fold the patch in half. 4. Place patch into the sewer system as per recommendations of product labeling. 6. Sign in (medication administration record) MAR that the fentanyl patch was changed, with second licensed staff co-signing. This signature indicates the patch was discarded as directed per (Food and Drug Administration) FDA guidelines and product labeling recommendations.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		6/24/19

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 05/16/2019

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 756	Continued From page 74 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmacist recommendations were acted upon for 1 of 5 residents (R1) reviewed for unnecessary medication use. Findings include: R1's Order Summary Report signed 4/30/19, identified R1's current physician orders included Seroquel 25 mg(milligrams) by mouth in the evening. R1's Consultant Pharmacist's Medication Review dated 4/13/19, identified the consulting pharmacist (CP) identified an irregularity to ensure that an orthostatic blood pressure was monitored at least once a month. R1's subsequent Pharmacist's Medication Review dated 5/6/19, identified the CP had again	F 756	The goal of Pine Haven Care Center is to maintain the resident's highest practicable level of physical, mental and psychosocial well-being and prevent or minimize any adverse consequence related to medication therapy to the extent possible, by providing medication oversight and review by a licensed pharmacist, attending physician, medical director, and the director of nursing. Pine Haven Care Center contracts with a licensed pharmacist to review the resident's medical chart and drug regimen at least once a month. The pharmacist reports irregularities to the resident's attending physician, the medical director and director of nursing, and these reports are acted upon. The Director of Nurses has reviewed the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 05/16/2019

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 756	Continued From page 75 identified the same irregularity to ensure that an orthostatic blood pressure was monitored at least once a month. On 5/14/19, at 3:33 p.m. the director of nursing (DON) stated the pharmacy recommendations to implement orthostatic blood pressure monitoring for R1 had not been done. On 5/16/19, at 9:49 a.m. the CP stated, "Orthostatic blood pressure monitoring is a standard side effect monitoring tool for antipsychotics. The goal is to have one orthostatic blood pressure taken a month to ensure the resident is not having a drop in blood pressure upon rising. Antipsychotic use can cause the blood pressure to drop and increase the risk of falling." The facility's Drug Regimen Review/Medication Regiment Review policy dated 11/27/17, included: "Pharmacist recommendations not requiring a prescriber order should be addressed within 30 days."	F 756	procedures for responding to the pharmacist recommendations which were found to be appropriate. Due to the anticipated discharge of resident number 1, her orthostatic blood pressure was not taken. It was subsequently checked on May 19, 2019 and will be checked monthly hereafter. The orthostatic blood pressures for other residents receiving an antipsychotic medication were audited and were found to have been checked within the recommended time frames. Compliance with timely response to the consulting pharmacist's recommendations will be monitored by the Medical Record Coordinator who will audit the pharmacist's review forms for 60 days to verify follow up to the recommendations. If noncompliance is noted, additional monitoring will be done. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		6/24/19

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 05/16/2019

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 761	Continued From page 76 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drops were dated when opened, or were discarded as identified by the manufacturer's inserts for 5 of 6 residents (R38, R6, R33, R7, and R35) reviewed for eye drops on 2 of 5 medication carts. In addition the facility failed to ensure stock medications were discarded after the expiration date, on 1 of 5 medication carts, and 2 of 3 medication rooms. This had the potential to affect all residents who required the use of eye drops and stock medications, reviewed for medication storage. Findings include: On 5/15/19, at 8:37 a.m. the 500 wing medication cart was observed and reviewed with licensed practical nurse (LPN)-D which identified the following: R38 had opened bottles of Lantaprost eye drop solution, (manufacturer instructions, identified	F 761	Pine Haven Care Center provides pharmaceutical services to meet the needs of each resident. The drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The medication administration policies and procedures were reviewed and found appropriate. Facility policies and procedures require that outdated and expired drugs and biologicals be discarded according to accepted practice standards and that medication/biological storage containers be dated when opened. During the meetings on June 18 2019, the licensed nursing staff and trained medication assistants will be reinstructed	

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 05/16/2019

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 761	Continued From page 77 used to reduce high pressure inside the eyes and should not be used for more than 6 weeks after opening). In addition, a bottle of Timoptic solution, (manufacturer instructions, identified used to reduce pressure in the eyes. The instructions lacked information on when the medication would be expired after opening) and a bottle of Liquid Tears. The pharmacy label identified the bottle of Lantaprost solution was filled by the pharmacy on 4/8/19, an open date was not identified. The pharmacy label identified the bottle of Timolol solution was filled by the pharmacy on 3/7/19, an open date was not identified. The pharmacy label identified the bottle of Artificial Tear drops was filled by the pharmacy on 12/14/18, an open date was 12/15/18. R6 had a bottle of Artificial Tear drops with no date opened, with a filled by pharmacy date of 7/9/18. R33 had a bottle of Artificial Tear drops, date opened 7/9/18, with a filled by pharmacy date of 6/25/18. R7 had a bottle of Artificial Tear drops with no date opened, with a filled by pharmacy date of 12/21/18. LPN-D verified the above eye drops were still in use, and should have been discarded. On 5/15/19, at 9:49 a.m. the 200 wing medication cart was observed and reviewed with the director of nursing (DON) which identified the following: R35 had a bottle of Refresh Plus solution date opened 10/30/18, and was filled by the pharmacy on 10/30/18. The DON was unsure of the	F 761	on the need to check expiration dates before administering medications/biologicals and to date medication containers when opened. The stock supply of medications that are not included on the standing orders will be discontinued. The eye drops for residents number 6, 7, 33, 35 and 38 which were expired or did not have date opened labels were discarded and replaced with new eye drops as necessary. All medication carts and storage areas were checked for expired medications/biologicals and open date labeling of medication/biological storage containers. Any expired or opened undated medication/biological containers were discarded. To monitor compliance with discarding of expired medications and open date labeling of medication/biologicals containers, the medication storage areas will be checked monthly for three months by a licensed nurse or trained medication assistant. Random audits will be done thereafter. Compliance will be reviewed during the July 2019 quarterly Quality Assurance Committee meeting.	

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 05/16/2019

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 761	Continued From page 78	F 761		

expiration date and stated, "I will get back to you on that."

On 5/15/19, at 9:49 a.m. the 400 wing medication cart was observed and reviewed with the director of nursing (DON) which identified the following:

A stock multivitamin bottle expired on 2/19, and a stock Senna lax 8.6 mg bottle expired 12/18. The DON verified the bottles were opened and currently in use and stated, "These bottles should have been removed to be destroyed when they expired."

On 5/15/19, at 9:55 a.m. the 100 wing medication room was observed and reviewed with the DON which identified the following:

Eleven bottles of stock multivitamins were found to be expired on 2/19. The DON verified this is stock medication for the whole building and stated, "Our medical record's person is responsible to make sure stock medications are not expired. Each nurse should be checking expiration dates prior to giving the medication to a resident also."

On 5/15/19, at 10:23 a.m. the 600 wing medication room was observed and reviewed with the director of nursing (DON) which identified the following:

A box of stock Bisacodyl suppositories stored in the medication refrigerator was found to have 28 suppositories expired on 3/2019. The DON verified they should have been discarded when they were expired.

During phone interview on 5/16/19, at 9:49 a.m.

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 05/16/2019

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 761	Continued From page 79	F 761		

when questioned regarding expiration of eye drops and stock medications, the consulting Pharmacist (CP) stated, "The pharmacy has new recommendations since CMS (Center for Medicare and Medicaid Support) came out with the new eye drop regulations. With Lantaprost after opened it is only good for 6 weeks. Timolol, artificial tear drops, and refresh tear drops should all be discarded 28 days after opening. This is why we recommend dating the eye drops upon opening them. Although I have personally never seen this, if used after the recommended 28 days you have the potential for eye infection. With Bisacodyl suppositories, multivitamin, and Senna lax, they should all be thrown out after their expiration date, it may not hurt you, but it potentially may not be as effective. Sounds like they need to be having some medication cart audits done. I will be contacting our nurse consultant to get some medication cart audits going."

The facility's policy Eye Drop Expiration dated 3/2019, included a policy statement to ensure the resident is administered eye drops in a safe manner, and to ensure that all eye drops administered are not expired. "Policy interpretation and Implementation: 1. before administration of eye drops, staff will ensure the medication is not expired. 2. Each eye drop bottle has a date opened sticker on it and when the medication is opened, staff will date the medication. D. Ophthalmic Solutions Ophthalmic drops/ointments e. Multiple see specific Product F. Xalatan (Lantaprost) when opened at room temperature is good for 42 days. 5. Beyond 28 days, using the eye drops may cause serious damage to the eye as bacteria may have been introduced. 6. The standard of practice is to

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 05/16/2019

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 761	Continued From page 80 record the date the eye drops are opened and should not use them after 28 days unless the manufacture provides a longer period for which the drops can be used after opening. 7. If the manufacturer does not provide a time frame for discarding the eye drops after opening, then the 28 day standard of practice is recommended." The facility's policy Storage of Medications revised 3/2019, indicated: "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident-	F 791		6/24/19

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 05/16/2019

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 791	Continued From page 81 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (R3) reviewed for dental services received services for dentures in a timely manner. Findings include: R3's admission Minimum Data Set (MDS) dated 10/18/17, was coded for dental as none of the above. Therefore, a care area assessment for Dental Care was not triggered for completion. During an observation and interview on 5/13/19,	F 791	Pine Haven Care Center assists residents in obtaining routine and emergency dental services including assistance in making appointments and arranging for transportation to and from the dentist’s office. The legal representative is routinely notified of lost, damaged, ill-fitting dentures and recommendations for dental services as appropriate. During the June 18, 2019 mandatory meetings, the nursing staff will be	

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 05/16/2019

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 791	Continued From page 82 at 2:12 p.m. R3 was observed without his lower dentures. When asked if R3 had any dental concerns, R3 replied "yes", and stated the problem was he had no teeth. R3 explained he had dentures that did not fit, as they are too small. R3 stated, "I should probably go to the dentist." R3 stated he eats with great difficulty and stated his food was ground. R3 stated he has not been asked if he would like to go to the dentist. R3's Admission Record in the electronic medical record indicated R3 was admitted to the facility on 7/31/18. R3's admission Nursing Oral Assessment completed 8/2/18 indicated R3 had lower dentures that he did not wear, as "they do not fit". For follow up immediate referral to dental professional was answered, "No". R3's physician orders dated 8/1/18 included dentures lower partial. Does not wear d/t (due to) being too tight. On 5/15/19, at 3:18 p.m. social services (SS) verified R3's admission dental assessment had identified his lower denture did not fit. SS stated she was unable to find any follow up regarding his dental concerns in the medical record from what she had reviewed so far. SS stated she would have expected the facility to follow up with R3 regarding his dental concern identified on the admission dental assessment. On 5/16/19, at 1:11 p.m. the director of nursing (DON) stated we should have done follow up on R3's dentures not fitting or charted that we did it. The DON stated we ask residents quarterly at	F 791	reminded of the need to 1) reassess any resident who has difficulty chewing or complains of mouth pain or other dental related problems 2) initiate a dental/physician referral as necessary to address pain symptoms/chewing problems and 3) arrange dental services at resident/family request. An assessment of the residents' oral/dental status and mouth discomfort will be completed at the time of admission and at least quarterly. The Director of Nursing interviewed resident number 3 on June 11, 2019. He indicated he would like to get his dentures repaired. Apple Tree Dental was notified and insurance/payment issues were discussed. A message was left for the resident's daughter regarding scheduling an appointment at her convenience. The resident denied mouth pain, has had no issues with chewing or swallowing with no weight loss in the past six months. The monitor compliance, in the next three weeks, the registered nurse MDS Coordinator/designee will assess residents who flag for loosely fitting dentures, obvious cavities, broken/loose teeth, and/or mouth pain on the most recent minimum data set (MDS) assessment to determine if dental services are indicated/requested. Oral/dental assessments will continue to be done quarterly for all residents. The need for a dental referral and the resident's/family's preferences for dental services will be addressed during the quarterly interdisciplinary care conference.	

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 05/16/2019

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 791	Continued From page 83 care conference about dental needs but we did not capture this in our charting. The DON verified there was nothing charted in R3's medical record regarding R3's dental needs following the admission dental assessment that indicated his dentures did not fit, as they were too tight. A policy on dental services was requested and not provided.	F 791	All new admissions are assessed for unmet dental needs and referred for dental care as necessary. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	
F 880 SS=F	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 §483.70(e) 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:	F 880		6/24/19

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 05/16/2019

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 84 (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 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:	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 05/16/2019

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 85 Based on interview and document review the facility failed to ensure surveillance logs were completed which included prevention measures, failed to complete investigations of infections and/or infectious trends, and failed to perform and document infection prevention measures based on infectious trends. This had the potential to effect all residents, visitors, and staff. In addition, the facility failed to minimize risk for spread of infection when licensed staff failed to ensure a multi-use glucometer (device used to test blood sugar levels) was disinfected properly after use for 2 of 2 residents (R1, R20), and further failed to ensure handwashing was completed after the procedure, reviewed for medication administration. This practice had the potential to affect 8 of 8 residents who required physician ordered blood sugar checks. Lastly, the facility failed to ensure proper hand hygiene during wound care for 1 of 1 residents (R4) observed during a dressing change. Findings included: The facility's Resident Infection Report log included the following: onset date, resident name, room number, antibiotic order, site of infection, lab test, culture results, microbe, last day of antibiotic, resolution date, and if the infection was acquired in the hospital or in house . The Infection logs were reviewed from October 2018 through May 2019. February infection documentation indicated on 2/11/19, a report to the Minnesota Department of Heath indicated three residents had respiratory illnesses with one case that was confirmed as influenza. The onset date of the first case recorded on the report was 2/8/19. The infection	F 880	Pine Haven Care Center has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections. The infection control program includes 1) identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. The IPCP will be reviewed annually and updated as necessary. Antibiotic stewardship and the infection control policy changes will be reviewed with the Medical Director. The facility's monthly Resident Infection Report log tracks resident name, room number, onset of infection, site of infection, laboratory tests, culture results, microbe, whether antibiotic was appropriate, last day of antibiotic, infection resolution date, and whether infection was acquired in the hospital or at the facility. The date the symptoms of infections were first noted will be added to the Resident Infection Report. Collected data will be analyzed by the Director of Nursing/Infection Preventionist; infection trends and clustering will be identified and investigated. The results will be reviewed weekly with the nurse managers and	

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 05/16/2019

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 86 control logs lacked identification of residents who were diagnosed with influenza and the two residents that were recorded on the log who had diagnosis of pneumonia lacked identification of symptoms and onset date of symptoms. The log also reflected 8 urinary tract infections (UTI)'s and 3 skin infection which also lacked identification of onset date of illnesses symptoms. March infection control log indicated one resident with influenza, 4 residents with skin infections, and 2 urinary tract infections. The logs reflected the antibiotic start date and lacked identification of the onset date of illness symptoms. April's log indicated one resident had clostridium difficile (a toxin-producing bacterium which can infect the bowel, causing illness with diarrhea and fever, especially in people who have been treated with antibiotics), 4 residents with UTI's, 3 residents with skin infection, and two residents with respiratory infections. The logs lacked reflected the antibiotic start date and lacked identification of the onset date of illness symptoms. During an interview on 5/16/19, at 4:02 p.m. director of nursing (DON) stated she was responsible for the infection control surveillance program. The infection control logs were reviewed with the DON. The DON stated the onset date on the logs reflected the start date of the antibiotic and not the onset of symptoms of the illness. DON indicated the log was not completed in real time; information was entered into the log when there was an antibiotic prescribed. DON confirmed that aside from influenza cases in February, the documentation lacked evidence infections and/or infectious	F 880	department supervisors to determine whether prevention and/or intervention strategies should be implemented. The Director of Nursing/Infection Preventionist discusses infection incidences, trends, and clustering with the Medical Director as needed. An analysis summary of resident and employee infections will continue to be presented during the quarterly Quality Assurance Committee meetings. During the June 18, 2019 educational meetings, the direct care staff will be informed of the importance of being alert to symptoms of infections and notifying the licensed nurses of any symptoms that could be indicative of an infection. The licensed nurses will be informed of the change in procedure to notify the Infection Preventionist of the onset of infection symptoms and the importance of completing the infection control symptom/treatment tracking form. To monitor compliance, for three weeks the Director of Nursing/designee will compare the Situation, Background, Assessment, Recommendation (SBAR) forms that are completed to alert the physicians/nurse practitioners of infection symptoms with the forms used for in-house infection notification to ensure accurate/complete data tracking. If incomplete data collection is noted, additional auditing and staff training will be completed.	

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 05/16/2019

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 87 trends were investigated, analyzed, and appropriate prevention and/or intervention strategies were implemented. Facility policy Infection Control Program dated 2/2019, included A. Surveillance: Systematic data collection to identify infections, when transmission based precautions should be in place, and identify education opportunities for staff, residents, and resident family members. 1) Resident infections are recorded by the team nurses on the "Infection Report Tool". During morning clinical, nurse managers report to the DON of infections throughout the facility. 4) Resident infection trends are used to identify the needs for educational programs and procedures to help minimize infections. B. Infection outbreak/epidemic control: 1) Surveillance data is used to detect potential or actual infection outbreaks. 4) Documentation of individual infections, outbreaks, control measures and evaluations are kept by the Infection Preventionist and copied to the DON. GLUCOMETER CLEANING AND HAND WASHING During observation on 5/15/19, at 8:04 a.m. registered nurse (RN)-B obtained a glucometer from the 400 medication cart, which was stored in a basket with glucometer strips, lancets, alcohol wipes, and cotton balls. RN-B stated, residents on the 400 wing shared this glucometer. RN-B walked into R20's room, donned gloves, and checked R20's blood sugar using the glucometer. RN-B then removed gloves places them in the garbage and carries basket containing the	F 880	GLUCOMETER CLEANING AND HAND WASHING The infection control guidelines for cleaning multiple-resident use glucometers and hand washing before and after checking blood sugars were reviewed and found appropriate. During the June 18, 2018 mandatory meetings, licensed nurses and direct care staff were instructed on the procedures for hand hygiene and glove use when there is a risk of contact with body fluids. The nurses will be reinstructed on the infection control techniques related to glucometer use with focus on keeping the glucometer moist with with sanitizer for two minutes and then air dry. HAND WASHING WITH DRESSING CHANGES The Wound Care policy was reviewed and found to appropriately address hand washing during dressing changes. During the June 18, 2019 mandatory meetings, the nurses will be reeducated on glove use during dressing changes. The small open areas on the buttock's of resident number four are continuing to decrease in size and are nearly resolved. There is no drainage from the sites and the resident has no complaints of pain related to the open areas. Staff continue to dress the wounds as ordered using appropriate infection control techniques. To monitor compliance, the Director of	

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 05/16/2019

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 88 glucometer and supplies, walks back to the medication cart and sets the basket on top. RN-B then takes an Oxivir TB Wipe (disinfectant wipe), and wipes down the glucometer for approximately 15 seconds, disposed of wipe in the garbage and places glucometer back in the basket. RN-B was not observed to wash her hands before or after the procedure. During observation on 5/15/19, at 8:20 a.m., of the Oxivir TB wipe container, directions on the container indicated allow surface to remain treated for a full two minutes. During observation on 5/15/19, at 8:48 a.m. licensed practical nurse (LPN)-D obtained a glucometer from the medication cart, which was stored in a basket with glucometer strips, lancets, alcohol wipes, and cotton balls. LPN-D verified residents on the 600 wing shared this glucometer. LPN-D walked into R1's room, donned gloves, and checked R1's blood sugar using the glucometer. LPN-D then removed gloves places them in the garbage and carries basket containing the glucometer and supplies, walks back to the medication cart and sets the basket on top. LPN-D then takes an Oxivir TB Wipe, and wipes down the glucometer for approximately 20 seconds, disposed of wipe in the garbage and places glucometer back in the basket. LPN-D then cleansed hands with hand sanitizer. During interview on 5/15/19, at 10:44 a.m. director of nursing (DON) verified the glucometers on each cart are shared and stated, they should be properly sanitized after each use. They need to be wiped down with Oxivir TB wipe and wrap the glucometer and let it sit for 2 minutes. DON stated, all licensed staff should	F 880	Nursing/Infection Preventionist will observe the licensed nurses and trained medication aides perform a return demonstration on proper hand washing during a blood sugar check, cleaning of a glucometer machine, and hand washing with a dressing change. If breaches in infection control technique are observed, additional training will be provided. Compliance will be addressed during the July 2019 Quality Assurance Committee meeting.	

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 05/16/2019

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 89	F 880		

sanitize their hands before and after giving a blood sugar.

Facility policy entitled, "Glucometer Cleaning Policy," dated 1/2010, revised 5/2018, identified a purpose to assure sanitation of glucometer before and after use. Procedure: 1. Gather equipment 2. Cleanse hands 3. Explain procedure 4. Apply gloves 5. Provide privacy 6. Perform blood glucose test after cleansing area to be punctured with alcohol swab, wipe dry with cotton ball or allow drying. 7. Dispose of used lancet and blood glucose strip into sharps container 8. Wipe down glucometer with EPA approved germicide/bactericide disposable wipe or as recommended by the glucometer manufacturer. Wipe surface of the glucometer thoroughly, thoroughly use a second towelette if necessary to maintain wetness for a period of 2 minutes, let air dry. 9. Remove gloves 10. Cleanse hands 11. Clean glucometer with Sani-wipe after each use if sharing glucometer from one to another.

Evencare Proview Blood Glucose Monitoring system User's Guide, dated 2016, disinfection instructions: Step 1: before disinfecting clean the meter as described in the cleaning your meter process. Step 2: wash hands with soap and water, put on single-use medical protective gloves. Step 3: Prepare the Caviwipes towelette or other EPA-registered disinfecting wipe. Take out a wipe from the container and follow the instructions on the package. Step 4: Wipe the glucose meter thoroughly including the front, back and sides, take care not to get any liquid in the strip port and serial port. Do not wrap the meter in the wipe. Step 5 if using the Caviwipes towelette, allow to remain wet for 2 minutes. For other EPA-registered disinfecting wipes, allow the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 05/16/2019

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 90 surface to remain wet for the contact time listed on the disinfecting wipes instructions for use. Dispose of wipe when finished. Step 6. After disinfection, user should take off gloves and wash hands thoroughly with soap and water before proceeding to the next patient. HAND WASHING During an observation of wound care on 5/16/19, at 11:11 a.m. registered nurse (RN)-B gathered supplies for wound care, washed her hands and applied clean gloves. RN-B then assisted a nursing assistant (NA)-B to stand R4, handling a gait belt and touching R4. Then RN-B assisted NA-B to pull down R4's slacks. RN-B then removed her gloves and disposed of them. RN-B did not wash her hands or perform hand hygiene after removal of her gloves. RN-B then opened a sterile bottle of saline. RN-B then applied a clean pair of gloves without washing hands. At that time, R4 became tired and had to sit down. RN-B assisted her to sit down. NA-B then retrieved a mechanical lift to assist R4 to stand. RN-B removed a sterile square of gauze from a package, applied sterile saline to the gauze, balled up the gauze in her right gloved hand and held it there. She then assisted NA-B with the application of the mechanical lift harness, touching the harness, the lift and R4 with her other gloved hand. After R4 was standing, RN-B removed a soiled dressing from R4's sacral area (the bony area between the buttocks and above the anal area) with her left hand and then patted the sacral area with the wet gauze that had been	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 05/16/2019

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 91	F 880		

balled up in her right hand. The sacral area had three open wounds present. RN-B rolled the soiled dressing into her glove and removed the gloves, followed by hand washing. RN-B retrieved a fresh pair of gloves and placed these on top of the gauze package on R4's bedside table. NA-B assisted R4 to the toilet. While waiting, RN-B placed her hands on her hips. After R4 was finished on the toilet, RN-B applied the gloves she had laying on the bedside stand and assisted with removing R4 from the bathroom with the mechanical lift. She touched the lift and touched the resident. Then RN-B quickly applied the clean dressing over the three open wounds on the sacrum without changing the gloves or performing hand hygiene again.

According to an interviewon 5/16/19,at 2:25 p.m. RN-B stated hand washing should be done before starting the wound care process and taking off the old dressing and when finished. RN-B added that hand hygiene should be performed in-between if needed. RN-B confirmed that hands should be washed each time gloves were removed.

According to an interview on 5/16/19, at 3:48 p.m. DON stated it was facility policy for nurses to perform handwashing before performing a dressing change and application of gloves. DON said hand washing should be performed after a soiled dressing was removed and before applying clean gloves or the application of a clean dressing. DON stated hand washing should occur every time a pair of gloves was removed and should also occur after every step of the wound care process was complete.

A policy related to hand hygiene with wound care

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 05/16/2019

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 92 was requested. A policy titled Wound Care originally dated 12/2017 and revised 2/2019 was received. The document indicated that prior to wound care a nurse should "wash and dry your hands thoroughly" and "put on exam glove." Following removal of the soiled dressing the policy indicated the gloves should be removed and hands again washed and dried thoroughly. The policy indicated fresh gloves should be applied after washing hands and before further wound care. After finishing with the treatment, the policy indicated the nurse should dispose of all soiled items, remove gloves and wash and dry hands. Furthermore, the policy indicated the nurse should sanitize reusable supplies and clean the resident area; following this, the nurse should wash and dry hands again.	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 **01 - MAIN BUILDING 01** B. WING _____	**05/13/2019**

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
K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Pine Haven Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2019

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 **01 - MAIN BUILDING 01** B. WING _____	**05/13/2019**

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
K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: fm.hc.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Pine Haven Care Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1970, addition was constructed to the North Wing that was determined to be of Type II(111) construction. In 1991, another addition was added to the West Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/13/2019**

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
K 000	Continued From page 2 census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This **REQUIREMENT** is not met as evidenced by: The facility failed to comply with Life Safety Code (19.7.1.4 through 19.7.1.7) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observation and documentation reviewed revealed the following: During documentation review of fire drill reports observed inconsistent data capture and participant staff signatures regularly missing from reports	K 712	The fire drill report logs will be complete with all required data documented including signatures of participating staff. The administrator will monitor compliance with completion of fire drill report logs for six months. If noncompliance is noted, additional auditing and staff training will be done.	6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/13/2019**

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
K 712	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923		6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/13/2019**

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
K 923	Continued From page 4 considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observations and staff interview revealed the following: During walk-through of the facility observed Med Gas (O2) Storage RM 100L had mixed storage of cylinders, no clear separation of cylinders, no signage indicating location for empty / full cylinders This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	The full and empty oxygen cylinders were separated May 14, 2019. There are signs indicating the location to store full and empty oxygen cylinders. The staff will be instructed on the need to separate full and empty oxygen cylinders in storage during the educational meetings on June 18, 2019. Compliance will be monitored by the administrator/designee through checks of the storage area four times weekly for two weeks and random checks thereafter. If noncompliance is noted, more frequent audits and staff education will be done.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Pine Haven Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2019

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 **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: fm.hc.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Facility is an addition, a 1 story building with no basement, was constructed in 2016 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. At the time of this survey the 34 bed addition and was found not in compliance The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211		6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 211	Continued From page 2 exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.2.2 through 19.2.11, 19.2.1, 7.1.10.1) This deficient practice could affect the safety of all (34) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observations and staff interview revealed the following: During walk-through of the facility observed exit door egress was obstructed in the Physical Therapy Room This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211	The portable exercise steps were relocated away from the exit door egress in the Physical Therapy Room. The physical therapy staff have been educated that passage way to the door must not be blocked. The Director of Rehabilitation will monitor compliance through random observations of equipment placement to ensure there is no equipment blocking exit doors.	
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:	K 223		6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 223	Continued From page 3 * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.2.2.2.7, 19.2.2.2.8) This deficient practice could affect the safety of all (34) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observations and staff interview revealed the following: During walk-through of the facility observed: (1) exit door adjacent to RM 516 did not self-close and latch upon testing (2) fire doors adjacent to RM 637 did not self-close and latch upon testing This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 223	The exit door adjacent to Room 516 and the fire doors adjacent to room 637 have been adjusted and now self-close and latch. All doors with self-closing devices were tested and appropriately self-close and latch. The Maintenance Director will monitor compliance. The doors are tested annually with the results recorded on the "Fire Door Assembly Inspection" log.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 353	Continued From page 4 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (34) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observations and staff interview revealed the following: During walk-through of the facility observed high storage in RM 538 and RM 526 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	The items on the shelving that exceeded the height restrictions were removed May 22, 2019. A yellow line will be painted on the wall to define the maximum height of storage on shelving. Signs will be placed instructing staff not to store items extending above the yellow line. Shelf storage height restrictions will be addressed during the June 18, 2019 mandatory educational meetings. The Environmental Services Director will monitor compliance with storage height restrictions.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric	K 511		6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 511	Continued From page 5 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.5.1.1, 9.1.1, 9.1.2, NFPA 70) This deficient practice could affect the safety of all (34) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observations and staff interview revealed the following: During walk-through of the facility observed RM 662 had items stored in front of electrical access panels This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	The items stored in front of the electrical panel in room 662 were removed May 21, 2019. The staff were educated that the area in front of electrical panels must remain open and that items cannot be placed/stored there. Compliance will be monitored by the Maintenance Director through random observations of the electrical panels.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 712	Continued From page 6 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.7.1.4 through 19.7.1.7) This deficient practice could affect the safety of all (34) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observation and documentation reviewed revealed the following: During documentation review of fire drill reports observed inconsistent data capture and participant staff signatures regularly missing from reports This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	The fire drill report logs will be complete with all required data documented including signatures of participating staff. The administrator will monitor compliance with completion of fire drill report logs for six months. If noncompliance is noted, additional auditing and staff training will be done.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923		6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 923	Continued From page 7 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) This deficient practice could affect the safety of all (34) the residents, staff and visitors within the	K 923	The full and empty oxygen cylinders were separated May 14, 2019. There are signs indicating the location to store full and empty oxygen cylinders. The staff will be instructed on the need to separate full and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**05/13/2019**

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
K 923	Continued From page 8 smoke compartment/ Facility. Findings Include: On facility tour between 01:00 PM and 05:00 PM on 05/13/2019, observations and staff interview revealed the following: During walk-through of the facility observed Med Gas (O2) Storage RM 541 had mixed storage of cylinders, no clear separation of cylinders, no signage indicating location for empty / full cylinders This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	empty oxygen cylinders in storage during the educational meetings on June 18, 2019. Compliance will be monitored by the administrator/designee through checks of the storage area four times weekly for two weeks and random checks thereafter. If noncompliance is noted, more frequent audits and staff education will be done.	