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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PDT9

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 **06/01/2017** (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 **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
XA. 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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	66			
(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 :
Kyla Einertson, HFE NE II 7/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/20/2017 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245359

July 20, 2017

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

Dear Mr. Ziller:

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 May 30, 2017 the above facility is certified for:

66 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 66 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 20, 2017

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

RE: Project Number S5359027

Dear Mr. Ziller:

On April 25, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 30, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on April 6, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 30, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 6, 2017, as of May 30, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 30, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions::

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PDT9

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(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

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6. DATE OF SURVEY **04/06/2017** (L34)

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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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13.Total Certified Beds **66** (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
	66			
(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 :
Josephine Hassinger, HFE NE II 05/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/22/2017 (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
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3. Both of the Above :
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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**
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04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
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00-Active

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29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 25, 2017

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

RE: Project Number S5359027

Dear Mr. Ziller:

On April 10, 2017, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective April 30, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 July 6, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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 _____	04/06/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=E	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		5/4/17

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

Electronically Signed | 05/04/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	04/06/2017

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 156	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 156		

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 _____	04/06/2017

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 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

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 _____	04/06/2017

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 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 156		

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F 156	Continued From page 4 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 156		

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare Non-Coverage with required 48 hours prior to continuation of covered services 4 of 5 residents (R34, R51, R17, R76). In addition,	F 156	The goal of Pine Have Care Center is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, and as	

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F 156	Continued From page 6 failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of Medicare Part A skilled services for of 3 of 5 residents (R34, R17 & R76) who continued to stay in the facility, reviewed for liability and beneficiary rights. Findings Include: R34 was discharged from Medicare Part A on 3/16/17, had used 14 days and remained in the facility. The facility did not provide R34 and/or his legal representative with a Notice of Medicare Non-coverage within the required 48 hours prior to discontinuation of covered services. Also did not receive SNFABN form. R51 was discharged from Medicare Part A on 1/12/17, had used 43 days and remained in the facility. The facility did not provide R51 and/or his legal representative with a Notice of Medicare Non-coverage within the required 48 hours prior to discontinuation of covered services. R51 had received a Notice of Medicare Non-coverage stating the effective date coverage of your current skilled nursing home service will end on 1/12/17, R51 signed form and no other date is present. R17 was discharged from Medicare Part A on 11/11/16, had used 56 days and remained in the facility. The facility did not provide R17 and/or her legal representative with a Notice of Medicare Non-coverage within the required 48 hours prior to discontinuation of covered services. R17 received a Notice of Medicare Non-coverage stating the effective date coverage of your current skilled nursing home service will end on 11/11/16, R17 signed form and no other date is present. In additional, had not received the SNFABN/Centers	F 156	appropriate during the resident's stay. The facility routinely notifies the resident/family before Medicare benefits are discontinued and of their right to have an independent review of the decision to deny benefits. The policies and procedures for resident/family notification of reduction or discontinuation of Medicare benefits were reviewed and found appropriate. Whenever required, the family/legal representative will be provided with and requested to sign 1) an Advanced Beneficiary Notice of denial of benefits explaining the reduction or discontinuation of Medicare benefits, payment liability, and the right to have a demand bill submitted and 2) a notice of the right to an expedited appeal of the decision to discontinue Medicare benefits. If the resident/legal representative is unable/unavailable to receive/sign the required notices, the notifications are sent by certified mail. With changes in staffing, the responsibility for issuing required notices for Medicare noncoverage was recently reassigned. The staff member currently responsible for notifying residents/legal representatives of the denial of Medicare benefits is aware of the requirement for providing 1) an Advanced Beneficiary Notice which includes an explanation of the right to submit a demand bill and 2) a notice of Medicare Non-coverage which includes instructions for appealing the noncoverage decision by the facility. Duplicate copies of all related forms will	

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F 156	Continued From page 7 for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R76 was discharged from Medicare Part A on 3/10/17, had used 25 days and remained in the facility. The facility did not provide R76 and/or her legal representative with a Notice of Medicare Non-coverage within the required 48 hours prior to discontinuation of covered services. R76 received a Notice of Medicare Non-coverage stating the effective date coverage of your current skilled nursing home service will end on 3/10/17, R76 signed form and date 3/9/17, which is only 24 hours prior to discontinuation of covered services. In additional, the facility did not provide R76 and/or her legal representative with SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. During interview with financial director on 4/4/17 at 10:15 a.m. regarding notice of Medicare non-coverage not being dated for R51 and R17. He stated he was informed not to put a date on the form. When asked why R17 did not received the SNFABN when she remained in the facility. He stated, "When the previous person abruptly left, we did not know that we need to do them (SNFABN) but we are doing them now though, as she was giving the notices at that time." Asked when it was identified that they needed to be giving both the notice of Medicare Non-coverage and the SNFABN. He stated, "We had a consultant here the week of February 14, 2017, so they were asking for both forms at that time." When asked , about R34 Notice of Medicare	F 156	be retained by the facility. As instructed by the state regulatory representative, if the resident/legal representative does not date the form, a date will be recorded and initialed by the facility staff. The notification requirements relating to discontinuation of Medicare benefits for residents number 17, 34, 51 and 76 were reviewed by the staff member responsible for issuing the notices as part of the facility's continuing quality improvement process. There have been no subsequent questions or concerns from residents or legal representatives regarding discontinuation of Medicare benefits. In the future, timely resident notifications relating to discontinuation of Medicare benefits will be provided as required. In the event of changes in personnel, administrative staff will reassign the notification responsibilities. The Administrative Assistant will be responsible for monitoring compliance by comparing census/Medicare logs and completed notification forms for sixty days. If noncompliance with notifications requirements is noted, additional auditing will be done. Compliance will be reviewed during the July quarterly Quality Assessment and Assurance Committee meeting.	

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F 156	Continued From page 8 Non-coverage. He stated, "I don't have one, so it must not have been completed. I know that we need to do both forms." Also stated, that no SNFABN was completed for R76 in March 2017. Received Pine Haven Care Center Policy and Procedure for Medicare Noncoverage notice, with revision date 3/2016. stating upon discharge or end service the resident or responsible party will be provided with and requested to sign letters from Medicare.	F 156		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 157		5/4/17

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F 157	Continued From page 9 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident representative was notified of an accident and changes in medications for 1 of 1 resident (R61) reviewed for notification of change. Findings include: During interview on 4/3/17, at 4:47 p.m., responsible party (RP)-F stated had not been notified of falls R61 had at the time the falls occurred and a nurse had called and said R61 was being sent to the emergency room and that was the first time of being informed R61 had fallen.	F 157	Pine Have Care Center staff routinely inform the resident, consult with the resident's physician, and notify the resident's legal representative or an interested family member when there is 1) a fall or an accident involving the resident which results in injury and has the potential for requiring physician intervention 2) a significant change in the resident's physical, mental, or psychosocial status and/or 3) a need to alter treatment significantly (i.e., discontinuing an existing form of treatment due to adverse consequences or starting a new form of	

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F 157	Continued From page 10 R61's Fall Scene Investigation Worksheets and Progress notes included the following: Fall on 3/30/17, at 1:45 p.m. Resident was found on floor in room. The resident had been sitting in her wheelchair and stated she was trying to get to her phone that was ringing, and she forgot she could not walk. The worksheet and R61's progress notes lacked documentation of RP-F having been notified. Fall on 3/31/17, at 12:45 a.m., heard someone yelling for help and found the resident lying on the floor by her bed. Resident stated she was going to go to the bathroom. The worksheet and R61's progress notes lacked documentation regarding RP-F having been notified. Progress note dated 3/31/17, resident sent via non-emergent ambulance at 11:10 a.m. for change in condition: severe pain-generalized, complained of extreme fatigue, weakness and two unwitnessed falls on 3/30 and 3/31. Family/POA (power of attorney)(RP-F) notified and gave permission to have resident sent to ER to be checked out. Progress note dated 3/31/17, indicated resident returned from emergency room with orders to reduce Coreg to 1/2 tab and reduce Amlodipine to 5 mg once daily. Resident is sleeping at this time. Will continue to monitor. R61's record lacked documentation RP-F having had been notified of the medications changes related to the ER visit. On 4/5/17, at 1:28 p.m., registered nurse (RN)-C stated the facility system for notifying families was if there was a change in condition the floor staff usually notified the family or the floor staff contact	F 157	treatment/medication). The facility's policies and procedures addressing notification of the family/representative of changes in the resident's condition/treatments were reviewed and revised. During the May 9, 2017 mandatory meeting, the nursing staff will be educated on 1) the regulatory notification requirements and 2) the facility's policies and procedures for notifying the family/representative of changes in the residents' condition/treatments including timely notification of falls and medication changes. Resident 61 – The interdisciplinary care team investigated the lack of timely notification of the power of attorney (POA) regarding an incident and medication change. The staff is aware that the POA is to be notified of incidents, changes in condition/medications etc., in a timely manner according to facility policy. The POA routinely attends care conferences by phone or in person and will be encouraged to contact the nursing or social service staff with any concerns about cares and services. The POA's ongoing satisfaction with cares/notification of changes will be routinely reviewed during the resident's care conferences. The Director of Nurses/designee will monitor compliance with timely and appropriate family/representative notification of incidents and changes in the resident's treatment plan through	

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F 157	Continued From page 11 me and I would notify the family. RN-C stated staff should document notifying families of changes in the resident record. RN-C confirmed R61's record lacked documentation R61's responsible party was not notified of the falls at the time the falls occurred. RN-C confirmed R61's record lacked documentation R61's responsible party had been informed of the changes in medications related to the ER visit. On 4/5/17, at 1:44 p.m., the director of nursing (DON) stated I know R61's responsible party had not been called at the times the falls occurred. The DON stated nursing was to call family for all things, such as falls, order changes, routine doctor visit changes. The facility policy Acute Change in Resident Condition Notification, dated revision 5/2016, indicated Procedure: 3. Notify the family and resident of the new orders received form the physician and document accordingly, with changes to care plan as warranted.	F 157	random record reviews for one month. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the monthly Quality Assurance and Assessment (QAA) Committee meeting and during the July quarterly QAA Committee meeting.	
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (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. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this	F 166		5/4/17

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F 166	Continued From page 12	F 166		

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;

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F 166	Continued From page 13 (iv) Consistent with §483.12(c)(1), immediately 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 interview and document review, the facility failed to ensure a family concern related to timely administration of sinemet (a medication used to control Parkinson's disease symptoms)	F 166	Pine Haven Care Center staff respects the residents' right to autonomy and choice and protects and promotes the residents' legal rights as well as their right	

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F 166	Continued From page 14 was resolved for 1 of 1 resident (R52) whose family member (FM)-A reported an unresolved concern. Findings Include: R52's FM-A on 4/5/17, 2:36 p.m. stated had voiced concerns related to the administration of R52's sinemet timely to the facility. FM-A stated the facility had not followed up with her regarding her concerns related to the sinemet. FM-A also was unaware facility had gotten timers to use to help administer time sensitive medications such as the sinemet. FM-A also quit voicing concerns related to sinemet not given as ordered because it did not do any good, did not make a difference and R52's had gotten worse with Lewy bodies dementia, Parkinson's dementia and a lot of people will not keep residents with these problems. R52's diagnosis located in the current care plan printed 4/4/17, Parkinson's disease, dementia with Lewy bodies and psychotic disorder with hallucinations due to known physiological condition. Also was admitted to the facility on 2/24/16 and currently lives in the facility. R52's quarterly Minimum Data Set (MDS) and assessment dated 1/24/17, indicated R52 had severe cognitive impairment, and required extensive staff assistance with bed mobility, transferring, locomotion on and off unit and activities of daily living. R52's physician order dated 9/10/15 instructed staff to administer, "Carbidopa-Levodopa [sinemet] 25-100 MG [milligrams] give 2 tablet by mouth three times a day for Parkinsonism." The	F 166	to privacy and a dignified existence. The staff encourage the residents to voice concerns about care and/or services and respect their right to have prompt staff attention to help resolve grievances including concerns about medication administration. The policies and procedures for responding to residents' grievances were reviewed and revised to clarify the location of the Problem Resolution Report forms. After receiving a complaint/grievance, the facility seeks a resolution in a timely manner and keeps the resident/family appropriately apprised of the progress toward resolution. The residents/families will continue to be asked about concerns regarding cares and services during the quarterly interdisciplinary care conferences and more often as necessary. The grievance reporting procedure is addressed in the Resident Handbook which is provided to the resident at the time of admission. Problem Resolution Report forms are located in the brochure holder near the business office and are available from any staff member. Concerns expressed orally or documented on the comment form are reviewed by the social worker and addressed in a timely manner. Resident/family grievances and concerns are reviewed during the shift-to-shift reports, clinical review meetings Monday through Friday, weekly interdisciplinary team meetings, quarterly care	

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F 166	Continued From page 15 medication administration record (MAR) revealed R52 was to be administered this medication at these three specific times: 7:00 a.m., 11:00 a.m. and 4:00 p.m. Review of R52's sinemet administration times, revealed R52 was administered sinemet an hour after the scheduled time forty two times from 1/1/17 to 2/18/17, Seven times from 2/18/17 to 3/4/17 and fourteen times from 3/21/17 to 4/4/17. On 4/5/17, at 8:40 a.m., registered nurse (RN)-C verified the sinemet had been given an hour or more from specific physician ordered time as identified on the MAR from 1/1/17 to 4/4/17. On 4/4/17, at 2:48 p.m. RN-C stated sinemet is a time sensitive medication and should be administered within 15 minutes prior or after the scheduled administration time of the medication. RN-C stated R52 would be at increased risk for falls if the sinemet was not given timely, as it could impair the way he is able to function, making it hard for him to complete tasks on his own. RN-C stated occasionally R52's FM-A would call and ask us to check to make sure the sinemet had been given on time. RN-C stated FM-A had not called me lately, but I do not know if she has contacted the floor staff. RN-C stated she was aware administration time of R52's sinemet was a concern for FM-A. RN-C stated she had investigated FM-A's concern by looking at medication administration records and educating staff members. RN-C stated we have even went so far as to provide "timers" for the nurses to use for time sensitive medications and this was done specifically for the concerns related for R52 getting the sinemet on time. RN-C stated during the investigation of the concern from FM-A, and found the times R52 received sinemet	F 166	conferences, and the Quality Assessment and Assurance Committee meetings. During the mandatory meeting May 9, 2017, all staff were reinstructed on 1) the residents' right to present grievances 2) the facility's policies and procedures for handling resident grievances/concerns 3) the tool used to communicate/report grievances and 4) the responsibility of all staff to report resident grievances/concerns. Discussion will include the resident's right to have care and services provided as ordered by the physician, following the resident's plan of care, and with respect and sensitivity to the resident/family preferences. The staff will be reminded of the procedures to alert the social worker and other appropriate staff of their concerns/observations and the concerns expressed by the residents/families. Residents' rights are reviewed with the staff annually and are included as part of new employee orientation. The wife of resident number 52 was contacted by the clinical nurse manager and the administrator on April 6, 2017. A meeting was subsequently scheduled for April 11, 2017 to address concerns regarding cares and timely administration of Sinemet; the meeting was attended by the administrator, social worker, and clinical nurse manager. The resident's wife was informed of the availability of the regional Ombudsman to be a participant in the care plan team and a resource for	

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F 166	Continued From page 16 were off and sometimes for quite a bit of time off. RN-C stated the longest she has seen the medication being administered late had been one and a half hours after scheduled administration time. RN-C stated the last time she investigated administration times of R52's sinemet it was in March 2017. On 4/5/17, at 2:54 p.m. the director of nursing (DON) stated she expected staff to administer sinemet within 15 minutes before or after the scheduled order. The DON stated this was nursing judgement, knowing the medication and the need to give it at the prescribed time. On 4/6/17, at 10:36 a.m. the administrator and director of nursing (DON) stated no formal grievance forms had been completed regarding concerns related to sinemet being administered timely for R52. The administrator stated if any person was upset or had a concern, a problem resolution report was to be completed. The administrator stated residents, family members or staff can complete the form on behalf of the resident or family. The administrator stated the resident or family concerns are completed on the forms and turned into social services department and the process was to be implemented right away for resolution of the concern. The DON stated she has had conversations with R52's family regarding her concerns and stated she had always felt the problems had been resolved. The administrator stated, "yes" a grievance should have been completed to address FM-A's ongoing concerns with timely administration of R52's sinemet. The administrator stated he was unaware FM-A had any concerns with R52's sinemet administration times.	F 166	identifying family support groups. The clinical nurse manager and/or the social worker will follow up with the resident's wife to discuss her satisfaction with the administration of Sinemet. The resident's wife has not communicated any care concerns to the social worker. The social worker and/or the clinical nurse manager will contact the wife of resident number 52 monthly for the next three months to determine her satisfaction with cares including Sinemet administration. For resident number 52, a medication time tracking log was implemented from April 6 to April 25, 2017 requiring two nurses to verify the time Sinemet was administered. The log data show that the medication has been routinely administered in a timely manner. The Medication Administration Record has been updated to include the notation that the resident's Sinemet is a time-sensitive medication to be given within a 30-minute time frame. The Social Worker will monitor compliance by asking members of the Resident Council for feedback regarding their satisfaction with the staff responsiveness to the concerns about cares and services. During the quarterly interdisciplinary care conference, the residents/families will continue to be asked about concerns regarding cares or other issues and their satisfaction with the facility's response to their concerns. For three months, the administrator/designee will review grievance reports to ensure	

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F 166	Continued From page 17 Review of the policy, The Problem Resolution Policy- Resident/Family, with a reviewed date of 2/05, included, Resident Differences: Optimum communication between staff and resident and their families or responsible parties is necessary to enhance meeting the needs of residents; however, misunderstanding may occur. This procedure is to be used to resolve resident differences when misunderstandings may occur. A. The staff member who receives the complaint from the resident shall refer it to his/her department manager. If the department manager is unable to resolve the concern within a twenty-four hour time frame, the concerns shall be referred to the Social Service department. B. Family members who have a complaint may initiate a Problem Resolution Report form which may be obtained from Medical records office or from Nursing. This report should be turned into the Social worker. C. The Social Worker will gather needed information and respond to the aggrieved resident/family member within five working days. The response will be documented on the Problem Resolution Report form. D. If the difference is still unresolved, the Social Worker will then refer it to Administration who will respond to the resident in writing within five working days. The response will be logged on the Problem Resolution Report form.	F 166	appropriate and timely staff follow up. Compliance will be routinely reviewed at the monthly and quarterly Quality Assessment and Assurance Committee meetings.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278		5/4/17

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F 278	Continued From page 18 each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review facility failed to ensure the Minimum Data Set (MDS) an assessment had been correctly coded for falls with minor injury for 2 of 3 residents (R17 and R52) reviewed for accidents. Findings include: R17's diagnosis found on the Admission Record	F 278	Pine Haven Care Center staff routinely complete assessments that accurately reflect the residents' status. Assessments are completed according to CMS guidelines as outlined in the User's Manual for the Resident Assessment Instrument (RAI). A registered nurse conducts or coordinates each assessment with the appropriate participation of health	

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F 278	Continued From page 19 dated 9/19/16, indicates repeated falls, age related cognitive decline, weakness and other malaise. Care Area Assessment (CAA) dated 9/26/16, identifies R17 to be at risk for falls. Problem statement identifies R17 to have experienced delirium with suspected underlying dementia. R17 is identified as having a cognitive deficit as evidenced by scoring 6 out of 15 on the BIMS assessment. R17 requires need for supervision, direction and cares related to memory loss and impairment. R17 is identified as having difficulty maintaining sitting balance and balance during transitions. Review of fall incident reports indicates R17 had a fall on 1/2/17, with injury that required a transfer to the emergency room for possibly stitches to a laceration on forehead and bleeding from the mouth. R17 had a fall on 2/13/17, which resulted in an abrasion to the lower back. Quarterly Minimum Data Set (MDS) dated 3/24/17, indicates R17 had two or more falls during the look back period. MDS indicates R17 had no falls with minor injury during this time. Interview on 4/6/17, at 8:03 a.m. registered nurse (RN)-C stated minor injuries would be considered anything with bruising or lacerations. RN-C stated she should have coded the two falls as having minor injuries. RN-C verified the MDS was inaccurately coded. Interview on 4/6/17, at 8:46 a.m. with director of nursing (DON) who stated R17's falls taking place on 1/2/17 and 2/13/17, should have been coded on the MDS as falls with minor injuries. DON	F 278	professionals and signs to certify that the assessment is completed. Each individual who completes a portion of the assessment signs to certify the accuracy of that portion of the assessment. The policies and procedures for completing the minimum data set (MDS) were reviewed and found appropriate. The staff completing the MDS assessment 1) are qualified to assess relevant care areas 2) are knowledgeable about the resident's status and needs and 3) have been trained to accurately document the resident's medical, functional and psychosocial needs and condition. The clinical nurse managers who serve as the MDS Coordinators met with the Health Information Consultant on May 2, 2017 to review the RAI instruction manual for completion of MDS section J1700 addressing fall history and fall-related injuries. Copies of the RAI User's manual instructions for completion of MDS Section J1700 were provided to the Coordinators for reference. Resident number 17 – The resident's MDS with an assessment reference date of March 23, 2017 was reviewed by the MDS Coordinator. A corrected MDS which has falls correctly coded was completed May 3, 2017. Resident number 52 – The resident's MDS with an assessment reference date of January 24, 2017 was reviewed by the MDS Coordinator. A corrected MDS which	

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F 278	Continued From page 20 verified the MDS was inaccurately coded. R52's diagnosis located in the current care plan printed 4/4/17, Parkinson's disease, dementia with Lewy bodies and psychotic disorder with hallucinations due to known physiological condition. Also was admitted to the facility on 2/24/16 and currently lives in the facility. Review of fall incident reports indicated R52 had a fall on 12/25/16, which resulted in a skin tear to R52's left knee. R52 had a fall on 12/13/16, which resulted in a 1.5 centimeter diameter abrasion to his left elbow. R52 had a fall on 11/19/16, which resulted in right elbow having signs of bruising. R52's quarterly Minimum Data Set (MDS) dated 1/24/17, indicated R52 had severe cognitive impairment, and required extensive staff assistance with bed mobility, transferring, locomotion on and off unit and activities of daily living. In addition, the MDS indicated R52 had sustained 0 (zero) fall with injury within the MDS reference period. However, R52 had a fall on 1/24/17 which was within the quarterly MDS evaluation time frame. On 4/6/17 at 11:30 a.m., registered nurse (RN)-C stated the quarterly MDS completed on 1/24/17, should have been coded R52 had two or more falls with injuries. RN-C verified the MDS was inaccurately coded. On 4/6/17, 11:35 a.m. the director of nursing (DON) stated the quarterly MDS completed on 1/24/17, should have been coded to reflect R52 had 2 or more falls with minor injury. DON verified the MDS was inaccurately coded. Requested policy related to MDS coding. 4/6/17,	F 278	has falls correctly coded was completed May 3, 2017. To monitor compliance, the Director of Nursing/designee will audit Section J1700 of the MDS forms of residents who have had falls with an assessment reference date of March1 through May 1, 2017 to determine whether falls were accurately coded. If further noncompliance is noted with coding of falls, additional auditing and staff training will be done. Compliance will be reviewed as part of the monthly Quality Assurance and Assessment (QAA) Committee meeting and during the July quarterly QAA Committee meeting.	

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F 278	Continued From page 21 at 9:45 a.m. DON stated the RAI Manual is used for MDS completion.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280		5/4/17

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F 280	Continued From page 22 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280		

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F 280	Continued From page 23 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise a care plan to include hypertension and hypotension blood pressure problems for 1 of 1 resident (R52) reviewed for unnecessary medications and failed to revise the care plan to include interventions to reduce the chance of falls for 1 of 4 residents (R61) reviewed for accidents. Findings include: R52's care plan with a print date of 4/4/17 revealed R52 did not have a care plan developed to address hypertension or hypotension. R52's diagnosis located in the current care plan printed 4/4/17, Parkinson's disease, dementia with Lewy bodies and psychotic disorder with hallucinations due to known physiological condition. Also was admitted to the facility on 2/24/16 and currently lives in the facility. R52's quarterly Minimum Data Set (MDS) dated 1/24/17, indicated R52 had severe cognitive impairment, and required extensive staff assistance with bed mobility, transferring, locomotion on and off unit and activities of daily living. R52's physician order dated 3/9/17 instructed staff to administer, "Hydralazine HCl tablet 10MG [ten milligrams], Give 1 tablet by mouth as needed for blood pressure =/> [equal or greater than] 150/90 four times a day."	F 280	Pine Haven Care Center staff develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their families/legal representatives are encouraged to participate in the care planning process and the quarterly care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. The care plan policies and procedures were reviewed and will be revised to include more specific reference to content of the nursing assistants "pocket care plans" (PCPs) and communication of the information included on the PCPs. During the mandatory meeting May 9, 2017, the nursing staff will be 1) informed of the need to be aware of and follow the residents care plan 2) reminded that the residents' care plans should be current at	

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F 280	Continued From page 24 R52's physician order dated 3/30/17 instructed staff to administer, "Hydralazine HCl tablet 10MG, Give 1 tablet by mouth as needed for HTN [hypertension] give is SBP [systolic blood pressure] >150/90 four times a day and/or DBP [diastolic blood pressure] > 90 four times a day." R52's medication administration record revealed R52 did not receive as needed (PRN) hydralazine the months of March 2017 or April 2017 per the physician orders. On 4/4/17, at 3:14 p.m. registered nurse (RN)-C stated R52 should have received PRN hydralazine 19 times since the PRN order was implemented on March 9, 2017. RN-C stated she was unaware doctor (Dr)-E had identified this medication was not being administered per the physician order on 3/30/17. On 4/5/17, 8:23 a.m. RN-C stated she knew the PRN order for the hydralazine had not been added to the resident's care plan as she completed the care plans and she had not gotten to it. RN-C stated, "I personally would not care plan the prn hydralazine. I keep the care plans more broad." RN-C verified R52 did not have a care plan developed to address ongoing blood pressures concerns related to hypertension and hypotension. RN-C verified a care plan should have been developed to address R52's blood pressures. During an interview on 4/5/17, at 2:54 p.m. the director of nursing (DON) stated she would have expected a care plan to be developed for hypertension and hypotension for R52. The DON stated she also expected the PRN hydralazine to be care planned for R52. The DON verified R52's	F 280	all times 3) reinstructed on the facility policies for care plan reviews and updates and 4) reminded of the importance of including issues that impact the resident's risk of fall/injury in the plan of care (history of orthostatic hypotension, placing personal items within reach, etc). Resident number 52 – The resident was admitted 2/24/14 with diagnoses that included Parkinson's Disease, major neurocognitive disorder presume Lewy body with psychosis-hallucinations, delusions, and mood disorder. Due to the lability of the resident's blood pressure, the physician discontinued Hydrazaline on April 10, 2017 and Norvasc was started. The April 13, 2017 nurse practitioner progress note states "recommendations are to discontinue Norvasc with no further blood pressure monitoring. The elevated blood pressure readings could place him at risk for stroke, however, goals for care are very conservative and further pharmacological intervention for BPs is placing him at high risk for orthostatic hypotension/falls." The care plan has been updated to reflect the problem of labile blood pressure, the discontinuation of blood pressure medications, and the related risks. The care plan will be reviewed quarterly and with changes in condition; revisions will be made as appropriate. Resident number 61 – The resident's care plan has been reviewed and revised to reflect that the resident's phone is to be placed within her reach. The staff is aware	

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	245359	A. BUILDING _____ B. WING _____	04/06/2017

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F 280	Continued From page 25 care plan should have been revised to include hypertension, hypotension and interventions to manage R52's blood pressure problems. Review of policy, The Care Planning Process, dated 4/2017, included, "8. The care plan is to be periodically reviewed and revised by the interdisciplinary team. The services provided by the facility must meet professional standards of quality care and be provided by qualified people in accordance with each's resident's care plan. 9. Care plans must be reviewed at least quarterly and when significant changes are identified for the resident. Since care plan information must reflect the current status of the resident. It will be necessary at times to revise and update part of the care plan even though it has been less than three months." R61's current care plan with print date of 4/5/17, included at risk for falls characterized by history of falls/ injury, multiple risk factors related to impaired balance, pain, use of psychotropic medications. Interventions included call light within reach at all times when resident is in room. Encourage resident to use handrails or assistive devices properly. Periodic fall risk assessment by a licensed nurse. Resident to wear proper and non-slip footwear. R61's Fall Scene Investigation Worksheet included the following: Fall on 3/30/17, at 1:45 p.m. Resident was found on floor in room. The resident had been sitting in her wheelchair and stated she was trying to get to her phone that was ringing, and she forgot she could not walk. Insights gained: phone needs to be placed in a spot that is easier for the resident to reach. Immediate interventions included call light close to resident and remind resident to all	F 280	the phone must be placed near the resident to decrease the risk of falling related to reaching for the phone. The care plan will be reviewed quarterly and with changes in condition. Revisions will be made as appropriate. To monitor compliance, the clinical nurse managers/designee will review the fall-related care plans of residents who have fallen within the last three weeks to ensure that safety interventions are appropriately addressed. The safety interventions for other residents will be reviewed within the next 90 days. If noncompliance is noted, additional auditing and staff training will be done. Ongoing care plan reviews will be done by the interdisciplinary team quarterly and with significant changes in condition. During the care reviews, the resident's fall history and safety interventions will continue to be addressed and the care plan will be reviewed for completeness, accuracy, and relevancy. Compliance will be reviewed as part of the monthly Quality Assurance and Assessment (QAA) Committee meeting and during the July quarterly QAA Committee meeting.	

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F 280	Continued From page 26 for help with getting up. R61's care plan failed to include phone to be in reach. On 4/5/17, at 1:44 p.m., the DON stated she would expect the care plan to include R61's phone was to be in reach. The facility policy Resident Incident, Accident and Injury Responsibilities, dated revision 1/2017, indicated all staff will respond promptly and appropriately to ensure the safety of all residents when an accident, injury or aggression is observed and or reported. Procedure: III. RN case manager: 2. Review incident at the next clinical review (i.e. morning report) where indicated, the need to interdisciplinary review of the issue at the next standup meeting and after determining the potential for other considerations such as therapy, changes in environmental situations or equipment, ensure the components are put into place in the resident's care plan and staff's pocket care plan.	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 282	Pine Haven Care Center provides care	5/4/17

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F 282	Continued From page 27 review, facility failed to ensure fall interventions were implemented per the care plan for 1 of 1 resident (R17) reviewed for accidents. In addition, based on observation, interview and document review, the facility failed to follow the care plan for 1 of 1 resident (R52) assessed to need assistance with oral cares. Also failed to follow care planned physicians order for Rooke Boots to be worn to relieve leg pain for 1 of 1 resident (R61) reviewed for pain. Findings include: R17's diagnosis found on the Admission Record dated 9/19/16, indicates repeated falls, age related cognitive decline, weakness and other malaise. Care area assessment (CAA) and quarterly Minimum Data Set (MDS) dated 9/26/16, identifies R17 to be at risk for falls. Problem statement identifies R17 to have experienced delirium with suspected underlying dementia. R17 is identified as having a cognitive deficit as evidenced by scoring 6 out of 15 on the BIMS assessment. R17 requires need for supervision, direction and cures related to memory loss and impairment. R17 is identified as having difficulty maintaining sitting balance and balance during transitions. R17's care plan last revised on 2/2/17, identifies at risk for falls characterized by history of falls/injury, multiple risk factors related to impaired balance, lack of safety awareness/judgment. Interventions include call light within reach at all times when in room (added 10/17/16), gripper socks on when shoes are not on (added 1/9/17), periodic fall risk	F 282	and services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicates the resident's care needs to the direct care givers by use of the "pocket care plan" (PCP). The policies and procedures will be revised to include more specific reference to content of the PCP and communication of the information included on the PCPs. The PCPs are routinely updated by the clinical managers to reflect revisions in the interdisciplinary plan of care. The Director of Nursing met with the Clinical Manager on May 2, 2017 to review the procedures for developing the PCPs; the importance of an accurate PCP with timely updates was discussed. The office assistant will be assisting with the PCP updates upon return from a medical leave. During the May 9, 2017 mandatory meeting, the nursing staff will be reminded/instructed 1) that the care plan	

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F 282	Continued From page 28 assessment by a licensed nurse, reinforce need to call for assistance (added 10/17/16), wear proper and non-slip footwear (added 10/17/16), and tabs alarm on while in wheelchair or chair in room (added 1/19/17). Pocket Care Plan (PCP) dated 4/4/17, indicates R17 to have gripper socks on at all times, wheelchair, walker, fall mats on both sides of bed. Remove fall mats when not in bed. Low bed, anti-lock brakes on wheelchair. PCP also identifies R17 to be alert and oriented times three. Interview on 4/4/17, at 10:38 a.m. with registered nurse (RN)-B stated R17's fall interventions include being toileted, alarm when in chair and bed, try and keep close to staff, gripper socks and shoes. Continuous observation on 4/4/17, beginning at 3:34 p.m. to 4:04 p.m. R17 was observed to be sitting in wheelchair in bedroom watching television. Bedroom light was not on, making room appear dark. Foot pedals on wheelchair. R17 was observed to be self-propelling in wheelchair through her bedroom despite the foot pedals being present. R17 propelled herself towards her walker which was located across the bedroom, and began pushing the walker through the room while remaining sitting in the wheelchair. At 3:40 p.m. R17 pushed walker in front of the closet doors and attempted to stand from wheelchair. R17 made no attempt to utilize the call light. Surveyor intervened at this time and directed staff to R17's room. Nursing assistant (NA)-B entered the bedroom. R17 explained she was trying to get her pajamas from the closet. NA-B attempted to redirect R17 with a snack,	F 282	must be followed and 2) that job performance expectations include being aware of and following the resident's plan of care including safety interventions, oral cares and use of Rooke boots. The orientation for new employees will continue to address the importance of respecting the resident's care preferences and following the resident's individualized plan of care. Resident number 17 – The resident's care plan and PCP were reviewed for accuracy with a focus on the safety interventions to reduce the risk of falls and injury. The use of gripper socks and tabs alarm to alert staff to unsafe positioning will continue; floor mats have been discontinued. The care plan will be reviewed quarterly, after falls or other incidents, and with changes in condition. Revisions will be made as necessary to meet the resident's assessed needs for care and safety. Resident 52 - The resident's care plan and PCP were found to correctly address the assistance needed by the resident for grooming including oral care. The direct care staff have been counseled regarding the need to provide oral care twice daily as part of the routine grooming procedures. Resident number 61 – The resident's care plan and PCP were updated to reflect use of the Rooke boots whenever the resident is in bed. The clinical nurse manager has counseled with the certified nursing assistants regarding the use of Rooke	

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F 282	Continued From page 29 removed the foot pedals from the wheelchair, offered snack which R17 declined and then exited the room. At 3:43 p.m. observation of R17 and interview with with NA-B stated he didn't know what fall interventions were in place for R17. R17 checked the pocket care plan (PCP) and stated there were no interventions. NA-B stated he checks on R17 frequently because she's always moving around. Continuous observation continued on 4/4/17, at 3:45 p.m. R17 continues to self-propel in wheelchair throughout bedroom. R17 attempted to shut the bedroom door. NA-B was walking by the room at this time and instructed R17 to leave the door open and exited the room. At 3:47 p.m. R17 continued to self-propel in wheelchair throughout the bedroom and moved towards the bed and began fixing the blanket. R17 rocking back and forth in wheelchair, reaching for the side table, reaching for the blanket and removing shoes. As R17 was removing shoes the tab alarm began to sound. NA-B entered the room at 3:52 p.m. and offered to assist R17 to bed. NA-B assisted R17 to bed and did not apply gripper socks before exiting the bedroom. Gripper socks observed to be folded and lying in glider chair next to the bed at 4:01 p.m. Observation and Interview on 4/4/17, at 4:04 p.m., asking DON to enter R17's room. DON verified R17 was not wearing appropriate foot wear to prevent a potential fall. DON stated R17 was supposed to have gripper socks on if not wearing shoes. DON stated it is care planned for her to have gripper socks on when not wearing shoes. DON stated she is aware R17 removes her shoes at times and that this had been discussed with staff and the importance of having	F 282	boots. The resident's care plan will continue to be reviewed at least quarterly and with significant changes in condition. Compliance will be monitored by random weekly observations/audits of the following for three weeks: 1) resident oral care 2) use of Rooke boots and 3) appropriate use of safety interventions. Observations will be assigned by the Director of Nursing/designee. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the July 2017 quarterly Quality Assurance and Improvement Committee meeting.	

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F 282	Continued From page 30 proper foot wear on at all times. Interview on 4/5/17, at 9:05 a.m. with DON stated DON stated it isn't clear what interventions were placed and when to prevent future falls. DON stated the PCP identifies floor mats to be used but R17 doesn't have floor mats. DON stated fall interventions should be placed on the PCP by the nurse managers after any updates or changes. Interview on 4/5/17, at 9:45 a.m. with NA-A stated R17's fall interventions include keeping the call light in reach, try and keep busy, alarm when in bed and wheelchair, gripper socks when in bed. NA-A checked the PCP and stated she didn't think R17 had floor mats. Interview on 4/5/17, at 2:06 p.m. with NA-C stated R17's fall interventions include tab alarm in bed and wheelchair, try and keep an eye on her, keep her occupied. Interview on 4/6/17, at 8:03 a.m. with registered nurse (RN)-C stated R17's fall interventions include gripper socks when shoes aren't on or when in bed and low bed. RN-C stated the PCP should include all fall interventions and should be updated with any changes. RN-C stated she was unsure when the last time R17's PCP was updated to reflect current interventions. RN-C verified outdated and unused interventions including floor mats were still on the PCP and shouldn't be. Interview on 4/6/17, at 8:46 a.m. with DON stated the fall interventions on the care plan are the interventions the staff should be following. Older interventions are still on the PCP and were not updated. Fall mat should have been removed.	F 282		

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F 282	Continued From page 31 The aides go by the PCP which needs to be updated for any changes that occurred in the care plan. LACK OF ORAL CARE: R52's quarterly Minimum Data Set (MDS) dated 12/4/17, identified required extensive assist of one for personal hygiene. R52's nursing assistant assignment guide undated, indicated assist of 1 staff for grooming. R52's care plan dated 3/6/14, instructed staff to encourage resident to rinse out mouth after meals, brush teeth, tongue and gums with soft bristle toothbrush or toothettes at least bid (twice a day), and prn (as needed). Set up supplies for shaving oral cares, partial bath within resident's reach, assist as needed R52 was observed on 4/3/17 at 7:13 a.m. sitting in his wheelchair in his room, resident was dressed and a nurse was putting on his Ted hose. During an interview on 4/4/17, at 7:15 a.m. nursing assistant (NA)-D stated she provided morning cares for R52 today. NA-D stated, "I still need to complete oral cares for R52." NA-D stated she would complete oral cares after he was done with breakfast. R52 was observed in the dining room on 4/4/17 having breakfast from 7:40 a.m. until 8:39 a.m. when R52 was removed from the dining room to the lobby right outside of the dining room. R52 was observed in the lobby area until activity staff member brought him to an activity at 9:03 a.m. Resident was observed in the activity area until 10:36 a.m., when the activity staff member	F 282		

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F 282	Continued From page 32 wheeled R52 to the hallway right outside of his room and turned the call light on. On 4/4/17, at 10:46 a.m. NA-A answered R52 call light and assisted him with toileting. During observation of cares with toileting, nursing assistant NA-D knocked on R52's door, entered the resident room and spoke with NA-A and told her she needed the Easy Stand when she was done assisting R52. NA-D did not report to NA-A that R52 needed oral cares completed. On 4/4/17, at 11:24 a.m. R52 still had not been offered to brush his teeth this morning. During an interview on 4/4/17, at 11:52 a.m. NA-D stated R52 went to activities right after breakfast. NA-D stated later when she saw NA-A with R52 in the bathroom, I should have communicated to her at that point R52 needed his teeth brushed. NA-D stated it slipped her mind, and she apologized for not getting oral cares completed this morning for R52. During an interview on 4/5/17, at 2:54 p.m. the director of nursing (DON) stated expected oral cares to be completed morning and night. The DON stated she expected the care plan to be followed for oral cares. Review of the policy, The Care Planning Process, dated 4/2017, included, "13. After the initial comprehensive care plan is developed, it needs to be implemented. Staff must be informed of tasks they are responsible to carry out. Each discipline is responsible for documenting that an approach was actually carried out and the resident's response, or lack of response, to the treatment or intervention."	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 33	F 282		

R61's quarterly Minimum Data Set (MDS) dated 1/5/17, identified the resident had occasional severe pain and had severe cognitive impairment. R61's Admission Record dated 4/5/17, included diagnoses of unspecified dementia without behavioral disturbance and peripheral vascular disease.

R61's physician progress note dated 3/20/17, indicated R61 reported pain in her right lateral ankle. "Onset during the night shift. Reports pain with movement and increased pain in the early morning hours. Acetaminophen helped to relieve the pain. It was previously reported as 3/10 (0 to 10 scale with 0 as no pain/discomfort) and after dosing the acetaminophen, it was reported as 1/10. Nursing staff reports that her Rooke boots have not been worn during the day. When I asked the patient about her symptoms, she states that the pain is no longer present. She states that when the pain is present, it is described as a needle sensation. Assessment: leg pain, likely multifactorial in nature, partially due to peripheral arterial disease as well as possibly a component of neuropathy. Plan: I clarified the Rooke boot order. Vascular specialist at Mayo has adjusted use of the Rooke boot for offloading while the patient is in bed. She is to wear these anytime she is lying in bed, whether it be daytime or nighttime for offloading. Continue to offer acetaminophen, repositioning and PRN oxycodone as needed for leg pain."

During observation on 4/4/17, at 8:16 a.m., nursing assistant (NA)-A entered R61's room and asked R61 if she was ready to get up. R61 stated, "I don't know. My feet hurt, they sting." R61 was observed to be laying in bed without the Rooke boots on, and her feet were bare.

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	245359	A. BUILDING _____ B. WING _____	04/06/2017

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F 282	Continued From page 34 R61's medication administration record dated 4/2017, identified Rooke boots to right and left legs for offloading while in bed (daytime or nighttime). On 4/5/17, at 9:22 a.m., nursing assistant (NA)-A verified R61 had complained of pain in her feet the prior morning and had not been wearing the Rooke boots while in bed. When asked whether R61 was to have the Rooke boots on while in bed, NA-A stated a while ago R61 used to have the Rooke boots on during the day. At that time, NA-A reviewed the nursing assistant care sheet dated 4/2/17, and confirmed the R61's care sheet lacked any direction about the use of the Rooke boots while in bed. On 4/5/17, at 1:34 p.m. RN-C verified R61's order for Rooke boots to be on when in bed and stated staff should be following the order. On 4/5/17, at 1:53 p.m. the DON stated the Rooke boots should be on the NA care plan. The DON verified R61's order for Rooke boots were for them to be on when in bed (daytime or nighttime) and stated she would expect the Rooke boots to be on in bed, or have documentation if the resident refused.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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:	F 312		5/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 35 Based on observation, interview and document review, the facility failed to ensure 1 of 3 resident (R52) who was dependent on staff for meeting activities of daily living (ADLs) had oral cares provided as assessed. Findings Include: R53's family had been interviewed on 4/3/17 at 3:38 p.m. family member (FM)-A was asked, "Does R52 get the help he needs getting dressed, toileting, or cleaning his teeth?" FM-A stated, "I do not think they complete oral cares." R52's quarterly Minimum Data Set (MDS) dated 12/4/17, identified required extensive assist of one for personal hygiene. R52 was observed on 4/3/17 at 7:13 a.m. sitting in his wheelchair in his room, resident was dressed and a nurse was putting on his Ted hose. During an interview on 4/4/17, at 7:15 a.m. nursing assistant (NA)-D stated she provided morning cares for R52 today. NA-D stated, "I still need to complete oral cares for R52." NA-D stated she would complete oral cares after he was done with breakfast. R52 was observed in the dining room on 4/4/17 having breakfast from 7:40 a.m. until 8:39 a.m. when R52 was removed from the dining room to the lobby right outside of the dining room. R52 was observed in the lobby area until activity staff member brought him to an activity at 9:03 a.m. Resident was observed in the activity area until 10:36 a.m., when the activity staff member wheeled R52 to the hallway right outside of his room and turned the call light on.	F 312	Pine Haven Care Center provides the necessary services to maintain good nutrition, grooming, personal care and oral hygiene 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 including assistance with oral care as outlined in the plan of care. The residents' need for assistance with personal hygiene is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary. During the mandatory meeting May 9, 2017, the nursing staff will be 1) reinstructed on the facility's policies for providing personal hygiene to the residents 2) reminded that their job description requires knowledge of and responsibility for following the resident's plan of care and 3) instructed on the importance of providing oral care. The need to provide cares as necessary to improve/enhance the residents' appearance, comfort, and dignity will be emphasized. The new employee orientation addresses personal hygiene for the residents. The grooming plan of care for resident number 52 was reviewed and found appropriate in addressing the resident's personal care needs. The direct care staff are aware of the need to provide twice-daily oral care as part of the routine	

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F 312	Continued From page 36 On 4/4/17, at 10:46 a.m. NA-A answered R52 call light and assisted him with toileting. During observation of cares with toileting, nursing assistant NA-D knocked on R52's door, entered the resident room and spoke with NA-A and told her she needed the easy stand when she was done assisting R52. NA-D did not report to NA-A that R52 needed oral cares completed. On 4/4/17, at 11:24 a.m. R52 still had not been offered to brush his teeth this morning. During an interview on 4/4/17, at 11:52 a.m. NA-D stated R52 went to activities right after breakfast. NA-D stated later when she saw NA-A with R52 in the bathroom, I should have communicated to her at that point R52 needed his teeth brushed. NA-D stated it slipped her mind, and she apologized for not getting oral cares completed this morning for R52. During an interview on 4/5/17, at 2:54 p.m. the director of nursing (DON) stated expected oral cares to be completed morning and night. Review of the policy, The Care Planning Process, dated 4/2017, included, "13. After the initial comprehensive care plan is developed, it needs to be implemented. Staff must be informed of tasks they are responsible to carry out. Each discipline is responsible for documenting that an approach was actually carried out and the resident's response, or lack of response, to the treatment or intervention."	F 312	grooming procedures. Compliance will be monitored by random weekly observations of oral care for three weeks. Observations will be assigned by the Director of Nursing/designee. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the monthly Quality Assurance and Assessment Committee meeting and the July 2017 quarterly Quality Assurance and Improvement Committee meeting.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		5/4/17

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F 323	Continued From page 37 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess falls to determine possible causative factors in order to develop resident centered interventions to minimize the risk of further falls for 4 of 4 residents (R17, R52, R34 and R61) who had a history of frequent falls. R17 and R52 sustained harm injuries, as a result of the falls. Findings include: R17's diagnosis found on the Admission Record	F 323	Pine Haven Care Center objects to and disagrees with both the findings of noncompliance and the scope and severity level of the deficiency citation. The Pine Haven Care Center staff do not believe there has been a deviation from this regulation. This corrective action regarding Tag F323 is submitted as required by law and is written solely to maintain certification in the Medicare and Medical Assistance Programs. Submission of this corrective action does	

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F 323	Continued From page 38 dated 9/19/16, indicated the resident had sustained repeated falls, age related cognitive decline, weakness and other malaise. A Care Area Assessment (CAA) dated 9/26/16, identified R17 to be at risk for falls. The corresponding problem statement indicated R17 had experienced delirium with suspected underlying dementia. A re-admission Minimum Data Set dated 9/26/17, indicated R17 had cognitive deficits as evidenced by scoring 6 out of 15 on a BIMS (brief interview for mental status) assessment. The CAA further indicated R17 required a need for supervision, direction and cues related to memory loss and impairment. R17 was also identified as having difficulty maintaining sitting balance and balance during transitions. R17's care plan last revised on 2/2/17, indicated the resident was at risk for falls characterized by history of falls/injury, multiple risk factors related to impaired balance, lack of safety awareness/judgment. Interventions for care included: call light within reach at all times when in room (initiated 10/17/16), gripper socks on when shoes are not worn (initiated 1/9/17), periodic fall risk assessment by a licensed nurse, reinforce need to call for assistance (initiated 10/17/16), wear proper and non-slip footwear (initiated 10/17/16), and tabs alarm on while in wheelchair or chair in room (initiated 1/19/17). Review of progress notes from December 2016 through March 2017. Progress notes completed daily for acute charting indicated R17 had demonstrated increased confusion and multiple self-transferring attempts when in bedroom.	F 323	not constitute an admission of noncompliance with any requirement and is not a legal admission that a deficiency in practice exists or that this deficiency was correctly cited. We wish to preserve our right to dispute these findings in their entirety. This plan of correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all state and federal regulatory requirements, and constitutes the facility's allegation of compliance. Pine Haven Care Center, Inc. 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 assistive devices to reduce the risk of accidents and injury. To provide additional guidance, the facility will develop a policy and procedures specific to falls. The interdisciplinary care team comprehensively assesses each resident at the time of admission to identify safety risks and develops a plan of care with resident-centered interventions that enhance mobility 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 impacts safety and functional status. The resident's care plan is modified as necessary to assure maximum function with minimal risk of injury. The resident's safety interventions are communicated to	

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F 323	Continued From page 39 The 4/4/17 nursing assistant's Pocket Care Plan (PCP) (included specific care information for nursing assistants to provide for individual resident), indicated R17 was to have gripper socks on at all times, wheelchair, walker, and a fall mat on both sides of the bed. The PCP also indicated R17 was alert and oriented times three, and included direction for staff to remove the fall mats when R17 was not in bed. To ensure a low bed was used and anti-lock brakes utilized on the wheelchair. Review of fall incident reports from December 2016 through March 2017 with the following findings: A fall on 12/19/16, at 1:25 p.m. occurred outside of R17's bedroom. R17 had been self-transferring to say goodbye to another resident. There were no injuries as a result of the fall. No immediate interventions were implemented at the time of the fall. The incident report indicated the Interdisciplinary Team (IDT) had reviewed the fall on an unknown date, had implemented physical and occupational therapy to re-evaluate, zip-tie glider chair in room or remove chair, and for R17 to wear gripper socks. (The gripper socks were not added as an intervention on the care plan until 1/9/17). A fall on 12/22/16, at 7:40 a.m. occurred in R17's bedroom. R17 had been self-transferring from chair to bathroom. R17 had been found not wearing shoes or gripper socks at the time of the fall. No injuries had occurred. Immediate interventions identified after the fall included for R17 to have shoes on when out of bed (which had been previously initiated 10/17/16). An IDT review had also been completed on 1/5/17 (two	F 323	the direct care staff during report and through the pocket care plan (PCP) which are routinely updated. During the mandatory meeting May 9, 2017, all staff will be reinstructed on 1) the regulatory mandate to ensure that the residents' environment remains as free of accidents hazards as possible and to report identified risks/hazards 2) the need to provide adequate supervision to reduce the risk of accidents/injury 3) the importance of following the resident's plan of care for safe transfers/mobility and 4) job performance expectations that include being aware of and following the resident's plan of care. The new fall policy and procedures will be reviewed. The staff will be reminded that personnel from all departments are to be aware of residents who are at highest risk for falls, be alert for residents needing assistance, and provide immediate interventions for residents observed in unsafe positions/circumstances. The licensed nurses will be instructed on the revised nursing-related policy/procedures and changes in the fall-related data gathering tools. Information that is to be documented at the time of the fall will be reviewed. The need for immediate interventions to lessen the risk of a recurring fall will be reinforced. The interdisciplinary team (IDT) will continue to meet weekly and more often as necessary to review circumstances of the resident falls, identify root causes/analyze causal	

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F 323	Continued From page 40 weeks after the fall), with no new fall interventions having been implemented. A fall on 12/25/16, at 4:15 p.m. occurred in R17's bedroom. At the time, R17 had been self-transferring from bed to reach the dresser. No injuries had occurred as a result of the fall. Documentation indicated that at the time of the fall, R17 had not been wearing shoes or gripper socks. No immediate interventions were implemented to prevent further falls. The documentation further indicated the IDT had reviewed the fall on 12/29/16, and had determined that R17's care plan had been followed leading up to the fall, except for R17 not having proper foot wear on. No new interventions had been identified or implemented. A fall on 12/31/16, at 3:00 p.m. occurred in R17's bedroom. At the time, R17 had been self-transferring from chair to access the closet. At the time of the fall, R17 had been found not to be wearing shoes or gripper socks. No injuries had occurred as a result of the fall. Immediate interventions identified to be implemented included for R17 to have proper footwear, which was an existing intervention from the care plan dated 10/17/16. The IDT had reviewed the fall on 1/5/17, and had not implemented any additional fall interventions. A fall on 1/2/17, at 1:05 p.m. occurred in R17's bedroom due to self-transferring. The fall note indicated R17 had been found lying face down on the floor of her bedroom in a pool of blood. R17 was observed to have had bleeding from lacerations on her forehead and mouth. Subsequently R17 was transferred to the emergency room for possible stitches as a result	F 323	factors, review the effectiveness of current safety interventions, and assess the need for additional resident-centered interventions. The fall analyses will be conducted at the next IDT meeting after the fall. The facility's system for communicating order changes to the clinical/nurse managers was reviewed. The progress notes from the physician, nurse practitioner, and other clinicians will be placed in a designated area for review by the nurse managers prior to filing in the resident's record. The nurses were instructed to be alert for PRN medications, especially PRN medications that are usually ordered to be given routinely. Resident number 17 – The resident's falls were again reviewed by the interdisciplinary care team and possible causal factors were investigated. The falls were felt not to be due to unmet needs such as hunger, being cold/hot, pain, boredom, etc. The resident received four weeks of physical therapy in February in an attempt to improve the resident's strength and balance. The consultant pharmacist reviewed the resident's medications April 7, 2017 and found "no irregularities." The resident's attending physician routinely reviews the resident's fall history. The April 13, 2017 physician's note regarding falls states, "Recent labs appropriate/non-contributory. Primary reason for falling appears to be dementia, secondary causes evaluated and none	

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F 323	Continued From page 41 of the fall. A tab alarm had been initiated as an immediate intervention upon R17's return from the hospital. However, the tab alarm intervention was not added to the care plan until 1/19/17 (17 days after fall with injury). An IDT review following the fall on 1/5/17 included; additional fluids three times daily, tab alarm and acute charting. A fall on 1/27/17, at 6:50 p.m. occurred in R17's bedroom due to self-transferring from wheelchair to bed. No injuries had occurred as a result of the fall. Immediate interventions implemented included to ensure the resident's call light was within reach (which was an existing intervention from the care plan dated 10/17/16). The IDT also reviewed the fall on 1/30/17 and at that time, implemented an evaluation of wheelchair fit/cushion needed. A fall on 2/13/17, at 3:35 p.m. occurred in R17's bedroom due to self-transferring from bed. Documentation indicated that at the time of the fall, R17 was found to not have shoes or gripper socks on. The fall had resulted in an abrasion to R17's lower back. An immediate intervention included for non-skid footwear to be worn at all times which was an existing intervention from the care plan dated 10/17/16. IDT reviewed fall on 2/14/17, with no new fall interventions implemented. A fall on 3/23/17, at 2:09 p.m. occurred in R17's bedroom due to self-transferring from bed. At the time of the fall R17 was found to not be wearing gripper socks or shoes. No injuries were identified as a result of the fall. The immediate intervention identified was to apply gripper socks (an existing intervention from the care plan dated 1/9/17). The IDT conducted their review on 4/3/17	F 323	are reversible. Continue to provide supportive care, medications regularly reviewed as are interventions to prevent falls during staff IDT" meetings. The resident's care plan was reviewed and found appropriate. Use of the alarm to alert staff of unsafe positioning will continue. The staff have been reinstructed on the resident's safety interventions to reduce the risk of falls, including the need for proper footwear and to frequently check the resident to ensure her needs are being met. All future falls will be reviewed with a focus on identifying the root cause of the incident. Any future falls will be reviewed with a focus on identifying the root cause of the incident. Resident number 52 – The resident was admitted 2/24/14 with diagnoses that included Parkinson's Disease, major neurocognitive disorder presume Lewy body with psychosis-hallucinations, delusions, and mood disorder. The resident's falls were reviewed by the IDT and causal factors were investigated. The Medication Administration Record has been updated to include the notation that the resident's Sinemet is a time-sensitive medication to be given within a 30-minute time frame. According to the March 9, 2017 attending physician progress note, the neurologist was contacted "regarding increased frequency of falls and severe orthostatic hypotension and he did not have any further recommendations regarding medications to help with managing Parkinson's disease, particularly his orthostatic hypotension . . .	

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F 323	Continued From page 42 (11 days after fall), and had identified no new fall interventions to be implemented. During an interview with the director of nursing (DON) on 4/5/17 at 8:26 a.m., the DON verified the following information: No immediate interventions had been implemented following R17's fall on 12/19/16. The DON also verified there was no date documented for when the IDT had reviewed the fall. The DON stated R17 had been seen by the medical provider on 12/20/16. Review of progress notes indicates R17 was seen by the medical provider for a 60 day recertification visit. The medical provider note indicated review of R17's current medication list, vital signs and weights, and indicated R17 had no pain or skin issues and no new orders were written. The provider note included: "she did slip out of her chair on 11/18, 11/19 and 12/3, and thankfully, these were without significant injury." As for R17's fall on 12/22/16, the immediate intervention was for R17 to have shoes on when up and out of bed. The DON addressed the fact the IDT hadn't reviewed the fall until 1/5/17, and stated the IDT usually meets one to two times weekly to review falls. However, the DON stated that in this instance the incident form was likely missing necessary information and their facility process was to return the form to the person responsible. The DON said the delay in getting the form back was likely what cause the delay in review by the IDT. The DON further verified the IDT had not implemented any new fall interventions as a result of the 12/22/16 fall. The DON stated regarding R17's fall on 12/25/16,	F 323	Staff have done a good job with offering diversional activities, using AO2 with any transfers and 3 with ambulation, and nursing home activities to keep him busy." Due to the lability of the resident's blood pressure, the physician discontinued Hydrazaline on April 10, 2017 and Norvasc was started. The April 13, 2017 nurse practitioner progress note states that the resident's blood pressure readings were discussed with the attending physician and "recommendations are to discontinue Norvasc with no further blood pressure monitoring. The elevated blood pressure readings could place him at risk for stroke, however, goals for care are very conservative and further pharmacological intervention for BPs is placing him at high risk for orthostatic hypotension/falls." Any future falls will be reviewed with a focus on identifying the root cause of the incident. The previous omissions of the antihypertensive medication were reviewed with the licensed staff and trained medication aides as part of the facility's ongoing quality improvement program. The care plan was reviewed and found appropriate. Resident number 34 - The resident's falls will be reviewed by the IDT and possible causal factors investigated. Trends/circumstances such as location of fall, time of fall, toileting schedule, pain control, medication regimen will be analyzed to facilitate implementation of resident-centered interventions. Any future falls will be reviewed with a focus	

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F 323	Continued From page 43 R17 had not been wearing appropriate foot wear at the time of the fall, and as such the care plan had not been followed. The DON verified no immediate fall interventions were implemented at the time of the fall, and verified after IDT review, no new fall interventions had been implemented. The DON stated the glider chair was zip tied at this time, despite being recommended after the fall on 12/19/16. As to R17's fall on 12/31/16, the DON verified R17 had not been wearing appropriate foot wear at the time of the fall. The DON verified the immediate intervention was restated to apply proper foot wear, despite this being an existing intervention. The DON verified the IDT had not implemented any new fall interventions after review. Regarding R17's fall on 1/2/17, the DON verified R17 was transferred to the emergency room for possible stitches for a laceration to the left eyebrow, and bleeding from the mouth. The DON stated after the IDT had reviewed the fall on 1/5/17, they had implemented an increase in fluids. This had been as a result of conversation with R17's family who had indicated R17 experienced increased confusion when not drinking enough fluids. In addition, notes from the Internal Medicine physician dated 1/3/17, indicated R17's medications had been reviewed due to frequent falls in the facility, and indicated laboratory values from a recent emergency room visit had been reviewed and appeared stable. The note included, "[R17] not currently taking any opioid, anticholinergic or benzodiazepine medication. Medication list is minimal and not suspicious for a contributing factor to falls. Primary reason for falling appears to be dementia	F 323	on identifying the root cause of the incident. Safe use of the resident's lift recliner will be reevaluated. The care plan will be reviewed and updated as necessary. Resident number 61 - The resident's falls will be reviewed by the IDT and possible causal factors investigated. Circumstances of the falls will be analyzed including the location of the resident's telephone and cardiac medications that could increase the risk of falls. Any future falls will be reviewed with a focus on identifying the root cause of the incident. The resident's care plan will be reviewed and updated as necessary. Compliance will be monitored by the Director of Nursing/designee through review of the documentation related to all resident falls for 30 days. Records will be audited for timely and complete documentation of the IDT fall investigation with a focus on root cause analysis, identification of causal factors, and resident-centered care plan interventions. Random auditing of fall related documentation will be done thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed as part of the monthly Quality Assurance and Assessment (QAA) Committee meeting and during the July quarterly QAA Committee meeting and ongoing.	

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F 323	Continued From page 44	F 323		

as she frequently forgets to call for assistance prior to ambulating."

The DON verified immediate intervention for the fall 1/27/17 was use of the call light. However, the DON verified the call light is not an effective intervention as R17 is unable to remember to use the call light or ask for help.

Regarding R17's fall on 2/13/17, the DON verified R17 was not wearing appropriate foot wear at the time of the fall and the care plan was not followed. The DON verified R17 suffered an abrasion to the lower back as a result of the fall, and again stated the immediate intervention was to remind R17 to use the call light. The DON further verified IDT review had not identified any new fall interventions as implemented. The Internal Medicine physician notes documented 2/16/17, again indicated R17 had frequent falls and that recent labs had been appropriate/non-contributory. The notes included: "Primary reason for falling appears to be dementia as she frequently forgets to call for assistance prior to ambulating. Continue working with therapy as have seen a decrease in falls."

The DON stated review of the fall on 3/23/17, indicated R17 had not been wearing appropriate foot wear at the time of the fall. The DON confirmed the care plan was not followed and the immediate intervention was to apply gripper socks, even though it was an existing intervention. Finally, the DON verified after IDT review no new fall interventions had been implemented.

Registered nurse (RN)-B was interviewed on 4/4/17, at 10:38 a.m. RN-B identified R17's fall

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 _____	04/06/2017

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 323	Continued From page 45	F 323		

interventions to include: assistance with toileting, alarm when in chair and bed, try and keep close to staff, gripper socks and shoes.

During continuous observation from 3:34 p.m. - 4:04 p.m. on 4/4/17, R17 was observed to be sitting in a wheelchair in her room watching television. The light was not on, making the room appear dark. R17 had foot pedals on in the wheelchair and was observed to self-propel herself in the wheelchair through her room despite the foot pedals being present. R17 was observed to propel herself towards her walker which was located across her room, and began pushing the walker through the room while still sitting in the wheelchair. At 3:40 p.m. R17 pushed the walker in front of the closet doors and attempted to stand from her wheelchair. R17 made no attempt to utilize the call light. At that time, the surveyor intervened and directed staff to R17's room. Nursing assistant (NA)-B entered the room and R17 explained she was trying to get her pajamas from the closet. NA-B attempted to redirect R17 with a snack which R17 declined, removed the foot pedals from the wheelchair, and then exited the room.

At 3:43 p.m. on 4/4/17, NA-B stated he didn't know what fall interventions were in place for R17. NA-B checked the pocket care plan (PCP) and stated there were no interventions. NA-B stated he checks on R17 frequently because she's always moving around.

At 3:45 p.m. on 4/4/17, R17 continued to self-propel in wheelchair throughout her room and attempted to shut the bedroom door. NA-B instructed R17 to leave the door open. At 3:47 p.m. R17 continued to self-propel in wheelchair

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 _____	04/06/2017

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 323	Continued From page 46	F 323		

throughout her room and moved towards the bed and began fixing the blanket. R17 was observed to be rocking back and forth in the wheelchair, reaching for the side table, reaching for the blanket and removing her shoes. As R17 was removing her shoes the Tab alarm began to sound. NA-B entered the room at 3:52 p.m. and offered to assist R17 to bed. NA-B assisted R17 to bed. Although R17 had removed her shoes, NA-B did not apply gripper socks before exiting R17's room as indicated in R17's care plan. Instead, the gripper socks were observed to be folded and lying in the glider chair next to R17's bed at 4:01 p.m.

At 4:04 p.m. on 4/4/17, the DON also observed R17 with the surveyor. At that time, the DON verified R17 was not wearing appropriate foot wear to prevent a potential fall. The DON stated according to the care plan, R17 was supposed to have gripper socks on if she was not wearing her shoes. The DON stated she was aware R17 removes her shoes at times and that she'd discussed with staff the importance of having R17 have proper foot wear on at all times.

During interview with the DON on 4/5/17 at 9:05 a.m., the DON stated the staff had not been completing a root cause analysis of each fall(s) for some time. When asked how they determine resident centered interventions without having conducted a root cause analysis, the DON stated, "during IDT meetings we look for any interventions from different departments, we try and look for patterns, we try and review multiple falls." However, the DON verified there wasn't good documentation of the plans or discussions from the IDT meetings. The DON added that it wasn't clear what interventions had been

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 _____	04/06/2017

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 323	Continued From page 47	F 323		

implemented or determined to prevent future falls. The DON indicated for example that the pocket care plan (PCP) identified floor mats to be used, however verified R17 doesn't have floor mats. The DON stated fall interventions should be placed on the PCP by the nurse managers after any updates or changes.

NA-A was interviewed on 4/5/17, at 9:45 a.m. NA-A stated R17's fall interventions included keeping the call light in reach, trying to keep her busy, applying the alarm when in she was in bed or in the wheelchair, and applying gripper socks when in bed. NA-A checked the PCP and stated she didn't think R17 had floor mats.

During interview with NA-C on 4/5/17 at 2:06 p.m., NA-C stated R17's fall interventions included: tab alarm in bed and wheelchair, to try and keep an eye on her, and to keep her occupied.

Registered nurse (RN)- C was interviewed on 4/6/17, at 8:03 a.m. RN-C stated R17's fall interventions included: gripper socks when shoes aren't on, or when in bed, and a low bed. RN-C also stated the PCP should include all fall interventions and should be updated with any changes. RN-C stated she was unsure when the last time R17's PCP had been updated to reflect current fall interventions. RN-C verified outdated and unused interventions including floor mats were still on the PCP and shouldn't be.
R52 was observed on 4/3/17 at 2:29 p.m. in bed, with the bed in the low position, and the call light within his reach.

On 4/3/17 at 5:23 p.m., R52 was observed in his room sitting in a Rock and Go wheel chair,

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 _____	04/06/2017

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 323	Continued From page 48	F 323		

leaning forward with his hands within a few inches of the floor, holding onto his call light. One of R52's shoes was off and the call light had been activated and was on. At that time, the surveyor notified staff, so immediate interventions could be implemented to prevent a fall from the wheelchair due to R52's position (leaning forward in wheel chair).

R52's current care plan printed 4/4/17, identified his diagnoses as including: Parkinson's disease, dementia with Lewy bodies and psychotic disorder with hallucinations due to known physiological condition. The care plan also indicated R52 had been admitted to the facility on 2/24/16, and currently lived in the facility. The care plan further indicated R52 was at risk for falls, characterized by history of falls/ injury and multiple risk factors related to use of psychotropic medications and dementia. The care plan indicated, the medical doctor documents that resident has "no insight into his fall risk", history of orthostatic hypotension. The care plan goal was that R52 would not be injured due to a fall, and fall interventions directed staff to: "keep call light within reach at all times when resident is in room, ensure environment is free of clutter, evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication periodically, has lack of safety judgment into falls, staff to observe frequently for safety, periodic fall risk assessment by a licensed nurse, resident to wear proper and non slip footwear, see use of wheelchair activity tray under mobility care plan for times when he is making attempts to self transfer multiple times, family (F)-A declines to continue with hipsters, risk and benefits reviewed with F-A, chance of breaking a hip or soft tissue

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 _____	04/06/2017

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 323	Continued From page 49	F 323		

injury if he falls without them on, F-A verbalizes understanding and declines to have them on him any longer."

R52's quarterly Minimum Data Set (MDS) assessment dated 1/24/17, indicated R52 had severe cognitive impairment, and required extensive staff assistance with bed mobility, transferring, locomotion on and off unit and activities of daily living. In addition, the MDS indicated R52 had sustained 0 falls with injury within the MDS reference period. During interview with RN-C on 4/6/17 at 11:30 a.m., RN-C stated the quarterly MDS completed on 1/24/17, had been inaccurate and should have indicated R52 had two or more falls with injuries.

A Fall Risk Assessment (tool used to determine falls risk) dated 3/27/17, identified R52 as being at high risk for falls.

Documentation indicated R52 had experienced 8 falls since 12/9/16 as follows:

On 3/26/17, at 4:15 p.m. R52 found on floor in his bathroom. Description of the incident indicated, "Resident was sitting on toilet. Slid off the toilet landing on his left side, holding onto his trousers."

The fall scene investigation worksheet completed after the fall on 3/26/17, indicated R52 had an unwitnessed fall, staff were alerted to the fall as the staff member, "went back to see if he was finished on the toilet." Resident was trying to pull up his pants. Vital signs at the time of the fall were lying 202/108 and sitting 189/98. The fall huddle indicated resident cannot be left on the toilet because of fluctuating blood pressures. New fall intervention on 3/27/17, care plan not to 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 _____	04/06/2017

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 323	Continued From page 50	F 323		

left alone on the toilet related to fluctuating blood pressures.

R52's neuro sheet revealed vital signs were monitored after the fall for 48 hours starting on 3/26/17. R52's blood pressures met the parameters to have the PRN hydralazine administered nine times with the blood pressures ranging from 211/101 to 160/84. At 4/5/17 at 9:03 a.m., registered nurse (RN)-C verified R52 had not received the PRN hydralazine during the month of March 2017 per physician order even though he met the parameters set forth by the doctor.

On 3/20/17, at 3:02 p.m. R52 found on the floor by staff while doing round at approximately 3:02 p.m. R52 was observed to be lying next to bed with head against the wall parallel to head of the bed, and a blood spot noticed on the wall. R52 was actively bleeding (small amount) on the occipital (back of head) section and a small cut was noticed under the bleeding. Pressure applied on the area with a gauze, and bleeding slowed down. Gauze applied on the area and a roll gauze applied around the head for pressure. Vital signs at the time of the fall were lying 145/71 and sitting 203/91. R52 was found with non-skid shoes on, and call light was within reach.

The fall scene investigation worksheet completed after the fall on 3/20/17, indicated R52 had unwitnessed fall. Resident stated he was trying to, "go to his car to drive or something." The fall huddle indicated regular checks on resident, remind resident on use of call light, and low bed always while in bed. No new interventions were implemented. In addition, no root cause analysis was completed and no actual causal factors 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 _____	04/06/2017

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 323	Continued From page 51	F 323		

identified.

R52's neuro sheet revealed vital signs were monitored after the fall for 48 hours starting on 3/20/17. R52's blood pressures met the parameters to have the PRN hydralazine administered nine times with the blood pressures ranging from 201/93 to 156/80. However, none was administered.

At 4/5/17 at 9:13 a.m., RN-C stated R52 had not received the PRN hydralazine during the month of March 2017 per physician order even though he met the physician parameters to give the medication. RN-C verified no new interventions were implemented and no actual causal factors were identified for this fall. RN-C stated R52 fell at 3:00 p.m. and R52 administered sinemet late this day. The 11:00 a.m. dose was given at 12:43 p.m. and the 4:00 p.m. dose was given at 5:59 p.m. The sinemet is given to reduce the symptoms of motor dysfunction due to Parkinson's disease.

On 2/6/17 at 9:15 p.m., R52 was found in room by aide during rounds. R52 was on the floor next to wheelchair located at the center of room approximately 5 feet from bed, and 8 feet from bathroom. Wheelchair observed to have rolled over. Vital signs at the time of fall included blood pressure of 200/88. R52 observed to have had a small skin tear to his right cheek measuring 0.6 centimeters (CM) by 0.3 cm, and 3 tears on his right shin measuring 3.6 cm x 1.8 cm, 1.9 cm x 0.8 cm, 1.3 cm x 0.8 cm respectively from top to bottom (head to toe direction). Resident also observed to have an abrasion to his left knee that is closed. Wheelchair (W/C) observed to have rolled over, and it could be possible that resident

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 _____	04/06/2017

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 323	Continued From page 52	F 323		

may have rolled from W/C as resident often tries to pick up things from floor. Call light observed to be within reach; W/C brakes unlocked, and had non-slide shoes on.

The fall scene investigation worksheet completed after the fall on 2/6//17, indicated R52 had unwitnessed fall. The fall huddle indicated more frequent checks on R52 as well as reminders to use the call light.

On 4/5/17, at 9:18 a.m. RN-C stated at times R52 would put the call light on. RN-C stated call light on was not on at time of this fall. RN-C stated R52's rocking Broda chair had broken and R52 was in a regular wheelchair at the time of the fall. RN-C stated she called on 4/5/17 to Midwest Respiratory to have them come out right away that day to repair R52's wheelchair.

On 1/24/17 fall note read, "Resident had been layed [sic] down in bed at 1:30 pm for a nap after being toileted and brief changed. Resident was in his room in his bed when CNA [certified nursing assistant] left room with call light within reach. CNA went across the hall to answer a call light and when she came out of the room noted that resident was lying on the floor with his head at the head of the bed and feet and legs stretched out at foot of bed." Information was requested in regards to the fall and none was provided.

On 4/5/17 at 9:21 a.m., RN-C stated she would need to look for the post fall investigation report for the fall on 2/6/17. RN-C was unable to recall if any new fall interventions were implemented to prevent further falls. Surveyor was later provided a sticky note that indicated the facility was unable to find the incident report from the fall on 1/24/17.

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 _____	04/06/2017

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 323	Continued From page 53	F 323		

On 1/7/17, at 2:20 p.m. fall note said R52 was found on the floor on his back. This was an unwitnessed fall. Resident stated he was lying in bed and wanted to get up. It is unknown when the resident was laid down and by whom. Resident had no bruising, no redness, no swelling anywhere but did say his right side of buttock and right side of head hurt. Once patient was toileted and up in the wheel chair, resident reported no pain.

The fall scene investigation worksheet completed after the fall on 1/7/17, indicated R52 had an unwitnessed fall. R52 said he was trying to walk and fell. The call light was on at time of the fall. The fall huddle notes indicated reinforced R52 to call for help. New intervention was to have medication regimen review completed.

On 4/5/17, at 9:24 a.m. RN-C stated R52 fell at 2:15 p.m. and R52 was administered sinemet late this day. The 11:00 a.m. dose was given at 12:02 p.m., RN-C verified there was not a root cause analysis of this fall completed and only causative factor reviewed was the possibility of receiving the sinemet late which affects gait/steadiness.

On 12/27/16, at 5:25 p.m. fall report said that a nursing assistant had walked by R52's room and noted that resident was on the floor sitting on his buttocks with his back against his wall dresser and his feet facing the head of the bed. No injuries noted at this time. Resident asked what he was going to do and resident stated, "I wanted to get back in that corner." Resident was referring to the corner of the head of the bed. When resident was asked why he stated, "cuz [because] I wanted to." Resident had been sitting in his

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 _____	04/06/2017

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 323	Continued From page 54 wheelchair. The fall scene investigation worksheet completed after the fall on 12/27//16, indicated R52 had an unwitnessed fall. The fall huddle report indicated it worked well when we had environmental services monitoring at risk fall residents. Immediate intervention were to keep resident within sight of staff with activities such as coloring. A referral was made for physical and occupational therapy. On 4/5/17, 9:32 a.m. RN-C said they referred him to physical and occupational therapy. RN-C verified there was not a root cause analysis completed of this fall completed and no actual causal factors were identified. 12/25/16 fall notes said that R52 received a left knee skin tear from fall at 3:00 p.m. Mepilex applied with no bleeding and minimal tenderness. The resident incident reporting form completed after the fall on 12/25//16, indicated R52 had an unwitnessed fall. R52 was laying on ground by his bed. R52 sustained a left knee skin tear and staff member indicated, "I think he tried to get up and walk around the room." R52 attempted to self-transfer and fell. Call light near resident and frequent observations done by nursing assistant and nurse. No new interventions were implemented. On 4/5/17 at 9:35 a.m., RN-C stated no new interventions were implemented for the fall on 12/25/16. RN-C verified there was not a root cause analysis completed of this fall and no actual causal factors were identified. RN-C stated facility did not complete root cause analysis of falls at this time. RN-C stated we talked about the	F 323		

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 _____	04/06/2017

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 323	Continued From page 55	F 323		

falls, the interventions and different things we want to try. RN-C stated they have identified for the most part his falls are in the afternoon and evening. RN-C stated they try to keep him busy with different things. RN-C stated he liked to paint, build and color. RN-C stated they try to keep him occupied.

On 12/13/16, at 1:55 p.m. fall notes said that R52 was found on the floor facing the foot of the recliner. His posterior head was against the dresser. He complained that he had hit his head on the dresser but "not that hard." He said his left arm was tender at the forearm, and across the elbow, (a 1.5 cm diameter abrasion without bleeding or exudate is present-was covered with a Band-Aid). He said his hip hurt yet there was no tenderness nor any discomfort expressed when the resident was Hoyer lifted off the floor. There were no bruises or other abrasions other than the elbow. Resident was alert and stated he had been daydreaming in the recliner about rounding up horses. Potential exists for a head injury. Resident states he didn't hit his head hard enough "to see stars" and landed with the left side and top of head against the dresser. There are no marks present initially and he will be monitored per protocol.

The fall scene investigation worksheet completed after the fall on 12/13/16, indicated R52 had an unwitnessed fall. R52 had been in the recliner in his room. R52 was wearing Ted hose as shoes had been removed when put into recliner. Staff member found R52 when they walked in his room. R52 stated he was daydreaming about rounding up horses. The fall huddle notes indicated closely monitor R52 when in hall during quiet time rather than resting in his room, 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 _____	04/06/2017

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 323	Continued From page 56	F 323		

recliner or bed. R52 now seated in hall interacting with staff. New intervention gripper socks on when shoes are not on.

On 4/5/17 at 9:39 a.m., RN-C verified the fall on 12/13/17 did not have an IDT review until 12/27/16, 14 days after fall. RN-C stated sometimes the fall reports were turned in uncompleted and this could have happened in this case, where I returned the worksheet to the nurse for completion and I did not receive it back timely for review. Also, RN-C stated the new intervention implemented at the time of this fall was gripper socks were to be on when R52 was not wearing shoes. RN-C verified the care plan included indicated R52 was to wear proper and non-slip footwear with an implementation date of the intervention of 3/6/14. RN-C verified there was not a root cause analysis of this fall completed and no actual causal factors were identified.

On 12/9/16, at 4:20 p.m. fall notes indicated R52 was in an upright position on the floor. R52's family (F)-B stated R52 wanted to rest in his recliner after F-B had left. Resident was toileted prior to fall and transferred to the recliner to rest as requested. R52 first stated he "may have bumped his head" when asked and later stated he "did not bump his head." No bruising or skin tear were noted.

The fall scene investigation worksheet completed after the fall on 12/9/16, indicated R52 had an unwitnessed fall. R52 had been sitting in the recliner in his room. R52 was "putting something together." The fall huddle indicated R52 was toileted prior to fall, F-B had just left and requested R52 to rest in recliner (where he

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 _____	04/06/2017

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

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F 323	Continued From page 57	F 323		

self-transferred from) all interventions were put into place. Immediate intervention: Transferred R52 to w/c and set up the side table with coloring books and crayons to give him something to focus on in the hallway so staff has eyes on him at all times. Seroquel PRN administered at 4:40 p.m. for restlessness. No new interventions were implemented. In addition, no root cause analysis was completed and no actual causal factors were identified.

On 4/5/17, 9:43 a.m. RN-C stated according to the fall scene investigation worksheet an interdisciplinary team review was not completed for this fall. RN-C stated she was unable to recall if any new interventions were implemented after this fall. RN-C verified there was not a root cause analysis of this fall completed and no actual causal factors were identified.

R52's physician order dated 9/10/15 instructed staff to administer, "Carbidopa-Levodopa [sinemet] 25-100 MG [milligrams] give 2 tablet by mouth three times a day for Parkinsonism." The medication administration record (MAR) revealed R52 was to be administered this medication at 7:00 a.m., 11:00 a.m. and 4:00 p.m.

R52's physician order dated 3/9/17 instructed staff to administer, "Hydralazine HCl tablet 10 MG, Give 1 tablet by mouth as needed for blood pressure =/> [equal or greater] 150/90 [millimeters ofmercury] four times a day."

R52's physician order dated 3/30/17 instructed staff to administer, "Hydralazine HCl tablet 10 MG, Give 1 tablet by mouth as needed for HTN [hypertension] give is SBP [systolic blood pressure with systolic being the first reading]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 58 >150/90 four times a day and/or DBP > 90 four times a day." On 4/4/17, at 11:08 a.m. RN-D stated as long as we stay on top of his sinemet medication (in regards to giving the medication at the specified times to be given per doctor's order to reduce falls due to gait and unsteadiness), I do not see any behaviors; otherwise, R52 gets "antsy" which is understandable with his Parkinson's disease. On 4/4/17, at 2:48 p.m. registered nurse (RN)-C stated sinemet is a time sensitive medication and should be administered within 15 minutes prior or after the scheduled administration time of the medication. RN-C stated R52 would be at increased risk for falls if the sinemet was not given timely, as it could impair the way he is able to function, making it hard for him to complete tasks on his own. RN-C stated she did not try to correlate the days his sinemet was administered late to the days he has had falls. On 4/5/17, at 1:31 p.m. the nurse practitioner (NP)-A stated her expectation was the Sinemet medication would be administered within 30 minutes on either side of the scheduled time. NP-A stated the timing of sinemet is important to keep at the appropriate intervals for symptom management, which included gait disturbance and motor function/steadiness. NP-A stated R52 could be at increased risk for falls if not receiving sinemet timely, theoretically. NP-A stated her expectation was medications were given on time and the sinemet administration time should be reviewed as a part of the post falls assessment for each fall to determine if the timely sinemet administration was related to not receiving the medication as ordered. NP-A stated she was	F 323		

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 _____	04/06/2017

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F 323	Continued From page 59	F 323		

never notified that the sinemet was given late that many times. NP-A stated doctor-E saw R52 recently and, "my guess was [doctor-E] was not aware of this" in regards to the sinemet not given timely and the frequent falls. NP-A stated her expectation would be staff to follow the order for the PRN hydralazine and stated doctor-E order should have been followed. NP-A stated the blood pressure management could certainly be a factor in R52's falls and that was the basis for doctor-E's order for the prn hydralazine. NP-A stated R52's high blood pressures warranted treatment according to doctor-E's order. NP-A stated a blood pressure reading of 201/101, she would have expected the physician to be notified and the blood pressure to be rechecked. NP-A stated R52 had a very labile (labile defined as blood pressure measures that may fluctuate abruptly and repeatedly from normal to high) blood pressure and it should have been rechecked especially if they were not going to notify anyone.

On 4/5/17, at 2:54 p.m. the director of nursing (DON) stated she expected staff to administer sinemet within 15 minutes before or after the scheduled order. The DON stated this was nursing judgement, knowing the medication and the need to give it at the prescribed time. The DON stated R52 had labile blood pressures and stated she just became aware the hydralazine PRN medication was not being administered per the physician order and stated her expectation was R52 receive the PRN hydralazine as ordered. The DON stated actual harm could have occurred related to R52's falls, administration of the sinemet and the PRN hydralazine medication not being administered and stated the facility was taking this very seriously. The DON stated our fall rate has been a concern in this facility for quite

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F 323	Continued From page 60 some time. R34's re-admission record dated 3/1/17, indicated the resident had diagnoses including: vascular dementia without behavioral disturbance, Parkinsonism, weakness and chronic pain syndrome. R34's admission MDS dated 3/8/17, indicated R34 had experienced falls prior to admission, one fall since admission, had occasional moderate pain, that his balance during transition and walking was not steady, and that he had moderate cognitive impairment. During observation on 4/5/17, at 2:57 p.m., R34 was seated in a recliner in his room and had shoes on both feet. R34's wheelchair was placed directly in front of R34. R34's current care plan with print date of 4/6/17, included requires assistance for mobility, positioning, locomotion, and ambulation related to decreased balance. At risk for falls characterized by history of falls/ injury, multiple risk factors related to: impaired balance, unsteady gait, deconditioning. Call light within reach at all times when resident is in room. Encourage resident to use handrails or assistive devices properly. Ensure environment is free of clutter. Periodic fall risk assessment by a licensed nurse. Reinforce need to call for assistance. Resident to wear proper and non-slip footwear. Transfer and change positions slowly. Transfers: provide one person constant guidance and physical assist with front wheeled walker and gait belt. Report to registered staff any decrease in ability to transfer resident safely. R34's Fall Risk Assessment, dated 3/29/17, indicated a score of 22, which is high risk for falls.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 61 R34's Fall Scene Investigation Worksheets and Progress notes, included the following: Fall on 3/6/17, at 3:10 p.m. Resident found in room on his knees next to the recliner. Had red areas on center of both knees. Resident stated he was going to get into his wheelchair. Immediate interventions included check resident status every 15 minutes and encourage use of call light. IDT signed the report on 3/7/16. However, R34's record lacked review of causative factors related to the fall, and interventions based on these factors. Fall on 3/16/17, at 2:45 p.m. Resident was found sitting on the floor in his room by an activity staff person. Resident stated he was trying to transfer himself from his recliner into his wheelchair. Immediate interventions included call light in reach and stressed to resident not to transfer without help and to use the call light. IDT signed the report on 3/17/16. Again R34's record lacked review of causative factors related to the fall, which included interventions. Fall on 3/26/17, at 2:25 p.m. Resident calling for help. The room door was closed. Found lying on his back. Resident said he slipped. Immediate interventions included unplug recliner, door propped open at all times unless receiving cares. Resident needs to be closely monitored to prevent self-transfer, monitor anxiety level, may need meds adjusted (no anti-anxiety medications ordered). IDT signed the report on 3/26/17 and 3/27/17 with note written that read look into anti-anxiety medications. Again R34's record lacked review of causative factors related to the fall, which included interventions.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 62 On 4/6/17, at 9:03 a.m., R34 stated he has had a couple of falls. One time I just slipped out of my chair. I do not remember the reason for the other one. I did not get hurt on either. I am so careful now, I hardly move. R34 stated if he needed help he usually pages, if anyone is around. On 4/6/17, at 10:50 a.m., RN-C confirmed causative factors had not been reviewed for the falls R34 had on 3/6/17, 3/16/17 and 3/26/17. On 4/6/17 at 11:03 a.m., the DON verified causative factors had not been reviewed, including interventions related to causative factors for the falls R34 experienced on 3/6, 3/16 and 3/26/17. R61's quarterly MDS dated 1/5/17, identified R61 had no falls, occasional severe pain, balance during transition and walking: not steady and had severe cognitive impairment. R61's Admission Record dated 4/5/17, included diagnoses of unspecified dementia without behavioral disturbance, hypertension and congestive heart failure. During observation on 4/4/17, at 9:30 a.m., R61 was seated in her wheelchair in her room and the call light was within reach attached to the resident's wheelchair. R61's current care plan included at risk for falls characterized by history of falls/ injury, multiple risk factors related to impaired balance, pain, use of psychotropic medications. Interventions included call light within reach at all times when resident is in room. Encourage resident to use handrails or assistive devices properly. Periodic fall risk assessment by a licensed nurse.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 63 Resident to wear proper and non-slip footwear. R61's Fall Risk Assessment, dated 4/3/17, indicated a score of nine, which is moderate risk for falls. R61's Fall Scene Investigation Worksheets and Progress notes included the following: Fall on 3/30/17, at 1:45 p.m. Resident was found on floor in room. The resident had been sitting in her wheelchair and stated she was trying to get to her phone that was ringing, and she forgot she could not walk. Insights gained: phone needs to be placed in a spot that is easier for the resident to reach. Immediate interventions included call light close to resident and remind resident to all for help with getting up. The worksheet lacked IDT signatures. R61's record lacked review of causative factors related to the fall, which included interventions. Fall on 3/31/17, at 12:45 a.m. Heard someone yelling for help and found the resident lying on the floor by her bed. Resident stated she was going to go to the bathroom. Immediate interventions included watching her frequently, check new shoes for adaptation to a gripper material. IDT signed the report on 4/3/17 with note written that read sent to ER (emergency room) in the a.m. low blood pressure/pulse and pain. X-rays negative, change to cardiac medications. R34's record lacked review of causative factors related to the fall, which included interventions. On 4/5/17, at 1:28 p.m., RN-C confirmed causative factors had not been reviewed, which included interventions related to causative factors for the falls R61 had on 3/30/17 and 3/31/17. RN-C confirmed the IDT had not signed the fall	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 64 report for 3/30/17. On 4/5/17, at 1:44 p.m., the DON verified causative factors had not been reviewed, which included interventions related to causative factors for the falls R61 had on 3/30/17 and 3/31/17. The DON confirmed the IDT had not signed the report for the fall on 3/30/17. The facility policy Resident Incident, Accident and Injury Responsibilities revised 1/2017, indicated all staff will respond promptly and appropriately to ensure the safety of all residents when an accident, injury or aggression is observed and or reported. Procedure: I. Direct care staff responsibility when discovering or told by resident of an incident, accident injury or aggression by anyone. ... L. Complete the Resident Incident Report Form or the Fall Scene Investigation Worksheet, sign, date and give to the charge nurse as soon as possible. II. Licensed nurse responsibility upon receiving notice of incident, accident, injury or aggression. ...10. Determine to the best of your ability what the cause of the incident, accident and or injury was and ensure that the current interventions are appropriate. Document effectiveness of the interventions on the incident report form and the care plan. If no longer deemed appropriate (or will not prevent the current cause from recurring) identify a potential solution to prevent recurrence to the best of your ability. It is our responsibility to ensure the best safety once the situation has been reported to you... 12. Whether this situation is abuse or an accident or injury, the licensed nurse is responsible to put an intervention in place to ensure that recurrence of the incident in being prevented or minimized.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 65 They are to put the intervention on the incident report and in the communication book in the front care plan section so that during off hours, staff are aware of what change they need to implement. 13. The licensed nurse on the subsequent shift after an intervention was put in place is responsible to document in the resident's record if the intervention selected is working. If not select a different intervention. III... RN case manager: 1. Review the investigation of the cause of the incident and report any concerns requiring staff interventions to the director of nursing/administrator in accordance with their findings... 2. Review incident at the next clinical review (i.e. morning report) where indicated, the need to interdisciplinary review of the issue at the next standup meeting and after determining the potential for other considerations such as therapy, changes in environmental situations or equipment, ensure the components are put into place in the resident's care plan and staff's pocket care plan... 4. Monitor implementation of the plan developed and report failure to comply by assigned staff and shifts to the director of nursing for disciplinary action. The Interdisciplinary Team: 1. Will review all incident occurrence reports related to accidents, elopement, resident aggression and/or injuries the next working day of the report and make an assessment of the interventions that were put into place to minimize further occurrences. 2. Will make suggestions and further recommendations as needed...	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		5/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 66 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 329		

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F 329	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor medication regimens to ensure optimal effectiveness of medications for 2 of 5 residents reviewed (R52 and R35) and failed to ensure parameters for use of an as needed (PRN) medication was identified for 1 of 5 (R61) residents whose medication regimens were reviewed. Findings include: R52's diagnoses located in the current care plan printed 4/4/17 included: Parkinson's disease, dementia with Lewy bodies and psychotic disorder with hallucinations due to known physiological condition. The care plan indicated R52 had been admitted to the facility on 2/24/16 and currently lives in the facility. R52's quarterly Minimum Data Set (MDS) and assessment dated 1/24/17, indicated R52 had severe cognitive impairment, and required extensive staff assistance with bed mobility, transferring, locomotion on and off unit and activities of daily living. R52's physician order dated 9/10/15 instructed staff to administer, "Carbidopa-Levodopa 25-100 mg [milligrams] give 2 tablet by mouth three times a day for Parkinsonism." The medication administration record (MAR) revealed R52 was to be administered this medication at 7:00 a.m., 11:00 a.m. and 4:00 p.m. Review of R52's sinemet administration times, revealed R52 was administered sinemet an hour after the scheduled time forty two times from	F 329	Pine Haven Care Center staff ensure that each resident's drug regimen is free from unnecessary drugs. The resident's drug regimen is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. The medication policies and procedures were reviewed and found appropriate. Pine Haven Care Center staff monitor medication regimens to ensure optimal effectiveness of medications and ensure there are proper parameters identified for PRN (as needed) medications. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during their routine 30/60 day visits and more often as indicated. During the quarterly care conference and more often if needed, residents are reassessed and the medication type, dose, and other related information are reviewed. The prescribing clinician is notified of concerns about the resident's medication regimen. During the May 9, 2017 mandatory meeting, the licensed staff and trained medication aides will be informed of the	

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F 329	Continued From page 68 1/1/17 to 2/18/17, Seven times from 2/18/17 to 3/4/17 and fourteen times from 3/21/17 to 4/4/17. On 4/05/2017, at 8:40 a.m., registered nurse (RN)-C verified the sinemet had been given an hour or more from specific physician ordered time and not consistently given. In addition, R52 had a physician's order dated 3/9/17, which instructed staff to administer, "Hydralazine HCl [antihypertensive medication] tablet 10mg [ten milligrams], Give 1 tablet by mouth as needed for blood pressure =/> [equal or greater] 150/90 four times a day." An updated physician order dated 3/30/17, instructed staff to administer, "Hydralazine HCl tablet 10mg, Give 1 tablet by mouth as needed for HTN [hypertension] give if SBP > [systolic blood pressure greater than] 150/90 four times a day and/or DBP > [diastolic blood pressure greater than] 90 four times a day." R52's medication administration record revealed R52 received NO PRN hydralazine during the months of March 2017 or April 2017. However a review of R52's blood pressure results indicated the resident's SBP and/or DBP had met the parameters for the PRN dose of Hydralazine HCL 8 times between 3/9/17 to 3/30/17, and three times between 3/30/17 and 4/4/17. There was no documented information as to why the resident was not administered the PRN Hydralazine per order nor as to whether the physician or nurse practitioner had been contacted. Blood pressures meeting the criteria for the PRN medication use were as follows: 3/9/17: 190/100 3/15/17: 198/82 3/17/17: 179/93	F 329	need to 1) administer time-sensitive medications according to facility policy and within the designated time frames 2) to request parameters for administration when multiple PRN analgesics are prescribed and 3) offer/provide and document nonpharmacological interventions for pain control. Resident number 52 – The staff have been instructed on the time-sensitivity of Sinemet dosing. A medication time tracking log was implemented from April 6 to April 25, 2017 requiring two nurses to verify the time Sinemet was administered. The log data show that the medication has been routinely administered in a timely manner. The Medication Administration Record has been updated to include the notation that the resident's Sinemet is a time-sensitive medication to be given within a 30-minute time frame. The use of antihypertensive medications was reviewed by the attending physician; the April 13, 2017 nurse practitioner note states, "recommendations are to discontinue Norvasc with no further blood pressure monitoring. The elevated blood pressure readings could place him at risk for stroke, however, goals for care are very conservative and further pharmacological intervention for BPs is placing him at high risk for orthostatic hypotension/falls." The care plan has been updated to reflect labile blood pressures, discontinuation of blood pressure medications and the related risks.	

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F 329	Continued From page 69 3/20/17: 190/95 3/20/17: 200/96 3/20/17: 184/92 3/20/17: 192/88 3/20/17: 181/89 3/20/17: 190/95 3/20/17: 196/90 3/20/17: 201/93 3/22/17: 156/80 3/22/17: 195/92 3/22/17: 195/92 3/24/17: 150/92 3/25/17: 188/88 3/26/17: 202/108 3/26/17: 189/98 3/26/17: 179/92 3/26/17: 172/86 3/26/17: 170/95 3/26/17: 160/84 3/27/17: 211/104 3/28/17: 174/97 3/28/17: 170/80 3/28/17: 174/97 3/31:17: 186/82 4/1/17: 200/101 4/3/17: 170/70. On 4/5/17 at 9:13 a.m., RN-C verified R52 had not received the PRN hydralazine form 3/9/17 to 4/3/17. On 4/4/17 at 2:48 p.m., RN-C stated sinemet is a time sensitive medication and should be administered within 15 minutes prior or after the scheduled administration time of the medication. On 4/5/17 at 2:54 p.m., the director of nursing (DON) stated she expected staff to administer sinemet within 15 minutes before or after the	F 329	Resident number 61 - The resident pain management regimen was reviewed. The resident will be offered PRN acetaminophen first for complaints of pain with oxycodone offered for pain not relieved by the PRN acetaminophen. The staff will be instructed to offer nonpharmacological interventions before administering PRN analgesic medication. The resident's pain management program will be reviewed with the nurse practitioner May 8, 2017. Compliance will be monitored by the Clinical Nurse Manager Assistant (LPN) who processes prescribing clinician orders. To alert the nurses/trained medication aides, the Nurse Manager Assistant in consultation with the consultant pharmacist will identify time sensitive medications that will be flagged on the electronic medication administration record (eMAR). The Clinical Nurse Manager Assistant will audit the eMARs for the next sixty days to ensure time-sensitive medications are flagged. To further monitor compliance with timely administration of Sinemet, administration time logs will be completed for all residents receiving Sinemet from May 8 through May 22, 2017. The Clinical Nurse Manager Assistant and the Director of Nursing have identified the residents who are receiving multiple PRN analgesics. The nursing staff will define parameters when possible; the prescribing clinician will be asked to provide parameters as necessary during	

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 _____	04/06/2017

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F 329	Continued From page 70 scheduled order. The DON stated staff used nursing judgement, knowing the medication and the need to give it at the prescribed time. The DON verified R52 had labile blood pressures and stated she'd just become aware the hydralazine PRN medication was not being administered as ordered. The DON stated her expectation was that R52 would receive the PRN hydralazine as ordered. The facility's policy titled Administration of Medication revised 8/7/16, included: The right time frame: administer drugs as instructed on the MAR and within the time frame of one hour before or after the time stated on the MAR. R61's quarterly Minimum Data Set (MDS) dated 1/5/17, identified the resident had occasional severe pain and had severe cognitive impairment. R61's Admission Record dated 4/5/17, included diagnoses of unspecified dementia without behavioral disturbance and peripheral vascular disease. R61's physician orders included the following: 3/20/17 clarification, 3/8/17, oxycodone (narcotic) 5 mg (milligrams)- give 0.5 tablet by mouth every four hours as needed for pain, acetaminophen 500 mg - give one tablet by mouth every 6 hours as needed for pain. Attempt non-pharmacological therapies before administration of PRN Oxycodone; e.g.. (example) assess pain/discomfort and environmental conditions such as noise, room temperature etc. every shift. Attempt non-pharmacological therapies before administration of PRN Acetaminophen; e.g..-assess pain/discomfort and environmental conditions such as noise, room temperature etc. every shift.	F 329	their next visit. For the next 30 days, the Clinical Nurse Manager will audit records to ensure parameters are addressed for all residents with multiple PRN analgesics. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed as part of the monthly Quality Assurance and Assessment (QAA) Committee meeting and during the July quarterly QAA Committee meeting and ongoing.	

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	245359	A. BUILDING _____ B. WING _____	04/06/2017

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F 329	Continued From page 71 R61's pain assessment dated 4/3/17, identified R61 had complaints of mild leg pain daily, and that PRN pain medication relieved the pain. The assessment indicated the current pain medication regime included acetaminophen PRN. Under the nonpharmacological interventions section, there was no documented information. Under evaluation the documentation included "satisfactory pain management, continue with current plan of care." R61's medication administration record (MAR) dated 3/2017 identified the use of the oxycodone and acetaminophen PRN and indicated R61 had received PRN oxycodone once on 3/28, twice on 3/29, and once on 3/30. The MAR indicated R61 had received Acetaminophen once on 3/20. However, there was no information to indicate whether R61 had received any non-pharmacological interventions prior to the administration of the PRN medications. R61's record also lacked parameters to know when to give which of the two pain medications of PRN oxycodone or when to use the PRN acetaminophen. On 4/5/17, at 1:53 p.m. the DON stated in regards to offering nonpharmacological interventions prior to administration of PRN pain medications, she would expect Rooke boots be offered, repositioning, ice, or changing shoes to be offered before administration of PRN medications and if the resident refused, she'd expect staff to document refusal of the nonpharmacological intervention and administer the PRN medication. The facility policy Administering PRN Pain Medications, dated 1/17, indicated the purpose of	F 329		

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F 329	Continued From page 72 this procedure is to provide guidelines for assessing the resident's level of pain prior to administering pain medication...Steps in the procedure 5. Evaluate and document the effectiveness of non-pharmacological interventions. 6. Administer pain medications as ordered.	F 329		
F 332 SS=E	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 9 residents (R59, R39, and R56) were given medication in accordance with physicians orders, resulting in a facility medication error rate of 14 percent. Findings include: R59's current physician orders included an order dated 3/20/17, for artificial tears right and left eyes PRN (as needed) for dry eyes. Administer after Timoptic (eye drop medication). During observation on 4/4/17, at 10:01 a.m., licensed practical nurse (LPN)-A stated she had artificial tears to administer to R59. LPN-A obtained a bottle of eye medication out of the medication cart and handed the bottle to surveyor to look at. The bottle of eye medication was Tetrahydrozoline HCI (Visine) (a decongestant used to relieve redness in the eyes and works by	F 332	Pine Haven Care Center has policies and procedures requiring that the preparation and administration of drugs and biologicals are in accordance with 1) physicians' orders 2) manufacturers' specifications and 3) accepted professional standards and principles. The goal is to have a medication error rate of less than 5% and be free of all significant medication errors. The medication administration policies and procedures were reviewed and found appropriate. During the May 9, 2017 mandatory meeting for nurses and trained medication aides (TMAs), the facility's policies and procedures addressing administering medication will be reviewed. Instruction will include following the "five rights" (right resident, medication, dose, route and time) of medication	5/4/17

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F 332	Continued From page 73 temporarily narrowing the blood vessels in the eye) 0.05 percent. The bottle had a written opened date of 3/27/17. Surveyor queried LPN-A if the eye medication bottle was artificial tears and LPN-A looked at the bottle and checked R59's Medications Administration Record (MAR), which read Artificial tears solution 0.4% (Hypromellose) install one drop both eyes one time daily for dry eyes. Administer after Timoptic. LPN-A stated she would have to check with pharmacy if the bottle of eye medication Tetrahydrozoline HCl 0.05 percent was artificial tears. LPN-A stated the Tetrahydrozoline HCl 0.05 percent eye medication was the facility house stock of artificial tears. On 4/4/17, at 2:15 p.m., the director of nursing (DON) observed the bottle of Tetrahydrozoline HCl eye drops for R59 and stated the eye medication was Visine and not artificial tears. The DON reviewed R59's physician orders and confirmed R59 had no physician order for the Tetrahydrozoline HCl eye drop medication. The DON stated the Tetrahydrozoline HCl eye drop medication was a floor stock facility medication. The DON reviewed the facility standing orders and stated the standing orders did not include an order for the Tetrahydrozoline HCl eye drop medication. The DON showed surveyor the facility standing orders included an order for artificial tears/ointment four times daily prn eye irritation/dryness per patient request or nurse assessment of need. The DON stated the Visine was ordered as a stock medication from McKessan (medical supply company), and the person who was responsible for ordering the facility stock medication was non-clinical and had ordered the Visine for artificial tears by mistake. The DON removed the Visine medication for R59	F 332	administration. The licensed nurses and TMAs were reminded to administer time sensitive medications according to facility policy and follow parameters/specific instructions associated with medication orders. Timely drug ordering was addressed. Medication errors will continued to be reviewed by the Consultant Pharmacist. The Consultant Pharmacist and the Director of Nursing discussed system changes to improve the efficiency and accuracy of the medication administration process including procuring another medication cart to eliminate the need to share carts between two nursing units. The Consultant Pharmacist will conduct a training session for licensed nurses and trained medication aides on May 11, 2017. Medication errors and general medication administration issues will be addressed. A registered nurse under contract with a local pharmacy will be observing medication passes to determine whether facility policies and best practices are being followed during the medication administration process. The observations will include administration of eye drops, inhalers, and time-sensitive medications. Findings will be reported to the nursing supervisory staff. The decongestant eye drops have been removed from the facility stock medication supply to avoid confusion with the lubricating eye drops. Resident number 59 – The resident is receiving artificial tears as ordered. The	

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F 332	Continued From page 74 from the medication cart. R39's physician orders, dated 3/23/17, included an order for Flovent Diskus (used to prevent asthma attacks) 250 mcg (microgram) inhaler, one puff inhale orally two times a day for breathing. On 4/4/17, at 9:58 a.m., LPN-A set up the inhaler for R39, handed the inhaler to R39 and stated to R39 take two puffs. At the time when queried if R39 was to take one puff or two puffs, LPN-A stated R39 always takes two puffs. LPN-A looked at the label on the Flovent inhaler and R39's electronic record MAR and stated, "Oh, one puff." LPN-A confirmed the label on the Flovent inhaler and R39's MAR read one puff. On 4/4/17, at 2:15 p.m., the DON stated receiving two puffs from an inhaler instead of one puff as ordered was a medication error. The DON stated she would expect staff to report the medication error and follow the medication error policy. R56's physician orders, dated 2/9/17, included an order for artificial tears solution 0.1 to 0.3 percent, install one drop both eyes four times a day for dry eyes and synthroid (thyroid hormone) 112 mcg one time a day for thyroid replacement. R56's MAR identified the synthroid was to be administered at 7:00 a.m. On 4/4/17, at 9:29 a.m., registered nurse (RN)-B was observed to administer oral medications to R56, which included synthroid 112 mcg, one tablet. RN-B stated at the time she was unable to administer artificial tears to R56, as there was no supply. RN-B stated she would have to order the artificial tears from the pharmacy. At 2:10 p.m.,	F 332	care plan has been revised accordingly. Resident number 39 – The staff have been informed that the resident is to receive one puff of inhaled medication. Resident number 56 – The staff have been informed that synthroid, scheduled for 7:00 a.m., is a time-sensitive medication and is to be given within time frames outlined in the facility medication policies and procedures. The Director of Nursing/designee will monitor compliance by conducting weekly random observations of medication passes for four weeks. Medication administration techniques will be observed and competency will be evaluated. Observations will include medication administration for residents number 36, 56, and 59 as well as inhaled medications, eye drops, and time-sensitive medications. If an unacceptable medication error rate is noted, additional auditing and staff training will be done. Medication errors will continue to be tracked and evaluated for frequency and need for corrective action. Compliance will be reviewed at the monthly and quarterly Quality Assessment and Assurance Committee meetings.	

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F 332	Continued From page 75 RN-B verified R56's MAR read to administer the synthroid at 7:00 a.m. and she had administered the synthroid at 9:29 a.m. On 4/4/17, at 3:51 p.m. the DON stated not giving the synthroid at 7:00 a.m. would be a medication error and she would expect staff to complete a medication error report. The DON stated in regards to the artificial tears, there should have been a supply available. The facility policy Administration of Medications, review date 8/17/16, indicated procedure: II. During the medication pass: "The 6 Rs" A. Before administering any medication, always check "The 6 Rs." 3. The right dosage form: verify against the MAR. 4. The right time: administer drugs as instructed on the MAR and within the time frame of one hour before and after the time stated on the MAR.	F 332		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 425	Pine Haven Care Center provides	5/4/17

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F 425	Continued From page 76 facility failed to ensure medications were administered timely and administered as prescribed by the physician, for 2 of 2 resident (R52 and R34) who were prescribed time sensitive medications. Findings Include: R52's diagnosis located in the current care plan printed 4/4/17, Parkinson's disease, dementia with Lewy bodies and psychotic disorder with hallucinations due to known physiological condition. Also was admitted to the facility on 2/24/16 and currently lives in the facility. R52's quarterly Minimum Data Set (MDS) and assessment dated 1/24/17, indicated R52 had severe cognitive impairment, and required extensive staff assistance with bed mobility, transferring, locomotion on and off unit and activities of daily living. R52's physician order dated 9/10/15 instructed staff to administer, "Carbidopa-Levodopa 25-100 MG [milligrams] give 2 tablet by mouth three times a day for Parkinsonism." The medication administration record (MAR) revealed R52 was to be administered this medication at 7:00 a.m., 11:00 a.m. and 4:00 p.m. Review of R52's sinemet administration times, revealed R52 was administered sinemet an hour after the scheduled time forty two times from 1/1/17 to 2/18/17, Seven times from 2/18/17 to 3/4/17 and fourteen times from 3/21/17 to 4/4/17. On 4/5/17, at 8:40 a.m., registered nurse (RN)-C verified the sinemet had been given an hour or more from specific physician ordered time. RN-C Verified there were no medication errors reports	F 425	pharmaceutical services (including accurate and timely acquiring, receiving, dispensing, and administering of drugs and biologicals) that meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of pharmaceutical procedures and services. The facility utilizes only persons authorized under state requirements to administer medications. The medication-related policies and procedures were reviewed and found appropriate. The Director of Nursing and the Consultant Pharmacist met May 4, 2017 to discuss medication errors, parameters for administration of PRN medications, and administration of time-sensitive medications. System changes to improve the efficiency and accuracy of the medication administration process were discussed including procuring another medication cart to eliminate the need to share carts between two nursing units. The Consultant Pharmacist will conduct a training session for licensed nurses and trained medication aides on May 11, 2017. Medication errors and general medication administration issues will be addressed. During the May 9, 2017 mandatory meeting, the licensed staff and trained medication aides will be informed of the need to 1) administer time-sensitive medications according to facility policy and within the designated time frame and	

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F 425	Continued From page 77 completed any time the sinemet was given great than hour after it was ordered. RN-C stated if a medication was given an hour after it was ordered it was considered a medication error. R52's physician order dated 3/9/17 instructed staff to administer, "Hydralazine HCl [antihypertensive medication]tablet 10MG [ten milligrams], Give 1 tablet by mouth as needed for blood pressure =/> [equal or greater] 150/90 four times a day." R52's physician order dated 3/30/17 instructed staff to administer, "Hydralazine HCl tablet 10MG, Give 1 tablet by mouth as needed for HTN [hypertension] give if SBP > [systolic blood pressure greater than] 150/90 four times a day and/or DBP > [diastolic blood pressure greater than] 90 four times a day." R52's medication administration record revealed R52 did not receive PRN hydralazine the months of March 2017 or April 2017 per the physician orders. R52's weights and vital signs report was reviewed and revealed R52 had met the physician ordered blood pressure parameters to give the as needed 8 times between 3/9/17 to 3/30/17 and three times between 3/30/17 and 4/4/17. However, the medication had not been given nor was there information as to why it was not given or if the physician or nurse practitioner had been contacted. At 4/5/17 at 9:03 a.m., registered nurse (RN)-C verified R52 had not received the physician ordered PRN hydralazine during the month of March 2017 per physician order. Even though	F 425	2) be alert to medication administration parameters such as blood pressure, pain levels, pulse, blood sugar readings, etc. Resident number 52 – The staff have been instructed on the time-sensitivity of Sinemet dosing. A medication time tracking log was implemented from April 6 to April 25, 2017 requiring two nurses to verify the time Sinemet was administered. The log data show that the medication has been routinely administered in a timely manner. The Medication Administration Record has been updated to include the notation that the resident's Sinemet is a time-sensitive medication to be given within a 30-minute time frame. The use of antihypertensive medications was reviewed by the attending physician; the April 13, 2017 nurse practitioner note states, "recommendations are to discontinue Norvasc with no further blood pressure monitoring. The elevated blood pressure readings could place him at risk for stroke, however, goals for care are very conservative and further pharmacological intervention for BPs is placing him at high risk for orthostatic hypotension/falls." The care plan has been updated to reflect labile blood pressures, discontinuation of blood pressure medications and the related risks. Resident number 34 - The staff have been instructed on the time-sensitivity of Sinemet dosing. To monitor timely administration of Sinemet, a medication time tracking log will be implemented from	

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F 425	Continued From page 78 R52 met the parameters to receive the medication. On 4/4/17, at 2:48 p.m. RN-C stated sinemet is a time sensitive medication and should be administered within 15 minutes prior or after the scheduled administration time of the medication. RN-C stated we have even went so far as to provide "timers" for the nurses to use for time sensitive medications and this was done specifically for the concerns related for R52 getting the sinemet on time. RN-C stated she had investigated this concern from FM-A, and found the times R52 received sinemet were off and sometimes for quite a bit of time off. RN-C stated the longest she has seen the medication being administered late had been one and a half hours after scheduled administration time. RN-C stated the times the sinemet was given incorrectly would be considered medication errors. On 4/4/17, at 3:14 p.m. RN-C stated R52 should have received PRN hydralazine 19 times since the PRN order was implemented on March 9, 2017. RN-C stated every time R52 did not receive the PRN hydralazine it would be considered a medication error. On 4/05/17, at 2:54 p.m. the director of nursing (DON) stated she expected staff to administer sinemet within 15 minutes before or after the scheduled order. The DON stated this was nursing judgement, knowing the medication and the need to give it at the prescribed time. The DON stated R52 had labile blood pressures and stated she just became aware the hydralazine PRN medication was not being administered per the physician order and stated her expectation was R52 receive the PRN hydralazine as	F 425	May 8 to May 22, 2017 requiring two nurses to verify the time Sinemet was administered. The Medication Administration Record has been updated to include the notation that the resident's Sinemet is a time-sensitive medication to be given within a 30-minute time frame. Compliance will be monitored by the Clinical Nurse Manager Assistant (LPN) who processes prescribing clinician orders. To alert the nurses/trained medication aides to time sensitive medications, the Clinical Nurse Manager Assistant in consultation with the consultant pharmacist will identify time sensitive medications that will be flagged on the electronic medication administration record (eMAR). The Clinical Nurse Manager Assistant will audit the eMARs for the next sixty days to ensure time-sensitive medications are flagged. To further monitor compliance with timely administration of Sinemet, administration time logs will be completed for all residents receiving Sinemet from May 8 through May 22, 2017. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed as part of the monthly Quality Assurance and Assessment (QAA) Committee meeting and during the July quarterly QAA Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 79	F 425		

ordered. The DON stated if a medication was not given within one hour before or after a medication was ordered, it would be a medication error and stated she would expect the nurse to self-report that.
R34's admission MDS dated 3/8/17, identified R34 required extensive assist with mobility, had falls prior to admission, had one fall since admission, had occasional moderate pain, balance during transition and walking: not steady and had moderate cognitive impairment. R34's Admission Record dated 4/6/17, included diagnoses of Parkinsonism and weakness.

R34's physician orders dated 3/17/17, instructed staff to administer Carbidopa-Levodopa 25-250 MG one tablet three times a day for Parkinsonism. R34's MAR dated 4/17 revealed R34 was to be administered this medication at 7:00 a.m., 11:00 a.m. and 4:00 p.m.

Review of R34's sinemet administration times dated 3/1/17 through 4/5/17, revealed R34 was administered the sinemet over an hour after the scheduled times 23 times.

On 4/6/17, at 11:03 a.m., the DON reviewed the administration times of the sinemet as above, and confirmed the medication had been given over an hour after the scheduled times 23 times. The DON stated giving the sinemet over an hour of the scheduled administration time would be a medication error. The DON stated the sinemet was a time sensitive medication and should be given on time.

Review of policy, Medication Errors and Drug Reactions, dated 10/19/16, included, 1. All medication errors and drug reactions must 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 _____	04/06/2017

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 425	Continued From page 80 promptly reported to the Director of Nursing Services, attending physician, and the family. 4. The staff nurse will be responsible for completing s Medication/Treatment Incident Report Form submitting the original to the director of nursing services and the Administrator.	F 425		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441		5/4/17

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	245359	A. BUILDING _____ B. WING _____	04/06/2017

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F 441	Continued From page 81 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly clean and store nebulizer equipment to prevent infection between use for 2 of 2 residents (R23 and R28)	F 441	Pine Haven Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment for	

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	245359	A. BUILDING _____ B. WING _____	04/06/2017

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F 441	Continued From page 82 observed with nebulizer equipment stored in room; failed to implement proper infection control practices for cleaning of a glucometer for 1 of 1 resident (R36) who required blood glucose monitoring and failed to implement proper infection control practices during administration of medications for 1 of 9 residents (R56) observed during medication administration. Findings include: CLEANSING NEBULIZER EQUIPMENT: R23 on 4/3/17, at 1:52 p.m., was seated in a recliner in her room. Observation revealed a nebulizer machine was laid on R23's bedside tray table with the medication cup and mask attached (used to administer the medication). Moisture was noted inside the medication cup. At 2:03 p.m. registered nurse (RN)-B entered R23's room to administer medication via nebulizer to R23 and confirmed the nebulizer equipment (medication cup and mask) had not been cleaned from previous use. RN-B stated the equipment was to be cleaned after each use by rinsing the equipment in water and air dry. R23's Medication Administration Record (MAR), dated 4/17, identified the last documented administration of DuoNeb (bronchodilator) solution administered to R23 was on 4/3/17 at 8:00 a.m. R28 on 4/3/17, at 3:34 p.m., was seated in a recliner in his room. Observation revealed a nebulizer machine was laid on R28's dresser with the medication cup and mask attached. Liquid was noted inside the medication cup. At 3:36 p.m., RN-C confirmed the nebulizer equipment had liquid inside the medication cup. RN-C stated R28 received medication as needed and after reviewing the medication administration record it	F 441	the residents and to prevent the development and transmission of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility has comprehensive infection control policies and procedures consistent with the current state and federal infection control regulations and recommendations. The policies address the surveillance and investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections. The policies and procedures for administering medications, sanitizing glucometers and cleaning nebulizer equipment were reviewed and found appropriate. During the May 9, 2017 mandatory meeting, the licensed nurses will be reinstructed on the infection control procedures for glove use during administering of medications, sanitizing glucometer machines and cleaning nebulizer equipment. Compliance will be monitored by the Director of Nurses/designee through direct observation of the nurses' glucometer sanitizing and nebulizer	

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	245359	A. BUILDING _____ B. WING _____	04/06/2017

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F 441	Continued From page 83 was noted that R28 had medication administered via nebulizer was documented on 3/21/17 at 1:33 p.m. RN-C stated the equipment should have been cleaned after use. On 4/3/17, at 4:00 p.m. the director of nursing (DON) stated staff should be rinsing out the nebulizer equipment after every use by disconnecting components so they can air dry fully and set on a paper towel. The facility policy Nebulizer, Cleaning and use of spacer, dated review date 4/2017, indicated Infection Control 4. Clean equipment per procedure below (unclean moist equipment can cause respiratory pseudomonas). Procedure 13. Upon completion of the treatment, encourage the resident to cough after several deep breaths. 15. Wash the nebulizer cup, mask and/or spacer with baby shampoo, rinse well with tap water. 16. Set the mask on a clean paper towel on nebulizer to air dry. CLEANSING GLUCOMETER: On 4/4/17, at 8:32 a.m., RN-D was observed to check R36's blood sugar, then removed gloves and washed hands. RN-D then placed the soiled glucometer uncovered in the pocket of her uniform and again washed hands. RN-D with the soiled glucometer in the pocket of her uniform contained helping other residents and pass medications. At 8:55 a.m. surveyor asked RN-D regarding sanitation on glucometer. RN-D reached into the pocket of her uniform and stated the glucometer is right here and then stated that each resident has their own glucometer assigned to them. Then RN-D with bare hands preceded to clean/sanitize the glucometer with Oxivir TB wipes (disinfectant cleaner) and when done she	F 441	cleaning techniques. Random observations will be done for two weeks. Compliance with infection control practices during medication administration will be monitored by a registered nurse under contract with a local pharmacy who has agreed to observe medication passes in the near future. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the monthly infection control meetings and the July quarterly Quality Assessment and Assurance Committee meeting.	

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F 441	Continued From page 84	F 441		

washed her hands. When queried regarding cleaning the glucometer after use, RN-D stated usually right away, to be honest I completely forgot I had put it (the glucometer) in my pocket. RN-D verified had no gloves on when cleansing the glucometer.

On 4/4/17, at 2:15 p.m., the DON stated she would expect staff not to place the used glucometer in a pocket as there are trays for use. The DON stated the glucometer should be cleansed before and after use using the Oxivir TB wipes and gloves should be worn when cleansing the glucometer.

The facility policy Glucometer Cleaning dated revised 5/2014, indicated Procedure 4. Apply gloves 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/bacterialcide disposable wipe. Unfold towelette and wipe surface of glucometer thoroughly use a second towelette if necessary to maintain wetness for a period of 2 minute, let air dry. 9. Remove gloves 10. Cleanse hands.

ADMINISTRATION OF ORAL MEDS:
On 4/4/17, at 9:29 a.m., RN-B was observed to wash hands, open the medication cart drawers to obtain medications from individual bottles and medication unit dose packages. RN-B placed the oral medications from the individual medication bottles into the palm of her hand (no gloves) and then placed the pill into a medication cup. RN-B entered R56's room, picked up each pill individually with her fingers (no gloves used) and

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	245359	A. BUILDING _____ B. WING _____	04/06/2017

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F 441	Continued From page 85 placed each pill into R56's mouth (touching R56's mouth), except for the last pill which had been given using a medication cup. On 4/4/17, at 2:15 p.m., the DON stated she would expect pills be given with a spoon or use gloves. A policy for oral medication administration was requested and the following was provided: a facility policy untitled and undated, indicated III. How to Administer Tablets and Capsules A. Do not touch the medication when opening a bottle or unit-dose package. A facility policy Medication Administration-General Guidelines, dated approved 1/21/16, indicated Policy Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.	F 441		

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	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/10/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Facility name) was found 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 18 Existing Health Care. 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 fully sprinkled. 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 census of 63 at the time of the survey.	K 000		

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

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

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	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**04/10/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY 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) was found 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 18 Existing Health Care. The Facility is a new addition 1 story building,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, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. At the time of this survey the 34 bed addition was found in substantial compliance.	K 000		

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