Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 19, 2023

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

RE: CCN: 245359
Cycle Start Date: August 24, 2023

Dear Administrator:

On October 18, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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October 19, 2023

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

Re: Reinspection Results
Event ID: VM5312

Dear Administrator:

On October 18, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 24, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 13, 2023

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

RE: CCN: 245359
Cycle Start Date: August 24, 2023

Dear Administrator:

On August 24, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 24, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 24, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 08/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/21/23 to 8/24/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the	E 024		10/4/23

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

Electronically Signed | 09/23/2023

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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E 024	Continued From page 1 policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures for volunteer support during an emergency as part of the facility's emergency preparedness plan. This deficient practice had the potential to affect all 60 residents who currently resided in the facility. Findings include: During an interview on 8/24/23 at 11:30 a.m., the administrator confirmed the facility's Emergency Preparedness plan lacked information regarding the use of volunteers and the volunteers' role.	E 024	The facility emergency preparedness plan was reviewed and revised to include policy and procedures for volunteer support during an emergency. The IDT team was educated on the policy and procedure changes. The emergency preparedness plan is reviewed by the QAPI committee annually or whenever changes are made to the plan. The Administrator or designee is responsible for the corrective actions and monitoring of compliance.	

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E 024	Continued From page 2 Review of the facility plan titled Emergency Preparedness dated 6/2023, lacked information regarding the use of volunteers and policies and procedures directing the use of the volunteer services.	E 024		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2),	E 041		10/4/23

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E 041	Continued From page 3 §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	E 041		

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E 041	Continued From page 4 (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4, 6.4.4.1.1.3, 6.4.4.1.1.4, 6.4.4.2 and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 8.3, 8.4, 8.4.2, 8.4.9. This deficient practice had the potential to affect all 60 residents residing in the facility. Findings include:	E 041	Maintenance will conduct monthly inspection and testing of the facility emergency generators. The 36 month □ 4-hour load bank test was last completed on 2/8/2022. The monthly inspections and testing will be included in the facility preventative maintenance program. All inspections, tests and maintenance of the emergency generators will be kept in the life safety binder. And will be audited by the Environmental services director.	

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E 041	Continued From page 5 On 8/23/2023 between 9:00 a.m. and 12:00 p.m., it was revealed by review of available documentation that there was no documentation presented to confirm that monthly inspection and testing of the facility emergency generators was occurring. On 8/23/2023 between 9:00 a.m. and 12:00 p.m., it was revealed by review of available documentation that there was no documentation presented to confirm that 36 month - four-hour load bank testing of the facility emergency generators was's occurring. An interview with Maintenance Director verified these deficient findings at the time of discovery.	E 041	The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
F 000	INITIAL COMMENTS On 8/21/23 to 8/24/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53594655C (MN00093349 and MN00093322) with a deficiency cited at (F689), and H53594707C (MN00091905) with a deficiency cited at (F689). The following complaints were reviewed. H53594603C (MN00095890), H53594683C (MN00096050), H53594703C (MN00095440), H53594704C (MN00095613 and MN00095690), H53594702C (MN00094879), and H53594706C (MN00091481).	F 000		

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F 000	Continued From page 6 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		10/4/23

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F 625	Continued From page 7 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 1 residents (R60) reviewed for hospitalization. Findings include: Review of the electronic medical record (EMR) for R60 under the "Census" tab revealed an admission date of 5/25/23. Review of the EMR, under the "Diagnosis" tab, revealed admitting diagnoses included dementia and weakness. Review of the R60's 6/2/23, progress notes identified R60 discharged to the hospital on 6/02/23, with a change in their medical condition. The progress notes lacked documentation the facility provided R60 or R60's representative a copy of the facility's bed hold policy at the time of transfer to the hospital. During an interview on 8/24/23, at 8:26 a.m. the director of nursing (DON) confirmed the facility did not provide the facility's bed hold policy to R60 or R60's representative upon transfer to the hospital. Review of facility policy titled Minnesota Notice of Bed-Hold Policy undated identified that The notice of Bed-Hold Policy would be provided to the resident/financially responsible party upon	F 625	It is the policy of the facility to give notice of the bed hold policy before a resident transfer to a hospital in a written format to the resident or resident representative per requirements. R60 was discharged from the facility. For all other residents who may be transferred to the hospital, the Bed Hold Policy will be provided to the resident or representative at the time of transfer to the hospital. Bed hold forms are reviewed with residents/families upon admission and have been placed in the transfer envelope packets so that they are addressed with the transfer paperwork at the time of transfer. The Policy and Procedure for Bed Hold/Transfer was reviewed and verified to align with current requirements. Education to the licensed nursing staff on their respective roles and responsibilities related to bed hold policy prior to transfer will be completed by 9/28/2023. A review of the transfer packets assembled for hospital transfer was completed with verification of inclusion of the bed hold policy and procedure. Bed hold audits will be performed on all transfers weekly for 4 weeks, and monthly for 2 months. Action will be taken immediately if trends for improvement are	

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F 625	Continued From page 8 admission and at the time of leave.	F 625	identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. Responsible party: Social Service Director or designee	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		10/4/23

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F 657	Continued From page 9 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise the care plan to include updated weight bearing and immobilizer interventions for upper and lower extremities for one resident (R53) reviewed for revision of care plan. Findings include: Review of R53's face sheet dated 8/23/23, identified R53 had been admitted to the facility on 7/17/23, with diagnoses which included displaced bicondylar fracture of right tibia (shin bone) and unspecified displaced fracture of surgical neck of right humerus (upper arm) Review of R53's admission Minimum Data Set (MDS) dated 7/23/23, identified R53 had moderately impaired cognition. Review of R53's care plan dated 7/17/23, identified R53 was to wear an immobilizer to right arm and right leg at all times. Indicated R53 was toe touch weight bearing to right lower extremity. Review of R53's physician's orders printed 8/23/23, revealed R53 had the following orders: -Non-weight bearing to right lower extremity (RLE). Knee immobilizer discontinued, may perform ROM. Encourage flexion to the knee to prevent stiffness with start date of 8/02/23. -Remove RUE shoulder immobilizer for hygiene/skin check and range of motion (ROM) - avoid right shoulder motion (reaching overhead,	F 657	It is the facility's policy to review and revise resident comprehensive care plans per the RAI process and/or resident condition changes or intervention changes. R53's care plan was updated and reviewed by the Inter-Disciplinary Team to reflect current needs and interventions. The resident and her sisters were part of the care planning process. For all residents receiving new physician orders, the care plans have been reviewed by the Interdisciplinary Team to coincide with current orders and intervention/approaches needed. Direct care staff have received education on the updates if indicated. Updates to the individualized care plans were given to the resident/representative if indicated. The Policy and Procedure on Comprehensive Care Plan completion, including updates/revisions to approaches respective to new physician orders was reviewed. Education to licensed nursing staff and the interdisciplinary team on their respective roles and responsibilities for comprehensive care plan revision will be completed by 9/28/2023. New physician orders requiring care plan updates will be audited weekly for 4 weeks, and monthly for 2 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken	

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F 657	Continued From page 10 etc.) Do perform right elbow/wrist/finger motion to prevent stiffness with start date of 8/02/23. Review of the orthopedic physician letter dated 8/2/23, identified R53 was evaluated for right tibial plateau fracture and right proximal humerus fracture. Indicated staff could remove shoulder immobilizer several times daily (at least three times per day) for hygiene purposes/skin checks and range of motion work. Indicated R53 was non-weight bearing to right lower extremity (RLE), however, it was okay to perform pivot transfers RLE. Provided instruction to discontinue knee immobilizer and stated it was okay to wear valgus off loader brace (custom brace) during standing/ambulating in physical therapy, and okay to remove brace while resting. Letter was signed by director of nursing (DON) and DON indicated "entered and noted." In addition, the letter was signed by nurse manager and nurse manager indicated "reviewed." During an observation and interview on 8/22/23 at 10:26 a.m., R53 was observed sitting in wheelchair with no immobilizer on lower or upper extremities. R53 stated they no longer had to wear the immobilizer. R53 did not know how long they had been without braces. During an interview on 8/22/23 at 3:15 p.m., with the DON revealed nurse managers were responsible for updating care plans. DON stated when they received new orders, they had two staff sign them. The DON stated they entered R53's physical copy of orthopedic orders on 8/02/2023, and placed them into the electronic health record. The DON stated the care plan should have been updated to reflect the new orders.	F 657	will be reported to the QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. Responsible party: Director of Nursing or Designee.	

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to implement fall interventions for 1 of 3 residents (R61) reviewed for accidents. In addition, the facility failed to modify interventions for 1 of 3 residents (R24) reviewed for accidents. Findings include: R61 Review of the facility Fall Investigation Incident Report, dated 5/04/23 at 3:30 p.m., revealed R61 was being transferred out of the bedroom via wheelchair when nursing assistant (NA)-B realized the foot pedals and arm bar were not present on R61's wheelchair. While NA-B returned to R61's room to obtain forgotten items, R61 fell out of the wheelchair and hit head on the floor. R61 complained of head hurting and the ambulance and R61's daughter were contacted. R61 was transferred to the emergency room and returned that evening of 5/4/2023, with no injuries noted from the fall. Review of R61's Face Sheet, located in the resident's electronic medical records (EMR) revealed the resident was admitted to the facility	F 689	It is the policy of the facility that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. R61 no longer resides at the facility. R24□s has been reassessed for fall prevention and the comprehensive care plan has been updated as indicated. A toileting plan has been put in place. For all others who may be affected, the facility morning meeting agenda has been updated to include a review and discussion on any falls that occurred. The Inter-Disciplinary Team will complete a Root Cause Analysis, determine the need for revised fall prevention interventions if indicated, and will update the resident's specific care plan to reflect the changes agreed upon by the team. Communication or training to direct care staff responsible for that resident will be completed if indicated. A review of the facility Policy and Procedure on Accidents/Incidents and fall prevention was completed.	10/4/23

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F 689	Continued From page 12 on 7/04/20, with diagnoses which included osteoporosis, chronic pain, epilepsy, muscle weakness and traumatic subdural hemorrhage without loss of consciousness. Review of R61's annual Minimum Data Set (MDS) dated 5/08/23, identified R61 was cognitively intact. Indicated R61 required extensive assistance of one person for locomotion on and off the unit. Identified R61 used a wheelchair for mobility and was impaired on one side for upper and lower extremities. Review of R61's care plan dated 3/8/23, identified R61 had a mobility/locomotion/positioning problem The following interventions were identified: R61 required total assistance from staff for wheeling longer distances, such as going to the dining room or to activities. R61 had a flip-away tray on wheelchair to assist with right arm and hand positioning, ensure right foot was on the footrest of the wheelchair. Review of R61's Visual/Bedside Kardex Report, dated 8/24/23, identified R61 required total assistance from staff wheeling longer distances, such as going to the dining room or to activities. R61 had a flip-away tray on wheelchair to assist with right arm and hand positioning, ensure right foot was on footrest of wheelchair. Interview attempted with NA-B on 8/23/23, and 8/24/23, with no return phone call received. During an interview on 8/24/23 at 10:07 a.m., the director of nursing (DON) stated she and the administrator met with NA-B after the fall. NA-B indicated they wheeled R61 about two rooms down from R61's room when NA-B realized they	F 689	Education on fall prevention, root cause analysis of falls, and respective roles and responsibilities was completed for the interdisciplinary team. Education on staff roles and responsibilities for fall prevention was completed by 9/28/2023. Fall intervention audits will be completed weekly for 4 weeks, and monthly for 2 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. Responsible party: Director of Nursing.	

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F 689	Continued From page 13 did not have the arm board or foot pedal on the wheelchair. They turned around to retrieve the items, NA-B began to push R61 in her wheelchair again when R61's foot became caught and R61 fell out of the wheelchair. The DON stated they provided immediate education to NA-B about the expected use of the foot pedals and arm board for R61. The DON stated R61 did not have any major injuries however did have bruising present on face. The DON stated their expectations were for staff to follow the care planned interventions for residents. During an interview on 8/24/23 at 10:20 a.m., the nurse manager interim (NMI) stated NA-B turned the wheelchair to go back to R61's room after NA-B realized they didn't have wheelchair foot pedals and arm rest on the chair and R61 fell. NMI stated they assessed R61 and called the DON. NMI stated R61 was sent out by ambulance to the local emergency department to be evaluated and R61 returned to the facility the same day with no major injuries. NMI confirmed the aide did not follow the plan of care for R61. NMI stated the expectation was for staff to follow the plan of care. R24 R24's quarterly Minimum Data Set (MDS) dated 6/22/23, indicated severe cognitive impairment and included diagnoses of non- traumatic brain dysfunction, traumatic subarachnoid hemorrhage and dementia. R24 had a history of multiple falls since admission. R24's Care Area Assessment (CAA) dated 3/23/23, indicated areas to focus specialized care	F 689		

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F 689	Continued From page 14 included, cognitive loss/dementia, visual function and falls. R24's care plan dated 11/15/22, indicated R24 was at risk for falls related to confusion, gait/balance problems and history of falls. The goal was R24 would be free of falls through the review period. Toileting interventions which began on 5/28/2023, identified staff were to provide toileting at 6:30 a.m., after lunch, before supper and before going to bed. Review of R24's progress notes indicated R24 had falls on 5/28/23, 6/12/23 and 6/26/23. Review of the Post Fall Evaluations (PFE) from 5/28/23, to 6/26/23, identified the following: -5/28/23 at 4:20 p.m. R24 was found on the floor in the bathroom and had been incontinent. Toileting interventions were added to the care plan. -6/12/23 at 3:49 p.m., R24 was found on the floor in the bathroom by a family member. R24 was incontinent and the root cause revealed R24 had self-transferred to the bathroom due to confusion. The evaluation lacked documentation if current interventions were effective or needed to be revised. -6/26/23 at 9:37 p.m., indicated R24 was found on the floor against the wheelchair with her brief and pants down to above her knees. The PFE indicated R24 was attempting to self-toilet and was incontinent when the fall occurred. The evaluation lacked documentation if the current interventions were effective or required revision.	F 689		

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F 689	Continued From page 15 During an interview on 8/23/23 at 9:48 a.m., nursing assistant (NA)-A stated R24 has had several falls since arriving at the facility. NA-A believed most of the falls were related to toileting needs. During an interview on 8/23/2023 11:26 a.m., registered nurse (RN)-B and RN-C stated they attended the interdepartmental team (IDT) meetings and the IDT reviewed resident falls. They stated the IDT reviewed each fall independently as they occurred and confirmed they would not review prior falls to determine if the interventions were effective and required modification. RN-A and RN-B stated they were aware R24 had several falls. During an interview on 8/23/23 at 12:45 p.m., the director of nursing (DON) reviewed the PFE's and confirmed the IDT had not reviewed R61's prior falls as part of the root cause analysis to assist in modifying or implementing new interventions in an effort to prevent further falls. Review of a facility policy titled Fall Prevention and Reduction dated 7/22, indicated all falls would be reviewed and preventive measures would be taken to decrease falls. The facility would determine the root cause to the fall and would implement interventions specific to the cause of the fall. Review of a facility policy titled Free of Accident/Hazards/Supervision/Devices, revised 10/22, revealed the facility would provide an environment that was free from accident hazards over which the facility had control and provided supervision and assistive devices to each resident to prevent avoidable accidents. This	F 689		

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F 689	Continued From page 16 included and was not limited to implementing interventions to reduce hazards and risks.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store bulk food in a manner to prevent cross contamination related to ongoing storage of plastic scoops in the bulk flour and sugar containers. In addition, the facility failed to ensure storage was free of dented cans. This deficient practice had the potential to affect 60 of 60 residents who resided in the facility and consumed food prepared from the facility's kitchen. Findings include:	F 812	The Dietary Manager completed an audit of the facility□s kitchen(s) and storage area(s). No further food products had compromised packaging. Completed 09/14/2023. Bulk storage containers of flour and sugar were emptied, cleaned, and replenished with dry ingredients. Completed 09/14/2023. Policy and procedures related to food storage were revised as of 09/14/2023. Education was provided to all Dietary Staff	9/22/23

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F 812	Continued From page 17 During an initial tour of the kitchen on 8/21/23 at 11:57 a.m., with the interim dietary cook (DC) present, the following observations were made: Dry Storage and kitchen: -Two six-pound cans, containing pumpkin and northern beans, were observed stored with large dents in them. -Two 20-liter clear containers, containing flour and sugar, were observed with scoops lying in the flour and sugar. During an interview on 8/21/23 at 12:02 p.m., the DC stated they normally let the food distributor know what cans were dented so that they could receive credit. DC stated they did not know why dented cans were on the shelf. DC stated scoops should not have been stored in the container and should have been stored in their own compartment on the outside. During an interview on 8/21/23 at 10:41 a.m., the dietary manager (DM) stated when staff found a dented can, they were expected to give it to her right of way so that she could send it back to the distributor and receive credit. DM stated their expectation was for staff to identify the can right way when stocking and give it to her to return. DM stated they expected scoops to be washed and put away in a drawer after being used. Review of the facility's undated policy titled Food Storage revealed scoops were not to be stored in food or ice containers however should have been kept covered in a protected area not near the containers. In addition, food should have been stored and handled to maintain the integrity of the	F 812	on food storage, prevention of cross-contamination, and revised policy and procedures for food storage. Staff were required to complete a competency quiz post-education session. Dietary Manager to perform a weekly audit of all food storage areas including bulk storage containers x1 month. The Dietary Manager will present findings to the QAA Committee to determine a resolution or the need of continued auditing, re-education, and/or policy revision. Responsible party: Dietary Manager	

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F 812	Continued From page 18 packaging until ready for use.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		9/20/23

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F 880	Continued From page 19 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a water management plan for Legionnaires Disease (a water-borne illness). This deficient practice had the potential to affect all 60 residents residing in the facility. Findings include:	F 880	It is the policy of this facility to implement a water management plan for Legionnaires Disease in accordance with the facility□s infection prevention and control program. A review of the facility□s Water Management Plan for Legionella was completed on 9/19/2023 for alignment	

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F 880	Continued From page 20 During review of the facility's plan titled Water Management Plan for Legionella dated 4/1/22, identified the water would be run in unoccupied rooms for three minutes and the toilets would be flushed twice on a weekly basis in unoccupied rooms. The policy indicated Legionella testing would be completed by the maintenance department or a testing company. The policy identified test results would be maintained in the water quality log and weekly entries would be made in the flush log for all unoccupied rooms. During an interview on 8/23/23 at 1:30 p.m., with the infection preventionist indicated due to changes in the maintenance department in March 2023, the facility had not been following the facility policy for the prevention and control of Legionnaires Disease. During a follow-up interview with the infection preventionist on 8/24/23 at 1:04 p.m., confirmed the facility had not been performing the water running and toilet flushing procedure as identified in the facility's plan. In addition, infection preventionist confirmed the facility had not completed testing for Legionnaire's organisms for more than a year as identified in the facility's plan.	F 880	with current requirements. The facility has completed the applicable Legionella testing on 9/20/2023. Results of the testing are maintained in the Maintenance Department on the water quality log. The Director of Environmental Services, and the facility Infection Preventionist (IP) have received education on the facility□s Water Management Plan for Legionella as it relates to their respective roles and responsibilities. This was completed on 9/19/2023. The facility Infection Preventionist will perform monthly audits on the testing and completion of the facility□s Water Management Plan for Legionella processes for adherence to requirements for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. Responsible party: Infection Preventionist.	

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	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY BLDG 01 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/20/2023. At the time of this survey, PINE HAVEN CARE CENTER - BLDG 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/22/2023

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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K 000	Continued From page 1 THE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. PINE HAVEN CARE CENTER - BLDG 01 is a one-story building with partial basement. The building was constructed at 3 different times. A one-story building with partial basement was constructed in 1964 and determined to be Type II (111). In 1970, an addition to the North Wing was constructed and determined to be Type II (111). In 1991, an addition was added to the West Wing and determined to be Type II (111).	K 000		

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K 000	Continued From page 2 Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to PINE HAVEN CARE CENTER - BLDG 02 which was determined to be of Type V (111) construction. There is a 2-hour fire rated wall separating the two buildings, and will therefore be surveyed as two buildings. The facility has a capacity of 70 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain emergency lighting testing documentation per NFPA 101 (2012 edition), Life Safety Code,	K 291	The Facility is fully backed up by an emergency generator and does not have any battery-operated emergency lighting. So, there are not any lights that require	10/4/23

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K 291	Continued From page 3 section 19.2.9.1, 7.9, and 7.9.3.1.1(5). This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that emergency light testing is occurring. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 291	any testing. Assurance of lighting during a power outage is accomplished through backup generator testing. Adequate lighting for emergencies will be monitored through the testing, inspection and maintenance of the back-up generators. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through	K 324		10/4/23

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K 324	Continued From page 4 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain inspection and maintenance documentation of the ansul type fire extinguishing equipment in accordance with the Life Safety Code NFPA 101 - 2012, sections 19.3.2.5, 9.2.3, 19.3.2.5.3, and the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, NFPA 96-2014, section 11.2. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that 6 month inspections and maintenance of the ansul type fire extinguishing equipment is occurring. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 324	The ansul type fire extinguishing system is inspected every 6 months. Documentation was found for the last test in July 2023 and also for the previous test in February 2023. Inspections will continue to be scheduled every 6 months and any identified maintenance will be addressed. A schedule for all inspections and preventative maintenance will be maintained. Inspection results and any documentation on completed repairs will be kept in the facility Life Safety Binder. The information will be reviewed through QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		10/4/23

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K 353	Continued From page 5 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5, 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 3.3.19, 4.3, 5.1, 5.2, 5.3, 5.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that quarterly inspections of the sprinkler systems are occurring. 2. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm when the last 5 year	K 353	The 5 year inspection and maintenance was last completed on 10/18/2021. Quarterly inspections of the sprinkler systems will be conducted and the documented. The quarterly inspections will be scheduled and documented in the preventative maintenance program. The sprinkler inspection company will educate the maintenance staff on the conducting of the quarterly inspections. The inspections will be reviewed in QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	

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K 353	Continued From page 6 inspection and maintenance was completed. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5, 15.6, 15.7. This deficient condition a widespread impact on the residents within the facility. This deficient condition could have a widespread impact on the residents within the facility. Findings include:	K 354	A sprinkler system □ out of service policy was developed and reviewed by QAPI. Staff education was completed on the new policy. The policy will continue to be reviewed and updated through QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	10/4/23

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K 354	Continued From page 7 On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility has a sprinkler system - out of service policy. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 354		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 This deficient condition could have a widespread impact on the residents within the facility.	K 372	Information on the facility fire/smoke dampers has been obtained. An inspection of the fire/smoke dampers was last completed on 10/4/2021 Annual inspection of the smoke dampers will be scheduled and maintained in the facility preventative maintenance program and any needed maintenance will be completed. Environmental services will monitor to	10/4/23

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K 372	Continued From page 8 Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm if the facility has fire / smoke dampers, the location of fire / smoke dampers, and that the facility is timeframe compliant testing of fire / smoke dampers. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 372	assure inspections are completed. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. This deficient condition could have a patterned impact on the residents within the facility. Findings include:	K 712	The facility fire drill policy and procedure has been reviewed and revised. Staff have been educated on the updated policy and procedure. Fire drills will be conducted on each shift every quarter □ 3 fire drills per quarter. A schedule to conduct the fire drills on a monthly basis was developed to assure	10/4/23

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K 712	Continued From page 9 On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting fire drills. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712	the fire drills will occur on each shift on a rotating basis and at staggering times. Documentation of the drills will be completed at the time of each drill, will be kept in the life safety binder. Environmental Services will present the fire drills for review at the safety committee meeting and at QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility.	K 761	Maintenance department will conduct annual maintenance, inspection and testing of the fire doors. The maintenance, inspection, and testing of the fire doors will be included in the preventative maintenance program. Environmental Services will audit the	10/4/23

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K 761	Continued From page 10 Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting annual maintenance, inspection and testing of doors. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761	preventative maintenance program to assure the maintenance, inspection, and testing of the fire doors is scheduled and completed. It will be reviewed at QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 914		10/4/23

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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
K 914	Continued From page 11 by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting annual inspection and testing of electrical outlets located in resident rooms. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 914	Maintenance will conduct annual inspection and testing of electrical outlets in all resident rooms. Testing will included tension, operation and polarity. The inspection and testing of the electrical outlets will be scheduled and documented in the preventative maintenance program. The documentation will be audited by the environmental services director. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2023**

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PINE HAVEN CARE CENTER INC	**210 NORTHWEST 3RD STREET** **PINE ISLAND, MN 55963**

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K 918	Continued From page 12 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4, 6.4.4.1.1.3, 6.4.4.1.1.4, 6.4.4.2 and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 8.3, 8.4, 8.4.2, 8.4.9. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that monthly inspection and testing of the facility emergency generators is	K 918	Maintenance will conduct monthly inspection and testing of the facility emergency generators. The 36 month □ 4-hour load bank test was last completed on 2/8/2022. The monthly inspections and testing will be included in the facility preventative maintenance program. All inspections, tests and maintenance of the emergency generators will be kept in the life safety binder. And will be audited by the Environmental services director. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	

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	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2023**

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K 918	Continued From page 13 occurring. 2. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that 36 month - 4-hour load bank testing of the facility emergency generators is occurring. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**08/23/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY BLDG 02 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/23/2023. At the time of this survey, PINE HAVEN CARE CENTER - BLDG 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/22/2023

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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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

6. A detailed description of the corrective action taken or planned to correct the deficiency.

7. Address the measures that will be put in place to ensure the deficiency does not reoccur.

8. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

9. Identify who is responsible for the corrective actions and monitoring of compliance.

10. The actual or proposed date for completion of the remedy.

PINE HAVEN CARE CENTER - BLDG 02 is a one-story building with no basement
The building was constructed in 2016 and determined to be Type V (111).

Because of the date of construction, the building was surveyed per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

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	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**08/23/2023**

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K 000	Continued From page 2 The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to PINE HAVEN CARE CENTER - BLDG 01 which was determined to be of Type II (111) construction. There is a 2-hour fire rated wall separating the two buildings, and will therefore be surveyed as two buildings. The facility has a capacity of 70 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		10/4/23

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K 353	Continued From page 3 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5, 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 3.3.19, 4.3, 5.1, 5.2, 5.3, 5.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that quarterly inspections of the sprinkler systems are occurring. 2. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm when the last 5 year inspection and maintenance was completed. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353	The 5 year inspection and maintenance was last completed on 10/18/2021. Quarterly inspections of the sprinkler systems will be conducted and the documented. The quarterly inspections will be scheduled and documented in the preventative maintenance program. The sprinkler inspection company will educate the maintenance staff on the conducting of the quarterly inspections. The inspections will be reviewed in QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined,	K 354		10/4/23

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K 354	Continued From page 4 recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5, 15.6, 15.7. This deficient condition a widespread impact on the residents within the facility. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility has a sprinkler system - out of service policy. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 354	A sprinkler system □ out of service policy was developed and reviewed by QAPI. Staff education was completed on the new policy. The policy will continue to be reviewed and updated through QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		10/4/23

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K 372	Continued From page 5 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm if the facility has fire / smoke dampers, the location of fire / smoke dampers, and that the facility is timeframe compliant testing of fire / smoke dampers. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 372	Information on the facility fire/smoke dampers has been obtained. An inspection of the fire/smoke dampers was last completed on 10/4/2021 Annual inspection of the smoke dampers will be scheduled and maintained in the facility preventative maintenance program and any needed maintenance will be completed. Environmental services will monitor to assure inspections are completed. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	

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K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting fire drills. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712	The facility fire drill policy and procedure has been reviewed and revised. Staff have been educated on the updated policy and procedure. Fire drills will be conducted on each shift every quarter □ 3 fire drills per quarter. A schedule to conduct the fire drills on a monthly basis was developed to assure the fire drills will occur on each shift on a rotating basis and at staggering times. Documentation of the drills will be completed at the time of each drill, will be kept in the life safety binder. Environmental Services will present the fire drills for review at the safety committee meeting and at QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	10/4/23
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		10/4/23

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K 761	Continued From page 7 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting annual maintenance, inspection and testing of doors. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761	Maintenance department will conduct annual maintenance, inspection and testing of the fire doors. The maintenance, inspection, and testing of the fire doors will be included in the preventative maintenance program. Environmental Services will audit the preventative maintenance program to assure the maintenance, inspection, and testing of the fire doors is scheduled and completed. It will be reviewed at QAPI. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		10/4/23

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K 914	Continued From page 8 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting annual inspection and testing of electrical outlets	K 914	Maintenance will conduct annual inspection and testing of electrical outlets in all resident rooms. Testing will include tension, operation and polarity. The inspection and testing of the electrical outlets will be scheduled and documented in the preventative maintenance program. The documentation will be audited by the environmental services director. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	

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K 914	Continued From page 9 located in resident rooms. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**08/23/2023**

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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K 918	Continued From page 10 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4, 6.4.4.1.1.3, 6.4.4.1.1.4, 6.4.4.2 and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 8.3, 8.4, 8.4.2, 8.4.9. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that monthly inspection and testing of the facility emergency generators is occurring. 2. On 08/23/2023 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that 36 month - 4-hour load bank testing of the facility emergency generators is occurring. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 918	Maintenance will conduct monthly inspection and testing of the facility emergency generators. The 36 month □ 4-hour load bank test was last completed on 2/8/2022. The monthly inspections and testing will be included in the facility preventative maintenance program. All inspections, tests and maintenance of the emergency generators will be kept in the life safety binder. And will be audited by the Environmental services director. The Environmental Services Director is responsible for the corrective actions and monitoring of compliance.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: VM5311

Dear Administrator:

The above facility was surveyed on August 21, 2023, through August 24, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: _____ B. WING _____	C 08/24/2023

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/21/23 to 8/24/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53594655C (MN00093349 and MN00093322) with a licensing order issued at 0830, H53594707C (MN00091905) with a licensing order issued at 0830. The following complaints were reviewed: H53594603C (MN00095890), H53594683C (MN00096050), H53594703C (MN00095440), H53594704C (MN00095613 and MN00095690), H53594702C (MN00094879), H53594706C (MN00091481), and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000		

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 830	Continued From page 3	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to implement fall interventions for 1 of 3 residents (R61) reviewed for accidents. In addition, the facility failed to modify interventions for 1 of 3 residents (R24) reviewed for accidents. Findings include: R61 Review of the facility Fall Investigation Incident Report, dated 5/04/23 at 3:30 p.m., revealed R61 was being transferred out of the bedroom via wheelchair when nursing assistant (NA)-B realized the foot pedals and arm bar were not present on R61's wheelchair. While NA-B returned to R61's room to obtain forgotten items, R61 fell out of the wheelchair and hit head on the floor. R61 complained of head hurting and the ambulance and R61's daughter were contacted.	2 830	Corrected	9/23/23

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2 830	Continued From page 4 R61 was transferred to the emergency room and returned that evening of 5/4/2023, with no injuries noted from the fall. Review of R61's Face Sheet, located in the resident's electronic medical records (EMR) revealed the resident was admitted to the facility on 7/04/20, with diagnoses which included osteoporosis, chronic pain, epilepsy, muscle weakness and traumatic subdural hemorrhage without loss of consciousness. Review of R61's annual Minimum Data Set (MDS) dated 5/08/23, identified R61 was cognitively intact. Indicated R61 required extensive assistance of one person for locomotion on and off the unit. Identified R61 used a wheelchair for mobility and was impaired on one side for upper and lower extremities. Review of R61's care plan dated 3/8/23, identified R61 had a mobility/locomotion/positioning problem The following interventions were identified: R61 required total assistance from staff for wheeling longer distances, such as going to the dining room or to activities. R61 had a flip-away tray on wheelchair to assist with right arm and hand positioning, ensure right foot was on the footrest of the wheelchair. Review of R61's Visual/Bedside Kardex Report, dated 8/24/23, identified R61 required total assistance from staff wheeling longer distances, such as going to the dining room or to activities. R61 had a flip-away tray on wheelchair to assist with right arm and hand positioning, ensure right foot was on footrest of wheelchair. Interview attempted with NA-B on 8/23/23, and 8/24/23, with no return phone call received.	2 830		

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2 830	Continued From page 5 During an interview on 8/24/23 at 10:07 a.m., the director of nursing (DON) stated she and the administrator met with NA-B after the fall. NA-B indicated they wheeled R61 about two rooms down from R61's room when NA-B realized they did not have the arm board or foot pedal on the wheelchair. They turned around to retrieve the items, NA-B began to push R61 in her wheelchair again when R61's foot became caught and R61 fell out of the wheelchair. The DON stated they provided immediate education to NA-B about the expected use of the foot pedals and arm board for R61. The DON stated R61 did not have any major injuries however did have bruising present on face. The DON stated their expectations were for staff to follow the care planned interventions for residents. During an interview on 8/24/23 at 10:20 a.m., the nurse manager interim (NMI) stated NA-B turned the wheelchair to go back to R61's room after NA-B realized they didn't have wheelchair foot pedals and arm rest on the chair and R61 fell. NMI stated they assessed R61 and called the DON. NMI stated R61 was sent out by ambulance to the local emergency department to be evaluated and R61 returned to the facility the same day with no major injuries. NMI confirmed the aide did not follow the plan of care for R61. NMI stated the expectation was for staff to follow the plan of care. R24 R24's quarterly Minimum Data Set (MDS) dated 6/22/23, indicated severe cognitive impairment and included diagnoses of non- traumatic brain dysfunction, traumatic subarachnoid hemorrhage and dementia. R24 had a history of multiple falls	2 830		

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2 830	Continued From page 6 since admission. R24's Care Area Assessment (CAA) dated 3/23/23, indicated areas to focus specialized care included, cognitive loss/dementia, visual function and falls. R24's care plan dated 11/15/22, indicated R24 was at risk for falls related to confusion, gait/balance problems and history of falls. The goal was R24 would be free of falls through the review period. Toileting interventions which began on 5/28/2023, identified staff were to provide toileting at 6:30 a.m., after lunch, before supper and before going to bed. Review of R24's progress notes indicated R24 had falls on 5/28/23, 6/12/23 and 6/26/23. Review of the Post Fall Evaluations (PFE) from 5/28/23, to 6/26/23, identified the following: -5/28/23 at 4:20 p.m. R24 was found on the floor in the bathroom and had been incontinent. Toileting interventions were added to the care plan. -6/12/23 at 3:49 p.m., R24 was found on the floor in the bathroom by a family member. R24 was incontinent and the root cause revealed R24 had self-transferred to the bathroom due to confusion. The evaluation lacked documentation if current interventions were effective or needed to be revised. -6/26/23 at 9:37 p.m., indicated R24 was found on the floor against the wheelchair with her brief and pants down to above her knees. The PFE indicated R24 was attempting to self-toilet and was incontinent when the fall occurred. The	2 830		

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2 830	Continued From page 7 evaluation lacked documentation if the current interventions were effective or required revision. During an interview on 8/23/23 at 9:48 a.m., nursing assistant (NA)-A stated R24 has had several falls since arriving at the facility. NA-A believed most of the falls were related to toileting needs. During an interview on 8/23/2023 11:26 a.m., registered nurse (RN)-B and RN-C stated they attended the interdepartmental team (IDT) meetings and the IDT reviewed resident falls. They stated the IDT reviewed each fall independently as they occurred and confirmed they would not review prior falls to determine if the interventions were effective and required modification. RN-A and RN-B stated they were aware R24 had several falls. During an interview on 8/23/23 at 12:45 p.m., the director of nursing (DON) reviewed the PFE's and confirmed the IDT had not reviewed R61's prior falls as part of the root cause analysis to assist in modifying or implementing new interventions in an effort to prevent further falls. Review of a facility policy titled Fall Prevention and Reduction dated 7/22, indicated all falls would be reviewed and preventive measures would be taken to decrease falls. The facility would determine the root cause to the fall and would implement interventions specific to the cause of the fall. Review of a facility policy titled Free of Accident/Hazards/Supervision/Devices, revised 10/22, revealed the facility would provide an environment that was free from accident hazards over which the facility had control and provided	2 830		

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2 830	Continued From page 8 supervision and assistive devices to each resident to prevent avoidable accidents. This included and was not limited to implementing interventions to reduce hazards and risks. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for resident' falls; then revise as needed to ensure the comprehensive assessment and care planning of such events; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		