

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

Electronically delivered

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



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.

Pine Haven Care Center Inc September 13, 2023 Page 2

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: Jeann buseth@state.mn.us

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

Pine Haven Care Center Inc September 13, 2023 Page 3

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.

Pine Haven Care Center Inc September 13, 2023 Page 4

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

PRINTED: 09/28/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245359	B. WING _		C 08/24/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	1 00/24/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPROPRIES (CORRECTIVE ACTION SHOUNDERS)	JLD BE COMPLETION
E 000	Initial Comments		E 00	00	
E 024 SS=C	with Appendix Z, Er Requirements for L §483.73(b)(6) was a recertification surve compliance. The facility's plan of as your allegation of Department's accepenrolled in ePOC, yeat the bottom of the form. Upon receipt of an onsite revisit of you validate substantial regulation has been Policies/Procedures CFR(s): 483.73(b)(6), §481.184(b)(6), §482.73(b)(6), §483.73(b)(6), §483.7	S-Volunteers and Staffing (6) 16.54(b)(5), §418.113(b)(4), 80.84(b)(7), §482.15(b)(6), 8.475(b)(6), §484.102(b)(5), 5.542(b)(6), §485.625(b)(6), 85.920(b)(5), §491.12(b)(4), 90.00000000000000000000000000000000000	E 02	24	10/4/23
	policies and proced plan set forth in parassessment at para and the communication. The perbe reviewed and up	nent emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least every 2 years acilities]. At a minimum, the			
_ABORATOR\	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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

Electronically Signed

09/23/2023

AND PLAN OF CORRECTION INTERPRETATION NUMBER:		A. BUILDII	TIPLE CONSTRUCTION NG) COM	(X3) DATE SURVEY COMPLETED	
		245359	B. WING _			C 24/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 024	(6) [or (4), (5), or (7) volunteers in an emstaffing strategies, for integration of Sthealth care profess during an emergen *[For RNHCIs at §4 procedures. (6) The emergency and oth strategies to addresse emergency. *[For Hospice at §4 procedures. (4) The an emergency and strategies, including integration of State health care profess needs during an em This REQUIREMENT by: Based on interview	Itures must address the (i) as noted above] The use of hergency or other emergency including the process and role ate and Federally designated ionals to address surge needs cy. (i) (3.748(b):] Policies and e use of volunteers in an her emergency staffing as surge needs during an (i) (18.113(b):] Policies and he use of hospice employees in other emergency staffing the process and role for and Federally designated sionals to address surge hergency. (ii) All (iii) The use of hergency staffing the process and role for and Federally designated sionals to address surge hergency. (iii) The use of hospice employees in other emergency staffing the process and role for and Federally designated sionals to address surge hergency. (iii) The use of hospice employees in other emergency staffing the process and role for and Federally designated sionals to address surge hergency. (iii) The use of hospice employees in other emergency staffing the process and role for and Federally designated sionals to address surge hergency.	E 02	The facility emergency prepared		
	for volunteer support part of the facility's plan. This deficient	elop policies and procedures ort during an emergency as emergency preparedness practice had the potential to its who currently resided in the		plan was reviewed and revised to policy and procedures for volunt support during an emergency. The IDT team was educated on and procedure changes. The emergency preparedness previewed by the QAPI committee or whenever changes are made	the policy lan is e annually	
	administrator confir Preparedness plan	on 8/24/23 at 11:30 a.m., the med the facility's Emergency lacked information regarding rs and the volunteers' role.		The Administrator or designee is responsible for the corrective acmonitoring of compliance.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	COM	E SURVEY PLETED
		245359	B. WING			C 24/2023
	PROVIDER OR SUPPLIER	NC	2	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTHWEST 3RD STREET INE ISLAND, MN 55963	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 024	Continued From pa	ge 2	E 024			
E 041	Preparedness date regarding the use of procedures directin services.	by plan titled Emergency d 6/2023, lacked information of volunteers and policies and g the use of the volunteer	E 041			10/4/23
	CFR(s): 483.73(e)	TC Emergency Power	□ U41			10/4/23
	hospital must imple power systems bas forth in paragraph (policies and proced	standby power systems. The ment emergency and standby ed on the emergency plan set a) of this section and in the lures plan set forth in and (ii) of this section.				
	(e) Emergency and [LTC facility CAH are emergency and sta	standby power systems. The nd REH] must implement ndby power systems based on set forth in paragraph (a) of				
	§485.625(e)(1) Emergency general must be located in a requirements found Code (NFPA 99 and Amendments TIA 1 12-5, and TIA 12-6) and Tentative Interior 12-2, TIA 12-3, and	2-2, TIA 12-3, TIA 12-4, TIA , Life Safety Code (NFPA 101 m Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, re is built or when an existing				
	482.15(e)(2), §483.	73(e)(2), §485.625(e)(2),				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		245359	B. WING			C 24/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 041	[hospital, CAH and the emergency powand [maintenance] Health Care Facilities Safety Code. 482.15(e)(3), §483. (3),§485.542(e)(2) Emergency general LTC facilities] that into power emergency for how it will keep operational during the evacuates. *[For hospitals at §4 REHs at §485.542(§485.625(g):] The standards inconsection are approved reference by the Diffederal Register in 552(a) and 1 CFR parameterial from the section are approved a copy at the Center, 7500 Security or at the National A Administration (NAI availability of this in 202-741-6030, or ghttp://www.archives_federal_regulation. If any changes in the incorporated by reference by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administration (NAI availability of this incorporated by reference to the National A Administr	tor inspection and testing. The LTC facility] must implement ver system inspection, testing, requirements found in the es Code, NFPA 110, and Life 73(e)(3), §485.625(e) tor fuel. [Hospitals, CAHs and maintain an onsite fuel source by generators must have a plan emergency power systems whe emergency, unless it 482.15(h), LTC at §483.73(g), g), and and CAHs rporated by reference in this ed for incorporation by rector of the Office of the accordance with 5 U.S.C. coart 51. You may obtain the ources listed below. You may use CMS Information Resource rity Boulevard, Baltimore, MD rchives and Records RA). For information on the laterial at NARA, call	E O	41		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	E SURVEY PLETED
		245359	B. WING		08/	2 4/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		.D BE	(X5) COMPLETION DATE
E 041	Batterymarch Park, Quincy, MA 02169, 1.617.770.3000. (i) NFPA 99, Health edition, issued Augu (ii) Technical interin NFPA 99, issued Auguii) TIA 12-3 to NFF (iv) TIA 12-4 to NFF (vi) TIA 12-6 to NFF (vii) NFPA 101, Life issued August 11, 2 (viii) TIA 12-1 to NF 2011. (ix) TIA 12-3 to NFF 2012. (x) TIA 12-3 to NFF 2013. (xi) TIA 12-4 to NFF 2013. (xii) NFPA 110, Standby Power Systems and (xiii) NFPA 110, Standby Power Systems and (2012 edition), Heast of the control o	otection Association, 1 www.nfpa.org, Care Facilities Code, 2012 ust 11, 2011. n amendment (TIA) 12-2 to ugust 11, 2011. A 99, issued August 9, 2012. A 99, issued March 7, 2013. A 99, issued August 1, 2013. A 99, issued March 3, 2014. Safety Code, 2012 edition,		Maintenance will conduct monthly inspection and testing of the facility emergency generators. The 36 month □ 4-hour load bank was last completed on 2/8/2022. The monthly inspections and testing be included in the facility prevental maintenance program. All inspections, tests and maintenance the emergency generators will be appropriated to the facility prevental maintenance program.	test ng will itive	
	Findings include:			the emergency generators will be the life safety binder. And will be a by the Environmental services directly the the the thick services directly the thick services are the thick services.	audited	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245359	B. WING _			C 24/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP COL 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	it was revealed by redocumentation that presented to confirm testing of the facility occurring. On 8/23/2023 between the second to confirm the second to confirm load bank testing of generators was so was a was load to so was a was not in complicate the second to confirm the second to so was not in complicate the second to complicate the second to so was not in complicate the second to complicate the second to so was not in complicate the second to so with a deficiency city of the second to so was not in complicate the	een 9:00 a.m. and 12:00 p.m., review of available there was no documentation in that monthly inspection and y emergency generators was een 9:00 a.m. and 12:00 p.m., review of available there was no documentation in that 36 month - four-hour fithe facility emergency ccurring. Italiantenance Director verified ings at the time of discovery. TS I/23, a standard recertification ted at your facility. A complaint also conducted. Your facility ance with the requirements of eart B, Requirements for Long is. Iolaints were reviewed: IO093349 and MN00093322) ted at (F689), and IO091905) with a deficiency Iolaints were reviewed. IO095890), IO095613 and MN00095690), IO095613 and MN00095690), IO095613 and MN00095690), IO095613 and MN00095690), IO094879), and	FO	The Environmental Services I responsible for the corrective monitoring of compliance.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	l \	TE SURVEY MPLETED
		245359	B. WING		08	C / 24/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 625	as your allegation of Departments accept enrolled in ePOC, yeat the bottom of the form. Your electronic be used as verificated. Upon receipt of an anonsite revisit of your validate substantial regulations has been Notice of Bed Hold CFR(s): 483.15(d) (1) Section 15(d) (1) Notice of	f correction (POC) will serve f compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 c submission of the POC will ion of compliance. acceptable electronic POC, an r facility may be conducted to compliance with the en attained. Policy Before/Upon Trnsfr		325		10/4/23
	nursing facility must the resident or residence specifies- (i) The duration of the any, during which the return and resume facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing face bed-hold periods, we paragraph (e)(1) of resident to return; at (iv) The information of this section.	t provide written information to dent representative that he state bed-hold policy, if he resident is permitted to residence in the nursing payment policy in the state of this chapter, if any; ility's policies regarding which must be consistent with this section, permitting a land specified in paragraph (e)(1) hold notice upon transfer. At				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	E SURVEY PLETED
		245359	B. WING _			2 4/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	1 001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETION DATE
F 625	facility must provided resident representations appecifies the duration described in parage This REQUIREME by: Based on interview facility failed to ensure representative was policy at the time of residents (R60) reversidents (R60) reversidents (R60) reversidents (R60) reversidents (R60) and a the diagnoses included Review of the R60 diagnoses included Review of the facility provided R60 diagnoses included R60 diagnoses i	nerapeutic leave, a nursing e to the resident and the ative written notice which ion of the bed-hold policy raph (d)(1) of this section. NT is not met as evidenced wand document review, the sure the resident or resident's informed of the bed hold f hospitalization for 1 of 1 viewed for hospitalization. Itronic medical record (EMR) I'Census' tab revealed an 5/25/23. Review of the EMR, sis'' tab, revealed admitting d dementia and weakness. Is 6/2/23, progress notes harged to the hospital on ange in their medical condition. In the solution of the solu	F 62	It is the policy of the facility to give of the bed hold policy before a restransfer to a hospital in a written for the resident or resident representative are all other residents who may be transferred to the hospital, the Ber Policy will be provided to the resident representative at the time of trans the hospital. Bed hold forms are now with residents/families upon admissand have been placed in the transfer envelope packets so that they are addressed with the transfer paper the time of transfer. The Policy and Procedure for Bed Hold/Transfer was reviewed and we to align with current requirements Education to the licensed nursing their respective roles and responsing	ident or ative per lity. et Hold ent or fer to eviewed sion fer work at erified ensfer a review for with hold	
	Bed-Hold Policy un notice of Bed-Hold	ndated identified that The Policy would be provided to ially responsible party upon		transfers weekly for 4 weeks, and for 2 months. Action will be taken immediately if trends for improven	monthly	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	` '	E SURVEY PLETED
		245359	B. WING _		08/	24/2023
	PROVIDER OR SUPPLIER VEN CARE CENTER I	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 657	Continued From pa admission and at the	e time of leave.	F 62	identified, and staff education and coaching will be provided if indicat Audit results and actions taken will reported to the QAA/QAPI Committends and determination of areas improvement. The Committee will recommendations if indicated. Responsible party: Social Service or designee	ed. I be ttee for of I provide	
	S483.21(b) Compress \$483.21(b)(2) A combe- (i) Developed withing the comprehensive (ii) Prepared by an includes but is not like (A) The attending postered number of forms (B) A registered number of forms (C) A number of forms (E) To the extent protection of the resident and the An explanation must medical record if the and their resident resident resident is care plant (F) Other appropriate disciplines as determined to a requested by (iii) Reviewed and resident resid	chensive Care Plans in 7 days after completion of assessment. Interdisciplinary team, that imited to hysician. Is with responsibility for the Indication of the participation of a resident's representative(s). Is be included in a resident's a participation of the resident be participation of the resident be presentative is determined the development of the the staff or professionals in mined by the resident's needs the resident. The system of the resident the presentative is determined the development of the the staff or professionals in mined by the interdisciplinary the sessment, including both the				10/4/23

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	1 ` ′	SURVEY PLETED
		245359	B. WING			2 4/2023
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP		
PINE HA	VEN CARE CENTER	INC		210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 657	by: Based on observate review, the facility for include updated we interventions for upone resident (R53) plan. Findings include: Review of R53's facidentified R53 had 7/17/23, with diagn bicondylar fracture unspecified displace right humerus (uppose Review of R53's ac (MDS) dated 7/23/2 moderately impaired Review of R53's cacidentified R53 was arm and right leg at toe touch weight be Review of R53's phase arm and right leg at toe touch weight be Review of R53's phase arm and right leg at toe touch weight be Review of R53's phase arm and right leg at toe touch weight be Review of R53's phase arm and right leg at toe touch weight be Review of R53's phase arm and right leg at toe touch weight be Review of R53's phase arm and right leg at toe touch weight bearing (RLE). Knee immorperform ROM. Encorporate ROM. Encorporate ROM.	NT is not met as evidenced tion, interview, and record failed to revise the care plan to eight bearing and immobilizer oper and lower extremities for reviewed for revision of care ce sheet dated 8/23/23, been admitted to the facility on oses which included displaced of right tibia (shin bone) and ced fracture of surgical neck of per arm) dmission Minimum Data Set 23, identified R53 had	F 6	It is the facility's policy to revise resident comprehence per the RAI process and/ocondition changes or interchanges. R53's care plan was update reviewed by the Inter-Disciplect current needs and in The resident and her sister the care planning process. For all residents receiving orders, the care plans have reviewed by the Interdisciplecoincide with current order intervention/approaches not care staff have received explanting updates if indicated. Updates if indicated. Updates if indicated individualized care plans were sident/representative if in The Policy and Procedure Comprehensive Care Plantincluding updates/revisions respective to new physicial reviewed. Education to licensed nurs the interdisciplinary team or respective roles and response comprehensive care planting updates will be audited we weeks, and monthly for 2 rewill be taken immediately in will be taken immediately in will be taken immediately in the resident completed by 9/28/2023.	resident vention ted and iplinary Team to nterventions. rs were part of new physician e been plinary Team to rs and eeded. Direct ducation on the ates to the vere given to the ndicated. on a completion, s to approaches in orders was sing staff and on their ensibilities for revision will be uiring care plantekly for 4 months. Action	
	hygiene/skin check	ulder immobilizer for and range of motion (ROM) - ar motion (reaching overhead		improvement are identified education and coaching wi indicated. Audit results an	ill be provided if	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245359	B. WING _			C 24/2023	
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH APPENDED TO THE AP	ULD BE	(X5) COMPLETION DATE	
F 657	Review of the orthon 8/2/23, identified Replateau fracture and fracture. Indicated simmobilizer several times per day) for hand range of motion non-weight bearing however, it was oka RLE. Provided instrimmobilizer and standing/ambulating to remove brace who by director of nursing "entered and noted signed by nurse maindicated "reviewed During an observat 10:26 a.m., R53 was wheelchair with no extremities. R53 stawar the immobilized they had been without During an interview the DON revealed responsible for upd when they received staff sign them. The R53's physical copy 8/02/2023, and place health record. The	pht elbow/wrist/finger motion to th start date of 8/02/23. spedic physician letter dated 53 was evaluated for right tibial dright proximal humerus staff could remove shoulder times daily (at least three hygiene purposes/skin checks in work. Indicated R53 was to right lower extremity (RLE), ay to perform pivot transfers ruction to discontinue knee ated it was okay to wear valgus astom brace) during g in physical therapy, and okay hile resting. Letter was signed ing (DON) and DON indicated" In addition, the letter was anager and nurse manager l" ion and interview on 8/22/23 at as observed sitting in immobilizer on lower or upper ated they no longer had to er. R53 did not know how long out braces. I on 8/22/23 at 3:15 p.m., with hurse managers were ating care plans. DON stated I new orders, they had two er DON stated they entered by of orthopedic orders on ced them into the electronic DON stated the care plan	F 65	will be reported to the QAA/QAF Committee for trends and deter of areas of improvement. The will provide recommendations if Responsible party: Director of N Designee.	mination Committee indicated.		
	R53's physical copy 8/02/2023, and place health record. The	y of orthopedic orders on ced them into the electronic					

		l \ /	E SURVEY PLETED			
		245359	B. WING			C 24/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	S483.25(d) Accided The facility must en §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on interview facility failed to impof 3 residents (R61 addition, the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents Findings include: R61 Review of the facility for 1 of 3 residents	nts. nsure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced v, and document review, the element fall interventions for 1) reviewed for accidents. In refailed to modify interventions (R24) reviewed for accidents. ty Fall Investigation Incident red out of the bedroom via ursing assistant (NA)-B edals and arm bar were not reheelchair. While NA-B oom to obtain forgotten items, wheelchair and hit head on the ned of head hurting and the ed to due to the emergency room and and of 5/4/2023, with no	F	It is the policy of the facility the resident environment remains accident hazards as possible each resident receives adeques supervision and assistance of prevent accidents. R61 no longer resides at the R24 shas been reassessed prevention and the comprehes plan has been updated as incompany to toileting plan has been put in For all others who may be affectly morning meeting agent updated to include a review a discussion on any falls that of later-Disciplinary Team will control to the control to	s as free of and that uate levices to facility. If for fall ensive care dicated. A place. fected, the nda has been and eccurred. The omplete a nine the need erventions if a resident's ne changes direct care	10/4/23
	Review of R61's Fa	ace Sheet, located in the c medical records (EMR) ent was admitted to the facility		completed if indicated. A review of the facility Policy Procedure on Accidents/Incidents prevention was completed.	and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG) COM	(X3) DATE SURVEY COMPLETED	
		245359	B. WING _		1	C 24/2023	
	PROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP 6 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	osteoporosis, chrone weakness and trause without loss of constitutions. Review of R61's are (MDS) dated 5/08/2 cognitively intact. In extensive assistant locomotion on and used a wheelchair on one side for upper Review of R61's care R61 had a mobility problem The follow identified: R61 required for wheeling longe the dining room or flip-away tray on wharm and hand position the footrest of the Review of R61's Vidated 8/24/23, identified assistance from states such as going to the R61 had a flip-away with right arm and foot was on footrest. Interview attempted 8/24/23, with no retained and inistrator met windicated they wheeling and interview director of nursing administrator met windicated they wheeling and interview wheeling and interview attempted administrator met windicated they wheeling and interview attempted at the problem and interview attempted at the problem and interview attempted at the problem at the problem and interview attempted at the problem and interview attempted at the problem at	agnoses which included nic pain, epilepsy, muscle matic subdural hemorrhage sciousness. Inual Minimum Data Set 23, identified R61 was ndicated R61 required be of one person for off the unit. Identified R61 for mobility and was impaired per and lower extremities. In plan dated 3/8/23, identified for mobility and was impaired per and lower extremities. In plan dated 3/8/23, identified for mobility and was impaired per and lower extremities. In plan dated 3/8/23, identified for distances, such as going to to activities. R61 had a neelchair to assist with right tioning, ensure right foot was ne wheelchair. In sual/Bedside Kardex Report, attified R61 required total aff wheeling longer distances, e dining room or to activities. By tray on wheelchair to assist mand positioning, ensure right	F 68	Education on fall prevention analysis of falls, and resperesponsibilities was completed roles and responsibilities for prevention was completed fall intervention audits will weekly for 4 weeks, and months. Action will be taken if trends for improvement and staff education and comprovided if indicated. Audit actions taken will be report QAA/QAPI Committee for the determination of areas of in The Committee will provide recommendations if indicated Responsible party: Director	eted for the acation on staff or fall by 9/28/2023. be completed onthly for 2 en immediately are identified, aching will be to the trends and the trends and mprovement.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILE	TIPLE CONSTRUCTION DING	\ \ /	(X3) DATE SURVEY COMPLETED	
		245359	B. WING	i	08	C / 24/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CO 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 689	wheelchair. They to items, NA-B began again when R61's fell out of the wheel provided immediate expected use of the for R61. The DON somajor injuries howedon face. The DON somajor injuries howedon for staff to follow the for residents. During an interview nurse manager interview has manager into the wheelchair to go NA-B realized they pedals and arm resonant stated they associated and arm some day with no not the aide did not followed.	m board or foot pedal on the grad around to retrieve the to push R61 in her wheelchair toot became caught and R61 lichair. The DON stated they be education to NA-B about the effoot pedals and arm board stated R61 did not have any ever did have bruising present stated their expectations were efformed interventions. Ton 8/24/23 at 10:20 a.m., the erim (NMI) stated NA-B turned to back to R61's room after didn't have wheelchair foot at on the chair and R61 fell. Seessed R61 and called the l61 was sent out by local emergency department to l61 returned to the facility the major injuries. NMI confirmed low the plan of care for R61, ectation was for staff to follow	F	589		
	6/22/23, indicated sand included diagnostic dysfunction, traumand dementia. R24 since admission.	imum Data Set (MDS) dated severe cognitive impairment oses of non- traumatic brain atic subarachnoid hemorrhage had a history of multiple falls sessment (CAA) dated areas to focus specialized care				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245359	B. WING		08/	C / 24/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		IOULD BE	(X5) COMPLETION DATE
F 689	and falls. R24's care plan dat was at risk for falls gait/balance problet goal was R24 would review period. Toile on 5/28/2023, ident toileting at 6:30 a.m and before going to Review of R24's prohad falls on 5/28/23. Review of the Post 5/28/23, to 6/26/23, to 6/26/23, -5/28/23 at 4:20 p.n in the bathroom and Toileting intervention plan. -6/12/23 at 3:49 p.n in the bathroom by incontinent and the self-transferred to the self-transfe	loss/dementia, visual function ed 11/15/22, indicated R24 related to confusion, ms and history of falls. The d be free of falls through the ting interventions which began ified staff were to provide a, after lunch, before supper		589		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	l \ /	(X3) DATE SURVEY COMPLETED	
		245359	B. WING _		30	C 8/24/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 15	F 68	39		
	nursing assistant (I several falls since a believed most of the needs. During an interview registered nurse (Fattended the interd meetings and the I They stated the ID	on 8/23/23 at 9:48 a.m., NA)-A stated R24 has had arriving at the facility. NA-A e falls were related to toileting on 8/23/2023 11:26 a.m., RN)-B and RN-C stated they epartmental team (IDT) DT reviewed resident falls. T reviewed each fall				
	they would not revi	ney occurred and confirmed ew prior falls to determine if ere effective and required and RN-B stated they were real falls.				
	director of nursing confirmed the IDT falls as part of the	on 8/23/23 at 12:45 p.m., the (DON) reviewed the PFE's and had not reviewed R61's prior root cause analysis to assist in menting new interventions in further falls.				
	and Reduction date would be reviewed would be taken to would determine the	policy titled Fall Prevention ed 7/22, indicated all falls and preventive measures decrease falls. The facility e root cause to the fall and atterventions specific to the				
	Accident/Hazards/S 10/22, revealed the environment that w over which the faci supervision and as	policy titled Free of Supervision/Devices, revised facility would provide an as free from accident hazards lity had control and provided sistive devices to each avoidable accidents. This				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		245359	B. WING		C 08/24/2023	
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
	interventions to red	ot limited to implementing uce hazards and risks.	F 689		0/00/00	
F 812 SS=F	Food Procurement, CFR(s): 483.60(i)(1 §483.60(i) Food sa The facility must -		F 812		9/22/23	
	approved or consident state or local author (i) This may include from local producer and local laws or refusion describing gardens, subject to safe growing and for (iii) This provision of from consuming for serve food in accordant standards for food This REQUIREMENT by: Based on observation of the facility from the facility from anner to prevent ongoing storage of and sugar container failed to ensure sto This deficient pract 60 of 60 residents with the facility of the faci	e food items obtained directly its, subject to applicable State igulations. The produce grown in facility compliance with applicable and lood-handling practices. Hoes not preclude residents and produce by the facility. The prepare is the professional in the product of the pr		The Dietary Manager completed an of the facility s kitchen(s) and stora area(s). No further food products has compromised packaging. Complete 09/14/2023. Bulk storage containers of flour and were emptied, cleaned, and repleni with dry ingredients. Completed 09/14/2023. Policy and procedures related to foostorage were revised as of 09/14/20 Education was provided to all Dieta	age ad ed I sugar shed od 023.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245359	B. WING _			C 24/2023	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER IN	C		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	1 00/24/2023		
PREFIX (EACH DEFICIENCY N	MENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
Dry Storage and kitch -Two six-pound cans northern beans, were dents in them. -Two 20-liter clear co and sugar, were obse flour and sugar. During an interview o DC stated they norms know what cans were receive credit. DC sta dented cans were on should not have been should have been sto compartment on the During an interview o dietary manager (DM dented can, they wer right of way so that si distributor and receiv expectation was for s way when stocking a DM stated they exper and put away in a dra Review of the facility' Storage revealed sco food or ice containers kept covered in a pro containers. In additio	of the kitchen on 8/21/23 at nterim dietary cook (DC) gobservations were made: nen: , containing pumpkin and e observed stored with large ntainers, containing flour erved with scoops lying in the ally let the food distributor e dented so that they could ated they did not know why the shelf. DC stated scoops a stored in the container and ored in their own	F 81	on food storage, prevention of cross-contamination, and revised and procedures for food storage, were required to complete a comquiz post-education session. Dietary Manager to perform a we audit of all food storage areas incoulk storage containers x1 month Dietary Manager will present find the QAA Committee to determine resolution or the need of continua auditing, re-education, and/or porevision. Responsible party: Dietary Manager Man	Staff petency ekly luding to a ed icy		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245359	B. WING				08/:	C 24/2023
	PROVIDER OR SUPPLIER	NC		210 NORT	DDRESS, CITY, STAT HWEST 3RD STRE AND, MN 55963	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN EACH CORRECTIVE OSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
F 812	Continued From pa	ge 18	F 8	312				
	packaging until read Infection Prevention CFR(s): 483.80(a)(n & Control	F 8	380				9/20/23
	infection prevention designed to provide comfortable enviror	tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable						
	program. The facility must es	tablish an infection prevention (IPCP) that must include, at owing elements:						
	reporting, investigate and communicable staff, volunteers, vis providing services arrangement based	upon the facility assessment g to §483.70(e) and following						
	procedures for the put are not limited to (i) A system of survey possible communications before the persons in the facili (ii) When and to who communicable dise reported;	eillance designed to identify able diseases or ey can spread to other						

NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC SITERET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 FREETY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC 24 jp			245359	B. WING _		08/24/202	3
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 imited 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. (iv) 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 with residents or their food in food with their food in food with their food			INC		210 NORTHWEST 3RD STREET	•	
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:	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLE	TION
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: It is the policy of this facility to implement a water management plan for Legionnaires Disease in accordance with the facility sinfection prevention and control program. A review of the facility water Management Plan for Legionella was completed on 9/19/2023 for alignment	F 880	to be followed to precive the contact will transmit (vi) The hand hygier by staff involved in \$483.80(a) (4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must has transport linens so infection. §483.80(f) Annual in \$483.80(f) A	event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility by es with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact. Stem for recording incidents afacility's IPCP and the taken by the facility. Indle, store, process, and the taken by the facility. Indle, store, process, and the taken by the spread of the	F 88	It is the policy of this facility to impa water management plan for Legionnaires Disease in accordant the facility□s infection prevention a control program. A review of the facility□s Water Management Plan for Legionella w	ce with and as	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245359	B. WING _			08/2	24/ 2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	CODE	1 00,2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 880	Management Plan identified the water rooms for three min flushed twice on a water rooms. The policy is would be completed department or a test identified test result water quality log an made in the flush log During an interview the infection prevent changes in the main 2023, the facility has facility policy for the Legionnaires Diseas During a follow-up is preventionist on 8/2 the facility had not be running and toilet fluin the facility's plan. preventionist confirmation of the prevention of	for Legionella dated 4/1/22, would be run in unoccupied autes and the toilets would be veekly basis in unoccupied adicated Legionella testing by the maintenance sting company. The policy is would be maintained in the diversely entries would be get for all unoccupied rooms. on 8/23/23 at 1:30 p.m., with ationist indicated due to intenance department in March did not been following the prevention and control of	F 88	with current requirements The facility has completed Legionella testing on 9/20 of the testing are maintain Maintenance Department quality log. The Director of Environment and the facility Infection Phave received education of Water Management Plantit relates to their respective responsibilities. This was 9/19/2023. The facility Infection Prever perform monthly audits on completion of the facility Management Plan for Leg processes for adherence for 3 months. Action will kimmediately if trends for in identified, and staff educat coaching will be provided Audit results and actions the reported to the QAA/QAPI trends and determination improvement. The Commercommendations if indicated Responsible party: Infection	the applicated in the testinate of the t	esults ater vices, ist (IP) ility sella as nd ed on vill ng and ements ent are ed. be tee for of provide	

F5359035

PRINTED: 09/26/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION 101 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245359	B. WING			08/2	23/2023
	PROVIDER OR SUPPLIER	NC		21	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTHWEST 3RD STREET INE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ΓS	K 0	000			
	conducted by the Management of National Conducted by the Nat	ety Code survey was linnesota Department of Fire Marshal Division on time of this survey, PINE ITER - BLDG 01 was found with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection 101, Life Safety Code (LSC), Health Care and the 2012 Health Care Facilities Code.					
	THE FACILITY'S PALLEGATION OF CONTENT OF CONTENT OF THE CMUSED AS VERIFICATION ON SITE REVISIT CONDUCTED TO SUBSTANTIAL CONTENT OF THE CONTEN	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION. The Fire Inspections Division Suite 145 -5145, OR			TITI F		(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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245359	B. WING		08/	23/2023
	PROVIDER OR SUPPLIER VEN CARE CENTER I	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	FOR THE FIRE SA (K-TAGS) TO: IF PARTICIPATING PAPER COPY OF TIS NOT REQUIRED. PLAN OF CORRECT DEFICIENCY MUSTOLLOWING INFO. 1. A detailed described taken or planned to to ensure the sustained. 2. Address the metaplace to ensure the sustained. 4. Identify who is actions and monitor to the remedy. FINE HAVEN CARLONE-story building was constructed in 1964 (111). In 1970, and was constructed and 111). In 1991, and and 111). In 1991, and and 11991, and 11991, and 11991, and 11991, and 11991.	E PLAN OF CORRECTION FETY DEFICIENCIES IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D. CTION FOR EACH T INCLUDE ALL OF THE DRMATION: cription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245359	B. WING		08/:	23/2023
	PROVIDER OR SUPPLIER VEN CARE CENTER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	compatible constructions buildings of this here as one building as National Fire Prote Standard 101, Life 19 Existing Health The facility is fully pautomatic sprinkler system with smoke spaces open to the automatic fire department of Type V (111) confire rated wall separated will therefore be sufficient.	al building and additions are action types allowed for existing ight, the facility was surveyed allowed in the 2012 edition of ction Association (NFPA) Safety Code (LSC), Chapter Care Occupancies. Protected throughout by an existence and has a fire alarm edetection in the corridors, according that is monitored for artment notification. Ched to PINE HAVEN CARE 22 which was determined to be astruction. There is a 2-hour rating the two buildings, and rveyed as two buildings.	K 0	00		
K 291 SS=F	The requirement at NOT MET as evide Emergency Lighting CFR(s): NFPA 101 Emergency Lighting is provided automa 18.2.9.1, 19.2.9.1 This REQUIREMED by: Based on a review and staff interview, emergency lighting	g	K2	The Facility is fully backed up by a emergency generator and does not any battery-operated emergency lig So, there are not any lights that req	t have ghting.	10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		l \ /	(X3) DATE SURVEY COMPLETED	
		245359	B. WING _		08	/23/2023	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	Continued From parsection 19.2.9.1, 7.9 deficient condition of impact on the resident findings include: On 08/23/2023 betwit was revealed by redocumentation that presented to confirm is occurring. An interview with Methic deficient finding Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment with NFPA 96, Stan and Fire Protection Operations, unless: * residential cooking appliances such as toasters) are used for cooking in accordant cooking in accordant cooking facilities of compartments with with the conditions or * cooking facilities in cooking facilities in cooking facilities or cooking facilities in coo	ge 3 9, and 7.9.3.1.1(5). This could have a widespread ents within the facility. veen 9:00 AM and 12:00 PM, eview of available there was no documentation in that emergency light testing aintenance Director verified at the time of discovery. is protected in accordance dard for Ventilation Control of Commercial Cooking	K 29	any testing. Assurance of lighting during a outage is accomplished throug generator testing. Adequate lighting for emergent monitored through the testing, and maintenance of the back-ugenerators. The Environmental Services D responsible for the corrective a monitoring of compliance.	oower h backup cies will be inspection ip	10/4/23	
	per 9.2.3 are not rechazardous areas, b corridor.	otected according to NFPA 96 quired to be enclosed as ut shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
245359		B. WING		08/23/2023		
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963			
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 324	Continued From pa 19.3.2.5.5, 9.2.3, TI		K 324			
	by: Based on a review and staff interview, inspection and main the ansul type fire elaccordance with the 2012, sections 19.3 Standard for Ventila Protection of Common NFPA 96-2014, section could have residents within the Findings Include: On 08/23/2023 between the between the common that the documentation that	veen 9:00 AM and 12:00 PM, eview of available there was no documentation n that 6 month inspections f the ansul type fire		The ansul type fire extinguishing sy is inspected every 6 months. Documentation was found for the latin July 2023 and also for the previous in February 2023. Inspections will continue to be scheevery 6 months and any identified maintenance will be addressed. A schedule for all inspections and preventative maintenance will be maintained. Inspection results and documentation on completed repair be kept in the facility Life Safety Bir The information will be reviewed the QAPI. The Environmental Services Directoresponsible for the corrective action monitoring of compliance.	ast test us test eduled any rs will nder. rough or is	
K 353 SS=F	this deficient finding Sprinkler System -	aintenance Director verified at the time of discovery. Maintenance and Testing	K 353			10/4/23
	Automatic sprinkler inspected, tested, a with NFPA 25, Stan	Maintenance and Testing and standpipe systems are nd maintained in accordance dard for the Inspection, ining of Water-based Fire				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245359	B. WING _		08/	23/2023	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 353	maintenance, inspermaintained in a section available. a) Date sprinkler is b) Who provided in REMAR any non-required or system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by: Based on a review and staff interview, and maintain the symith NFPA 101 (20 sections 19.3.5, 9.7 edition) Standard for Maintenance of Wasystems, sections This deficient condimpact on the resident impact on the resident condimpact conditions are represented to confirm the sprinkler system.	s. Records of system design, ection and testing are cure location and readily system last checked system test supply source. KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced of available documentation the facility failed to inspect prinkler system in accordance 12 edition), Life Safety Code, 7.5, 9.7.6, and NFPA 25 (2011 or the Inspection, Testing, and ater-Based Fire Protection 3.3.19, 4.3, 5.1, 5.2, 5.3, 5.4. ition could have a widespread lents within the facility.	K 35	The 5 year inspection and mainted was last completed on 10/18/2020 Quarterly inspections of the sprint systems will be conducted and the documented. The quarterly inspections will be scheduled and documented in the preventative maintenance program sprinkler inspection company will the maintenance staff on the concord the quarterly inspections. The inspections will be reviewed in the Environmental Services Directly inspective actions will be corrective action monitoring of compliance.	tor is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		` '	(X3) DATE SURVEY COMPLETED	
		245359	B. WING _		08/	23/2023	
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOUTH ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH AC	ULD BE	(X5) COMPLETION DATE	
K 353	An interview with M	ige 6 Intenance was completed. Indicate a second se	K 35	53			
K 354 SS=F			K 35	54		10/4/23	
	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.			A sprinkler system □ out of services developed and reviewed by Staff education was completed new policy. The policy will continue to be reand updated through QAPI. The Environmental Services Diresponsible for the corrective acmonitoring of compliance.	QAPI. on the viewed rector is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245359	B. WING _		08/2	3/2023
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 354	Continued From pa	ge 7	K 35	4		
I/ 272	it was revealed by a documentation that presented to confirm sprinkler system - of this deficient finding	there was no documentation mentation that the facility has a out of service policy. aintenance Director verified at the time of discovery.	L 27			10/4/00
K 372 SS=F	CFR(s): NFPA 101	ling Spaces - Smoke Barrie	K 37	2		10/4/23
	Construction 2012 EXISTING Smoke barriers shafire resistance ration be permitted to terr Smoke dampers ar penetrations in fully an approved sprink smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanin REMARKS.	all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall minate at an atrium wall. The not required in duct of ducted HVAC systems where aller system is installed for interest adjacent to the smoke smoke smoke control system.				
	Based on a review and staff interview, test, and inspect th system per NFPA 1 Code, sections 8.5, 105 (2010 edition) Assemblies and Ot section 6.5.2 This	of available documentation the facility failed to maintain, e facility smoke dampers 01 (2012 edition), Life Safety 8.5.5.2, 8.5.5.4.2, and NFPA, Standard for Smoke Door her Opening Protectives, deficient condition could have ct on the residents within the		Information on the facility fire/smoke dampers has been obtained. An inspection of the fire/smoke damper last completed on 10/4/2021 Annual inspection of the smoke dam will be scheduled and maintained in facility preventative maintenance presented and any needed maintenance will be completed. Environmental services will monitor	mpers n the rogram	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245359	B. WING		08/23/2023	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICITION DEFICIENCY)	O BE COMPLÉTION	
K 372	Continued From pa	ge 8	K 372			
	it was revealed by redocumentation that presented to confirm dampers, the location	there was no documentation main if the facility has fire / smoke on of fire / smoke dampers, is timeframe compliant testing		assure inspections are completed. The Environmental Services Direct responsible for the corrective action monitoring of compliance.	tor is	
K 712 SS=F	this deficient finding	aintenance Director verified g at the time of discovery.	K 712		10/4/23	
	signal and simulation conditions. Fire drill unexpected times used to least quarterly on exwith procedures and established routines between 9:00 PM announcement may alarms. 19.7.1.4 through 19.7.1.5 REQUIREMENT by: Based on a review and staff interview, fire drills per NFPA Code, sections 19.7.1.4 through 19.	e transmission of a fire alarm on of emergency fire is are held at expected and under varying conditions, at each shift. The staff is familiar id is aware that drills are part of where drills are conducted ind 6:00 AM, a coded is be used instead of audible 0.7.1.7 NT is not met as evidenced of available documentation the facility failed to conduct 101 (2012 edition), Life Safety 7.1. This deficient condition ned impact on the residents		The facility fire drill policy and prochas been reviewed and revised. Shave been educated on the update policy and procedure. Fire drills w conducted on each shift every quafire drills per quarter. A schedule to conduct the fire drills monthly basis was developed to as	itaff ed ill be rter 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01			
		245359	B. WING		08/	08/23/2023	
	PROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CO 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 761	it was revealed by documentation that presented to confir fire drills. An interview with Many this deficient finding	ween 9:00 AM and 12:00 PM, review of available there was no documentation m that the facility is conducting laintenance Director verified g at the time of discovery.	K 7	the fire drills will occur on ear rotating basis and at stagger Documentation of the drills work completed at the time of each kept in the life safety binder. Environmental Services will fire drills for review at the safety binder committee meeting and at Quantity The Environmental Services responsible for the corrective monitoring of compliance.	ring times. vill be the drill, will be present the fety API. Director is	10/4/23	
	Fire doors assembly annually in accordance for Fire Doors and Non-rated doors, in patient rooms and routinely inspected maintenance programment of the sting possess know that demonstrates Written records of infinity and are 19.7.6, 8.3.3.1 (LSC 5.2, 5.2.3 (2010 NFT) This REQUIREMED by: Based on docume the facility failed to NFPA 101 (2012 expections 7.2.1.15, a sections 5.2.1.	ing the door inspections and owledge, training or experience ability. Inspection and testing are available for review. C)		Maintenance department wi annual maintenance, inspec- testing of the fire doors. The maintenance, inspectior of the fire doors will be included preventative maintenance propressed in the fire doors will as the fire doors.	tion and n, and testing ded in the rogram.		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245359	B. WING _		08/2	23/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 914	it was revealed by redocumentation that presented to confirmannual maintenance doors. An interview with Methis deficient finding Electrical Systems - CFR(s): NFPA 101 Electrical Systems - Hospital-grade recellocations and where anesthesia is admininstallation, replace testing is performed documented performisted as hospital-grade tested at intervals nesthesia is adminingulation monitors (lintervals of less that actuating the LIM tested at intervals of less than actuating the LIM tested at intervals of less than actuating the LIM tested at intervals of less than actuating the LIM tested at intervals of less than actuating the LIM tested at intervals of less than actuating the LIM tested at intervals of less than actuating the LIM tested at intervals of less than actuating the LIM tested at intervals of less th	veen 9:00 AM and 12:00 PM, eview of available there was no documentation in that the facility is conducting e, inspection and testing of aintenance Director verified at the time of discovery. Maintenance and Testing eptacles at patient bed edeep sedation or general histered, are tested after initial ment or servicing. Additional at intervals defined by mance data. Receptacles not ade at these locations are of exceeding 12 months. Line LIM), if installed, are tested at in or equal to 1 month by est switch per 6.3.2.6.3.6, in visual and audible alarm. For tomated self-testing, this ormed at intervals less than or LIM circuits are tested per epair or renovation to the system. Records are red tests and associated ions, containing date, room or sults.	K 76	preventative maintenance program assure the maintenance, inspection testing of the fire doors is schedule completed. It will be reviewed at Q The Environmental Services Direct responsible for the corrective action monitoring of compliance.	n, and d and API. or is	10/4/23
		IT is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` '		E SURVEY PLETED		
		245359	B. WING		08/2	8/23/2023	
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	. -		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 918	and staff interview, electrical receptacle NFPA 99 (2012 edit Code, section(s) 6.3 deficient condition of impact on the resident impact on the resident impact on the resident it was revealed by redocumentation that presented to confirm annual inspection a located in resident in this deficient finding Electrical Systems CFR(s): NFPA 101 Electrical Systems Maintenance and Telectrical Systems Maintenance and Telectrical Systems in the generator or of and associated equipment in the generator or of an associated equipment in the generator or of an associated equipment is not metrocess shall be precapability for the life Maintenance and telegraphic intervals are under load 30 minution day intervals, and end associated equipment in the second in the sec	of available documentation the facility failed to conduct e testing in resident rooms pertion), Health Care Facilities 3.3.2, 6.3.4, 6.3.4.2. This could have a widespread ents within the facility. Ween 9:00 AM and 12:00 PM, review of available there was no documentation in that the facility is conducting and testing of electrical outlets rooms. aintenance Director verified at the time of discovery. Essential Electric System Essential Electric System	K 914	Maintenance will conduct annual inspection and testing of electrical in all resident rooms. Testing will intension, operation and polarity. The inspection and testing of the eoutlets will be scheduled and docu in the preventative maintenance properties of the environmental services director. The Environmental Services Directors responsible for the corrective action monitoring of compliance.	lectrical mented ogram. by the	10/4/23	

1 ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	` '	E SURVEY IPLETED
		245359	B. WING		08/	23/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 918	simulated cold state transfer of all EES competent person stored energy powaccordance with North circuit breakers are program for period components is est manufacturer requirementations are marked separate from north epossibility of disource is a design installations. 6.4.4, 6.5.4, 6.6.4 111, 700.10 (NFPAT This REQUIREMENT Descriptions of the possibility of disource is a design installations. 6.4.4, 6.5.4, 6.6.4 111, 700.10 (NFPAT This REQUIREMENT Descriptions of the residual descriptions of the residual descriptions of the residual documentation that presented to confident condition that presented to confident descriptions of the residual documentation that presented to confident descriptions of the residual documentation that presented to confident descriptions of the residual documentation that presented to confident descriptions of the residual documentation that presented to confident descriptions of the residual documentation that presented to confident descriptions of the residual documentation that presented to confident descriptions of the residual description descriptions of the residual descriptions of the residual	ons include a complete art and automatic or manual soloads, and are conducted by anel. Maintenance and testing of ver sources (Type 3 EES) are in NFPA 111. Main and feeder to e inspected annually, and a dically exercising the tablished according to uirements. Written records of testing are maintained and EES electrical panels and d, readily identifiable, and mal power circuits. Minimizing amage of the emergency power consideration for new (NFPA 99), NFPA 110, NFPA	K 9	Maintenance will conduct m inspection and testing of the emergency generators. The 36 month □ 4-hour load was last completed on 2/8/2 The monthly inspections and be included in the facility premaintenance program. All inspections, tests and mathe emergency generators with elife safety binder. And will by the Environmental services responsible for the corrective monitoring of compliance.	d bank test 2022. Id testing will eventative aintenance of vill be kept in ill be audited es director. S Director is	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		. ,	(X3) DATE SURVEY COMPLETED	
		245359	B. WING		0	08/23/2023	
	PROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP C 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	-		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		I SHOULD BE	(X5) COMPLETION DATE	
K 918	PM, it was revealed documentation that presented to confir bank testing of the is occurring. An interview with Management of the last section of	petween 9:00 AM and 12:00 d by review of available there was no documentation in that 36 month - 4-hour load facility emergency generators. Italiantenance Director verified ings at the time of discovery.	K 9	018			

F5359035

PRINTED: 09/26/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '			E SURVEY PLETED	
		245359	B. WING _		08/	23/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICITION DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	K 00	00		
	FIRE SAFETY	BLDG 02				
	conducted by the Manager Public Safety, State 108/23/2023. At the HAVEN CARE CEN not in compliance with participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Chapter 18 New Headition of NFPA 99, THE FACILITY'S PALLEGATION OF CODEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICAL UPON RECEIPT OF CONDUCTED TO SUBSTANTIAL CORDUCTED TO SUBSTANTIAL COREGULATIONS HAACCORDANCE WITH CORRECTION FOR CORRECTION F	MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO:				
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D.				
_ABORATOR\	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			TE SURVEY MPLETED	
	245359	B. WING		08/	23/2023	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER II	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
DEFICIENCY MUST FOLLOWING INFO 6. A detailed describation or planned to 7. Address the merplace to ensure the 8. Indicate how the future performance sustained. 9. Identify who is rractions and monitor 10. The actual or protection and monitor 10. The actual or protection was concept to be Type Because of the date was surveyed per the Fire Protection Associations and surveyed per the policy of the date was surveyed per the protection Associated and the surveyed per the protection Associated	Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: ription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. roposed date for completion of E CENTER - BLDG 02 is a with no basement onstructed in 2016 and	K 0				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			E SURVEY IPLETED	
		245359	B. WING		08/	23/2023
	PROVIDER OR SUPPLIER VEN CARE CENTER I	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG) BE	(X5) COMPLETION DATE
K 353	automatic sprinkler system with smoke spaces open to the automatic fire deparation of the building is attached to the center of the surface o	protected throughout by an system and has a fire alarm detection in the corridors, corridors that is monitored for artment notification. The ched to PINE HAVEN CARE that which was determined to be struction. There is a 2-hour rating the two buildings, and reveyed as two buildings. The chedital process of the surveyed as two buildings, and reveyed as two buildings. The chedital process of the surveyed as two buildings. The chedital process of the surveyed as two buildings. The chedital process of the surveyed as two buildings. The chedital process of the surveyed and had a stime of the surveyed. The chedital process of the surveyed and had a stime of the surveyed and had a stime of the surveyed. The chedital process of the surveyed and the surveyed and the sting are chedital process of the surveyed and testing are chedital process of the surveyed and testing are chedital process of the surveyed and testing are chedital process of the surveyed and the surveyed as two buildings, and reveyed as two buildings, and rev	K3	353		10/4/23
	Provide in REMARK any non-required or	KS information on coverage for				

AND DIANIOE CORRECTION I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - PINE HAVEN CARE CENTER (X3) DATE COMF		E SURVEY PLETED		
		245359	B. WING		08/2	23/2023
	DER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
9.7. This by: Base and with section of the section	sed on a review staff interview, I maintain the span NFPA 101 (201 stions 19.3.5, 9.7 stion) Standard for intenance of Wastems, sections 3 deficient conditionation that sented to confirm sprinkler system on 08/23/2023 by it was revealed to confirm sprinkler system on 08/23/2023 by it was revealed to confirm sprinkler system on 08/23/2023 by it was revealed to confirm sprinkler system on 08/23/2023 by it was revealed to confirm sented to con	and NFPA 25 NT is not met as evidenced of available documentation the facility failed to inspect orinkler system in accordance 12 edition), Life Safety Code, 7.5, 9.7.6, and NFPA 25 (2011 or the Inspection, Testing, and ster-Based Fire Protection 3.3.19, 4.3, 5.1, 5.2, 5.3, 5.4. tion could have a widespread ents within the facility. etween 9:00 AM and 12:00 I by review of available there was no documentation on that quarterly inspections of ons are occurring. etween 9:00 AM and 12:00 I by review of available there was no documentation on when the last 5 year on tenance was completed. aintenance Director verified ongs at the time of discovery. Out of Service	K 354	The 5 year inspection and mainter was last completed on 10/18/2021. Quarterly inspections of the sprinkl systems will be conducted and the documented. The quarterly inspections will be scheduled and documented in the preventative maintenance program sprinkler inspection company will e the maintenance staff on the condu of the quarterly inspections. The inspections will be reviewed in The Environmental Services Direct responsible for the corrective action monitoring of compliance.	er The ducate acting QAPI. for is and	10/4/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING (E SURVEY PLETED			
		245359	B. WING		08/2	23/2023
	PROVIDER OR SUPPLIER	NC	21	REET ADDRESS, CITY, STATE, ZIP CODE O NORTHWEST 3RD STREET NE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 354	or designated repredepartment and oth jurisdiction have be sprinkler system is hours in a 24-hour of the building affect approved fire watch system has been re 18.3.5.1, 19.3.5.1, 9.3.5.1, This REQUIREMENT by: Based on a review and staff interview, a sprinkler system of 101 (2012 edition), 19.3.5.1, 9.7.5 and Standard for the Instantance of Wassystems, section 15 condition a widespression a widespression a widespression a widespression of the facility. Findings include: On 08/23/2023 betwith was revealed by redocumentation that presented to confirm sprinkler system - 6. An interview with Management of the presented w	are submitted to management esentative, and the fire per authorities having en notified. Where the out of service for more than 10 period, the building or portion eted are evacuated or an is provided until the sprinkler eturned to service. 9.7.5, 15.5.2 (NFPA 25) NT is not met as evidenced of available documentation the facility failed to implement out of service policy per NFPA Life Safety Code, section NFPA 25 (2011 edition) spection, Testing, and periodic and impact on the residents of this deficient condition could impact on the residents within	K 354	A sprinkler system □ out of service was developed and reviewed by Q/Staff education was completed on the new policy. The policy will continue to be reviewed and updated through QAPI. The Environmental Services Direct responsible for the corrective action monitoring of compliance.	API. the ved or is	
	•	ling Spaces - Smoke Barrie	K 372			10/4/23

l ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG 02 - PINE HAVEN CARE CENTER	(X3) DATE SURVEY COMPLETED	
		245359	B. WING _		08/2	23/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 372	Construction 2012 EXISTING Smoke barriers shafire resistance ratin be permitted to terr Smoke dampers ar penetrations in fully an approved sprink smoke compartments barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This REQUIREMENT by: Based on a review and staff interview, test, and inspect the system per NFPA 1 Code, sections 8.5, 105 (2010 edition) Assemblies and Ot section 6.5.2 This a widespread impart facility. Findings include: On 08/23/2023 betwit was revealed by a documentation that presented to confirm dampers, the locatin and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and that the facility of fire / smoke dampers and the first facility of fire / smoke dampers and the facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first facility of fire / smoke dampers and the first	all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall minate at an atrium wall. The not required in duct of ducted HVAC systems where all ler system is installed for ents adjacent to the smoke small smoke control system. The shall be documentation the facility failed to maintain, the facility failed to maintain, the facility smoke dampers of (2012 edition), Life Safety 8.5.5.2, 8.5.5.4.2, and NFPA of Standard for Smoke Door ther Opening Protectives, deficient condition could have control to the residents within the smoke on of fire / smoke dampers, is timeframe compliant testing in the facility has fire / smoke on of fire / smoke dampers, is timeframe compliant testing	K 37	Information on the facility fire/smodampers has been obtained. An inspection of the fire/smoke damplast completed on 10/4/2021 Annual inspection of the smoke dawill be scheduled and maintained facility preventative maintenance pand any needed maintenance will completed. Environmental services will monito assure inspections are completed The Environmental Services Direct responsible for the corrective action monitoring of compliance.	ers was ampers in the program be or to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245359	B. WING		08/23/2023
	NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC			TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION
	signal and simulation conditions. Fire drill unexpected times used to least quarterly on exist with procedures and established routines between 9:00 PM announcement may alarms. 19.7.1.4 through 19.7.1.4 throug	of available documentation the facility failed to conduct 101 (2012 edition), Life Safety 7.1. This deficient condition ned impact on the residents ween 9:00 AM and 12:00 PM,	K 712	The facility fire drill policy and procedus been reviewed and revised. State have been educated on the updated policy and procedure. Fire drills will conducted on each shift every quart fire drills per quarter. A schedule to conduct the fire drills monthly basis was developed to asset the fire drills will occur on each shift rotating basis and at staggering time. Documentation of the drills will be completed at the time of each drill, when the life safety binder. Environmental Services will present fire drills for review at the safety committee meeting and at QAPI. The Environmental Services Director responsible for the corrective action monitoring of compliance.	aff be er □ 3 on a sure on a es. will be the
K 761 SS=F	Maintenance, Inspe CFR(s): NFPA 101	ection & Testing - Doors	K 761		10/4/23
	Maintenance, Inspe	ection & Testing - Doors			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION 3 02 - PINE HAVEN CARE CENTER	(X3) DATE SURVEY COMPLETED		
		245359	B. WING		08/2	23/2023
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	annually in accordator Fire Doors and Non-rated doors, in patient rooms and stroutinely inspected maintenance progrational programments and setting possess know that demonstrates as Written records of it maintained and are 19.7.6, 8.3.3.1 (LSC 5.2, 5.2.3 (2010 NFT This REQUIREMENT by: Based on document the facility failed to NFPA 101 (2012 expections 7.2.1.15, as sections 5.2.1. The have a widespread the facility. Findings include: On 08/23/2023 between the facility. Findings include: On 08/23/2023 between the facility. An interview with Mathis deficient finding the finding of t	ies are inspected and tested nce with NFPA 80, Standard Other Opening Protectives. cluding corridor doors to smoke barrier doors, are as part of the facility am. ing the door inspections and owledge, training or experience ability. Inspection and testing are available for review. C) PA 80) NT is not met as evidenced and review and staff interview inspect and test doors per lition), Life Safety Code, and NFPA 80 (2010 edition), his deficient condition could impact on the residents within ween 9:00 AM and 12:00 PM, review of available there was no documentation in that the facility is conducting e, inspection and testing of aintenance Director verified at the time of discovery.	K 76	Maintenance department will condannual maintenance, inspection antesting of the fire doors. The maintenance, inspection, and of the fire doors will be included in preventative maintenance program Environmental Services will audit the preventative maintenance program assure the maintenance, inspection testing of the fire doors is schedule completed. It will be reviewed at Completed. It will be reviewed at Completed to the corrective action monitoring of compliance.	testing the the to n, and ed and API. for is	10/4/23
K 914 SS=F	CFR(s): NFPA 101	- Maintenance and Testing	K 914			10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` '	` ′	TIPLE CONSTRUCTION NG 02 - PINE HAVEN CARE CENTER	(X3) DATE SURVEY COMPLETED	
		245359	B. WING		08/23/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPROPRIES OF CROSS-REFERENCE)	JLD BE	(X5) COMPLETION DATE
K 914	Hospital-grade reclocations and whe anesthesia is adminstallation, replace testing is performed documented perfolisted as hospital-grade tested at intervals isolation monitors intervals of less thactuating the LIM which activates be LIM circuits with a manual test is perfequal to 12 month 6.3.3.3.2 after any electric distribution maintained of require pairs or modificate area tested, and reference tested, and reference tested and staff interview electrical receptate NFPA 99 (2012 ed Code, section(s) 6 deficient condition impact on the residual transportation that presented to confirmation that presented the confirmation that presented the confirmation that presented the con	septacles at patient bed re deep sedation or general inistered, are tested after initial ement or servicing. Additional ed at intervals defined by rmance data. Receptacles not grade at these locations are not exceeding 12 months. Line (LIM), if installed, are tested at an or equal to 1 month by test switch per 6.3.2.6.3.6, oth visual and audible alarm. For utomated self-testing, this formed at intervals less than or s. LIM circuits are tested per repair or renovation to the a system. Records are uired tests and associated ations, containing date, room or	K 9	Maintenance will conduct annual inspection and testing of electric in all resident rooms. Testing witension, operation and polarity. The inspection and testing of the outlets will be scheduled and do in the preventative maintenance. The documentation will be audit environmental services director. The Environmental Services Dir responsible for the corrective acmonitoring of compliance.	al outlets Il include electrical cumented program. ed by the ector is	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G 02 - PINE HAVEN CARE CENTER	(X3) DATE SURVEY COMPLETED			
		245359	B. WING			08/23/2023	
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963	_ -		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 914	Continued From pa located in resident An interview with M		K 91	4			
		g at the time of discovery. - Essential Electric Syste	K 91	8		10/4/23	
	Maintenance and T The generator or of and associated equivariated within 10 secriterion is not met process shall be process and with NFPA 110. Generator sets are under load 30 minured and conditions simulated cold standard transfer of all EES competent personnatored energy power accordance with NFC circuit breakers are program for periodic components is established to the process of	resting other alternate power source sipment is capable of supplying econds. If the 10-second during the monthly test, a covided to annually confirm this esafety and critical branches. The esting of the generator and reperformed in accordance inspected weekly, exercised exercised once every 36 exercised once every 36 exercised once every 36 exercised once every 36 exercised once and test in sinclude a complete than automatic or manual loads, and are conducted by ele. Maintenance and testing of er sources (Type 3 EES) are in EPA 111. Main and feeder exinspected annually, and a cally exercising the esting are maintained and ES electrical panels and readily identifiable, and hal power circuits. Minimizing mage of the emergency power consideration for new					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - PINE HAVEN CARE CENTER			(X3) DATE SURVEY COMPLETED			
		245359	B. WING _		08/2	23/2023		
	PROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 918	111, 700.10 (NFPA This REQUIREMEND): Based on a review and staff interview, facility emergency promponents per NFC Care Facilities Code 6.4.4.1.1.4, 6.4.4.2 Standard for Emergency Systems, sections and deficient condition of impact on the resident findings include: 1. On 08/23/2023 be PM, it was revealed documentation that presented to confirm testing of the facility occurring. 2. On 08/23/2023 be PM, it was revealed documentation that presented to confirm testing of the facility occurring. An interview with Mercental section of the facility occurring.	NFPA 99), NFPA 110, NFPA	K 91	Maintenance will conduct monthly inspection and testing of the facility emergency generators. The 36 month □ 4-hour load bank was last completed on 2/8/2022. The monthly inspections and testin be included in the facility preventat maintenance program. All inspections, tests and maintenathe emergency generators will be athe life safety binder. And will be athe life safety binder are by the Environmental Services Direct responsible for the corrective action monitoring of compliance.	test g will ive nce of cept in udited ctor. tor is			



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 <u>only a suggestion</u> 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.

Pine Haven Care Center Inc September 13, 2023 Page 2

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

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

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00148	B. WING		C 08/24/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE	-	
PINE HA	VEN CARE CENTER I	NC 210 NOR	THWEST 3RI AND, MN 559	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLE	ETE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defication herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of the requirements of the number and MN Ru When a rule contain comply with any of lack of compliance, re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag ale number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department with	hearing on any assessments non-compliance with these to a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your faminnesota Department facility was NOT in Licensure and the finissued. Please indicates	CS: 23, a licensing survey was acility by surveyors from the nent of Health (MDH). Your compliance with the MN State ollowing correction orders are cate in your electronic plan of a reviewed these orders and				

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Electronically Signed

09/23/23

If continuation sheet 1 of 9

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00148	B. WING		C 08/24/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
PINE HA	VEN CARE CENTER I	NC	THWEST 3RE			
(V A) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	, 	PROVIDER'S PLAN OF CORRECTION	ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	identify the date wh	en they will be completed.				
	H53594655C (MN0 with a licensing order H53594707C (MN0 order issued at 083 The following comp H53594603C (MN0 H53594603C (MN0 H53594703C (MN0 H53594704C (MN0 H53594706C (MN0 orders were issued. Minnesota Department the State Licensing federal software. Ta assigned to Minnesota Department the State Licensing federal software. The appears in the far leaders in the far leaders in the far leaders in the state of the Suggested of the Suggested of the Suggested of the Minnesota Department on the findings which a statute after the state of the Suggested of the Suggested of the Suggested of the Minnesota Department of the	laints were reviewed: 0095890), 0096050), 0095440), 0095613 and MN00095690), 0094879), 0091481), and NO licensing lent of Health is documenting Correction Orders using lent of Health is documenting correction Orders using lent of a state statutes/rules for le assigned tag number left column entitled "ID Prefix left column entitled "ID Prefix left column entitled "ID Prefix left column also includes left in violation of the state lement, "This Rule is not met llowing the surveyors findings left had of Correction and left rection. participate in the electronic left consistent with left rection of Health				

Minnesota Department of Health

STATE FORM VM5311 If continuation sheet 2 of 9

Minnesota Department of Health

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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/inf obul.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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1 ` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER INC 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 (X4) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG 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			D WINC				
PINE HAVEN CARE CENTER INC 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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/inf obul.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		00148	B. WING		08/2	4/2023	
PINE HAVEN CARE CENTER INC	NAME OF PROVIDER OR SUPPLIE	ROVIDER OR SUPPLIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION & COMPLE PREFIX TAG CROSS-REFERENCE OF TO THE APPROPRIATE DATE	PINE HAVEN CARE CENTE	EN CARE CENTER INC					
### REGULATORY OR LSC IDENTIFYING INFORMATION) 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/inf obul.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 EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE DEFICIENCY) 2 000 2 000 E(ACH CORRECTIVE ACTION TO THE CROSS-REFERENCED TO TH	OVANID SLIMMADV S				TION	()/[)	
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/inf obul.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	PREFIX (EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE DATE	
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/inf obul.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	2 000 Continued From	Continued From page 2	2 000				
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.	is necessary for senter the word "of text. You must the State licensure prompletion date, corrected prior to Minnesota Depart PLEASE DISREGATION FOURTH COLUM "PROVIDER'S PLAPPLIES TO FEITHIS WILL APPEIS NO REQUIRE CORRECTION FOURTH CORRECTION FOURTH COLUMNESOTA STATE AND A STATE AN	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/inf obul.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.					

Minnesota Department of Health

STATE FORM VM5311 If continuation sheet 3 of 9

Minnesota Department of Health

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED	
		00148	B. WING			C 24/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
PINE HA	VEN CARE CENTER I	NC	HWEST 3RI AND, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 3	2 830				
2 830	Proper Nursing Car Subpart 1. Care in	Subp. 1 Adequate and e; General general. A resident must e and treatment, personal and	2 830			9/23/23	
	custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care, and the individual needs and the comprehensive plan of care as design.	supervision based on dispresent assessment and scribed in parts 4658.0400 and any home resident must be out possible unless there is a ne attending physician that the in in bed or the resident					
	by: Based on interview, facility failed to implor of 3 residents (R61) addition, the facility for 1 of 3 residents	ent is not met as evidenced and document review, the ement fall interventions for 1 reviewed for accidents. In failed to modify interventions (R24) reviewed for accidents.		Corrected			
	Findings include: R61						
	Report, dated 5/04/2 was being transferred wheelchair when nurealized the foot per present on R61's with returned to R61's returned to R61's refloor. R61 complain	y Fall Investigation Incident 23 at 3:30 p.m., revealed R61 ed out of the bedroom via ursing assistant (NA)-B dals and arm bar were not heelchair. While NA-B oom to obtain forgotten items, wheelchair and hit head on the ned of head hurting and the 1's daughter were contacted.					

Minnesota Department of Health

STATE FORM VM5311 If continuation sheet 4 of 9

Minnesota Department of Health

00148 B. WING 08/24/20 NAME OF PROVIDER OR SURPLIER STREET ADDRESS CITY STATE ZIR CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF DROVIDER OR SUDDUED.			00148	B. WING		1	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE HAVEN CARE CENTER INC PINE ISLAND, MN 55963		ROVIDER OR SUPPLIER	NC 210 NOR1	HWEST 3RE	STREET		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
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 traurnatic 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.	Rein Renooww Rijoelduo RR pidetifiao RdasRwein In	R61 was transferred returned that evening injuries noted from the reside of R61's Faresident's electronic revealed the reside on 7/04/20, with dialoste oporosis, chroroweakness and traus without loss of constitution on and electronic revealed the reside on 7/04/20, with dialoste oporosis, chroroweakness and traus without loss of constitution on and electronic revealed selectronic reports of R61's can an electronic reports and the following room or the filip-away tray on what and hand position the footrest of the Review of R61's Visit dated 8/24/23, identified as going to the R61 had a flip-away with right arm and hand resident right right arm and hand resident right right right arm and hand resident right r	d to the emergency room and ng of 5/4/2023, with no the fall. Ice Sheet, located in the emedical records (EMR) nt was admitted to the facility gnoses which included nic pain, epilepsy, muscle matic subdural hemorrhage sciousness. Inual Minimum Data Set 23, identified R61 was adicated R61 required se of one person for off the unit. Identified R61 for mobility and was impaired for mobility and was impaired for and lower extremities. Ire plan dated 3/8/23, identified flocomotion/positioning ing interventions were sired total assistance from staff of distances, such as going to to activities. R61 had a neelchair to assist with right sioning, ensure right foot was neelchair. Is wal/Bedside Kardex Report, tified R61 required total aff wheeling longer distances, edining room or to activities. If the total wheelchair. If wheelchair.				

Minnesota Department of Health

STATE FORM VM5311 If continuation sheet 5 of 9

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00148			B. WING		C 08/24/2023	
	PROVIDER OR SUPPLIER	NC 210 NORT	DRESS, CITY, S HWEST 3RI AND, MN 559			
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
	director of nursing (administrator met windicated they wheel down from R61's rounded not have the arrowheelchair. They tuitems, NA-B began again when R61's fell out of the wheel provided immediate expected use of the for R61. The DON's major injuries howed on face. The DON's for staff to follow the for residents. During an interview nurse manager intente wheelchair to go NA-B realized they pedals and arm residents and arm residents. DON. NMI stated they asson DON. NMI stated Resident and Resid	on 8/24/23 at 10:07 a.m., the (DON) stated she and the with NA-B after the fall. NA-B eled R61 about two rooms from when NA-B realized they in board or foot pedal on the trined around to retrieve the to push R61 in her wheelchair oot became caught and R61 chair. The DON stated they eleducation to NA-B about the effoot pedals and arm board stated R61 did not have any ever did have bruising present stated their expectations were elecare planned interventions on 8/24/23 at 10:20 a.m., the erim (NMI) stated NA-B turned to back to R61's room after didn't have wheelchair foot ton the chair and R61 fell. Sessed R61 and called the left was sent out by local emergency department to left returned to the facility the najor injuries. NMI confirmed by the plan of care for R61. The lectation was for staff to follow				
	R24	imum Data Cat (MADO) alataal				
	6/22/23, indicated s and included diagno dysfunction, trauma	imum Data Set (MDS) dated severe cognitive impairment oses of non-traumatic brain atic subarachnoid hemorrhage had a history of multiple falls				

Minnesota Department of Health

STATE FORM VM5311 If continuation sheet 6 of 9

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED	
	00148	B. WING		1) 4/2023
ROVIDER OR SUPPLIER	NC 210 NORT	HWEST 3RI	STREET		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
since admission. R24's Care Area As 3/23/23, indicated a included, cognitive I and falls. R24's care plan dat was at risk for falls gait/balance probler goal was R24 would review period. Toiler on 5/28/2023, identitoileting at 6:30 a.m and before going to Review of R24's prohad falls on 5/28/23 Review of the Post 5/28/23, to 6/26/23, to 6/26/23, to 6/26/23, -5/28/23 at 4:20 p.m in the bathroom and Toileting intervention plan. -6/12/23 at 3:49 p.m in the bathroom by incontinent and the self-transferred to the The evaluation lack interventions were exercised.	sessment (CAA) dated reas to focus specialized care oss/dementia, visual function ed 11/15/22, indicated R24 related to confusion, ms and history of falls. The dibe free of falls through the ting interventions which began ified staff were to provide, after lunch, before supper bed. Ogress notes indicated R24 , 6/12/23 and 6/26/23. Fall Evaluations (PFE) from identified the following: In. R24 was found on the floor dihad been incontinent. In swere added to the care In., R24 was found on the floor a family member. R24 was root cause revealed R24 had the bathroom due to confusion. The effective or needed to be and indicated R24 was found on the floor and family member. R24 was root cause revealed R24 had the bathroom due to confusion. The effective or needed to be and indicated R24 was found and ind	2 830	DEFICIENCY)		
and pants down to a indicated R24 was a	above her knees. The PFE attempting to self-toilet and				
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pages ince admission. R24's Care Area As 3/23/23, indicated a included, cognitive I and falls. R24's care plan dat was at risk for falls igait/balance probler goal was R24 would review period. Toiled on 5/28/2023, identitoileting at 6:30 a.m and before going to Review of R24's prohad falls on 5/28/23 Review of the Post 5/28/23, to 6/26/23, -5/28/23 at 4:20 p.m in the bathroom and Toileting intervention plan. -6/12/23 at 3:49 p.m in the bathroom by incontinent and the self-transferred to the The evaluation lack interventions were exercised. -6/26/23 at 9:37 p.m on the floor against and pants down to a indicated R24 was a findicated R24 was a findi	ODENTIFICATION NUMBER: OD148 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 plan6/12/23 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	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, S 210 NORTHWEST 3RI PINE ISLAND, MN 55' SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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	DENTIFICATION NUMBER: 00148 **BUNING** **BUNING** **BUNING** **BUNING** **BUNING** **BUNING** **STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET **PINE ISLAND, MN 55963 **SUMMARY STATEMENT OF DEFICIENCIES** (##ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **CROSS-REFERENCEOT OT THE APPRO DEFICIENCY* **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 5/28/203, 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 8/26/23, 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 and had been incontinent. Toileting interventions were added to the care plan. -6/12/23 at 9:37 p.m., indicated R24 was found on the floor in 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-foliet and	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL RECULATORY OR LSC IDENTIFYING INFORMATION). 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, gali/balance problems and history of falls. The goal was R24 would be free of falls through the review period. Toileting interventions which began on 5/28/20/3, identified staff were to provide toileting at 6:30 a.m., after lunch, before supper and before going to bed. Review of the Post Fall Evaluations (PFE) from 5/28/23, to 6/26/23, identified staff were to provide 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 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-foiled and

Minnesota Department of Health

STATE FORM VM5311 If continuation sheet 7 of 9

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
	00148	B. WING			C 24/2023	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN CARE CENTER I	NC 210 NOR	DRESS, CITY, ST THWEST 3RD AND, MN 559	STREET			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
During an interview nursing assistant (New several falls since as believed most of the needs. During an interview registered nurse (Reattended the interded meetings and the IDT independently as the they would not review the interventions we modification. RN-Ae aware R24 had seven During an interview director of nursing (confirmed the IDT falls as part of the modifying or impleman effort to prevent Review of a facility and Reduction date would be reviewed would be taken to dwould determine the would implement in cause of the fall. Review of a facility Accident/Hazards/San/22, revealed the	ocumentation if the current effective or required revision. on 8/23/23 at 9:48 a.m., NA)-A stated R24 has had arriving at the facility. NA-A e falls were related to toileting on 8/23/2023 11:26 a.m., N)-B and RN-C stated they epartmental team (IDT) of reviewed resident falls. Treviewed each fall ey occurred and confirmed ew prior falls to determine if ere effective and required and RN-B stated they were reral falls. on 8/23/23 at 12:45 p.m., the (DON) reviewed R61's prior oot cause analysis to assist in nenting new interventions in further falls. policy titled Fall Prevention of 7/22, indicated all falls and preventive measures lecrease falls. The facility e root cause to the fall and terventions specific to the	2 830				

Minnesota Department of Health

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE HAVEN CARE CENTER INC 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 8 2 830 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			00148	B. WING		1		
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) 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			00146			1 08/2	4/2023	
PINE ISLAND, MN 55963 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	210 NORTHWEST 3RD STREET							
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	PINE HAVEN CARE CENTER INC							
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	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE			
	2 830	supervision and associated to prevent included and was not interventions to reduce the SUGGESTED MET director of nursing (preview applicable president' falls; then the comprehensive planning of such evaludit to ensure ong TIME PERIOD FOR	sistive devices to each avoidable accidents. This of limited to implementing uce hazards and risks. THOD OF CORRECTION: The DON), or designee, could olicies and procedures for revise as needed to ensure assessment and care ents; then educate staff and oing compliance.	2 830				

Minnesota Department of Health