Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 6, 2024

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

RE: CCN: 245359
Cycle Start Date: July 17, 2024

Dear Administrator:

On July 17, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, Minnesota 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by October 17, 2024 (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 January 17, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING _____ B. WING _____	C 07/17/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/15/24, thru 7/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/15/24, thru 7/17/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: MN00097175 H53595580C MN00104697 H53595399C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2024

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

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to determine if self-administration of medication was appropriate for 1 of 1 resident (R 25) reviewed who was left alone to administer a medication with out staff present. Findings include: R25's quarterly Minimum Data Set (MDS) assessment, dated 5/15/24, indicated intact cognition, diagnosis of interstital pulmonary disease, and required assistance from staff for activities of daily living (ADL) and mobility. R25's physician's orders dated 4/10/24, indicated Budesonide inhalation suspension 0.5 milligram (mg)/2 milliliter (ml), 0.5 mg inhale orally via nebulizer two times a day related to interstitial pulmonary disease. Rinse mouth with water after use to reduce after taste and incidence of candidiasis (yeast infection). Do not swallow. R25's self administer medications (SAM) assessment dated 5/14/24, indicated R25 required assistance with inhalant medications, although marked in another area she was able to administer her own medications. R25's care plan dated indicated R25 may self administer the following medications: inhalers.	F 554	" R25 discharged on 7/26/2024. " All residents with a nebulizer have the potential to be affected. " All current residents receiving nebulizers had their Self Administration of Medication (SAM) assessment reviewed and revised as needed. " Policy and Procedure on Self administration of medications reviewed and updated. " LPN-B who noted to not know our process was an agency nurse who is on the do not return list since 7/25/2024. " Education to the licensed nursing staff on Self Administration of Medications policy and the assessment will be completed. " IDT team members were educated that SAM will be reviewed at daily IDT resident review. " All residents admitted with a nebulizer order will have a Self-Administration of Medication assessment completed. Self-Administration of Medications orders completed. " Corrective actions to monitor that deficient practices are being corrected and will not reoccur. Self-Administration of Medication Audit will be completed on 3 residents on each unit (Unit 200-400, Unit 500, & Unit 600) weekly x 4 weeks, then	8/26/24

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F 554	Continued From page 2 Ability to safely and accurately self administer select medications and continued desire to do so, will be evaluated on a quarterly and as needed basis. It also included the following interventions: ·Medications as ordered. ·Periodic self administration assessment by licensed nurse. ·Staff to assess for compliance with keeping mask on after set up and start of nebulizer periodically. ·Staff to assess periodically for self administration of nebulizer after set up and start. ·Staff to set up medications as ordered. During an observation on 7/15/24 at 9:37 a.m., R25 was sitting in her room with her mask on receiving a nebulizer treatment and there were no staff present. At 9:42 a.m., she took the mask off, looked at the medication cup, and shut off the nebulizer. She had another vial of medication in her hand and the surveyor asked her what the medication was. R25 responded "I don't know, I just take what they give me." She stated she takes a duo neb so staff set up the first one and she puts the medication in for the second one. R25 proceeded to squeeze the vial of medication through the hole hole of the mask (without removing the mask first from the medication cup holder) most of the drops were going into the lip of the mask and not into the cup. R25 stated it would probably work better if she took the mask off. Then she threw the vial into the garbage. During interview on 7/16/24 at 1:37 p.m., trained medication assistant (TMA)-A stated "I don't have a good answer for you." when asked how he would know if a resident was able to self administer medication. TMA-A further stated when administering a nebulizer, he would set it up	F 554	monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " All staff education provided on 8/14/2024 " Responsible party: Director of Nursing or Designee " Date of compliance 8/26/2024	

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F 554	Continued From page 3 for the resident and then leave the room and wouldn't wait until it had been administered. During interview on 7/16/24 at 1:41 p.m., licensed practical nurse (LPN)-B stated in order for a resident to self administer their medication they need to have a physician's order but don't necessarily need an assessment. LPN-B further stated when administering a nebulizer "I'll put the medication in the nebulizer (for the resident) and then walk out and come back to make sure it's being done." R25 should not be setting up her nebulizer/putting the medication in the cup by herself. "I've noticed overnights have left the vials of medication in her (R25) room before, and I've had to remove them. During interview on 7/16/24 at 3:12 p.m., registered nurse (RN)-A stated in order for a resident to be able to self administer medications, there needs to be a desire to do so, an assessment (SAM) which included the resident being aware of what medication was being given and a return demonstration. Then they would work with the care team to get a doctor's order. RN-A further stated R25 was able to be left alone once the nebulizer had been set up and verified there was a discrepancy in the SAM assessment. R25's medications should not be left in her room and she shouldn't be setting up her nebulizer treatments on her own. "I would expect the medication administration record (MAR) to specify "can self administer after set up." If a resident has not been assessed and was unable to administer their own medications, the nurse would need to wait until the medication was taken or the nebulizer treatment was completed. During an interview on 7/17/24 at 2:07 p.m. the	F 554		

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F 554	Continued From page 4 director of nursing (DON) stated in order for a resident to administer their own medications there would need to be a SAM assessment to determine which medications they are able to administer, a desire to self administer, and then they would ask the provider for an order. The order would be listed under orders and it should be written on the MAR. She would like the SAM to be more specific indicating R25 could administer medication "after set up." The discrepancy could be confusing if it's not filled out completely and would like there to be a note. It was important to ensure a resident has been assessed to self administer their medications because they are constantly changing and we want to know what is going on and why. It's important to keep the residents safe, things change and we need to make sure they are still able to keep administering medications safely. The facility's policy on self administration of medication dated 2/2017, indicated Pine Haven Care Center will allow alert, oriented, physically able residents to self-administer their medications. Residents have the right to self administer medication if the interdisciplinary team deems this practice clinically appropriate. Residents who desire to administer their own medications will be assessed to assure that medications will be safely administered.	F 554		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		8/26/24

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F 656	Continued From page 5 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 6 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive and individualized care plan was developed for 1 of 2 residents (R3) reviewed for psychotropic medication use. Findings include: R3's quarterly Minimum Data Set (MDS)assessment, dated 4/23/24, indicated R13 had mild cognitive impairment and diagnoses of bipolar disorder (mood disorder that caused intense shifts in mood and behaviors). R3 had no behaviors, delusions, or refusal of cares. Furthermore, R3's MDS indicated R3 received psychotropic medications on a routine basis. R3's psychotropic care area assessment (CAA) dated 11/3/23, indicated R3 currently received psychotropic medications and directed monitoring of R3's behaviors and mood was required. R3's care plan revised 4/23/24, indicated R3 required the use of psychotropic medications related to behavior management of depression and delusional disorder. Non-pharmacological interventions last revised on 7/26/2020, directed staff to discuss ongoing need of medication with provider and family, consult with pharmacy, provider, and family to consider GDR, monitor delusions of items stolen or missing from room, refusal of cares, and increased self-isolation and monitor/document mood or behavior changes. R3's care plan included the individualized intervention directing staff to provide assurance daughter has perceived missing or stolen items.	F 656	" (R3) Resident psychotropic care plan and Kardex reviewed and revised. " All residents receiving psychotropic medications have the potential to be affected. " Policy and Procedure on Care Plans, Comprehensive Person-Centered reviewed and updated. " Education to nursing staff on development and implementation of comprehensive care plan of psychotropic medications and required components 9on 8/14/2024. " All new admissions and current residents on psychotropics will be have their care plan reviewed and updated to reflect non-pharmological interventions. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " Responsible party: Director of Nursing or Designee " Date of compliance: 8/26/2024	

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F 656	Continued From page 7	F 656		

R3's care plan lacked individualized non-pharmacological interventions to support R3's mood and to minimize self-isolation, lethargy, and refusals of care.

R3's Kardex (used by nursing assistants) as of 7/15/2024, directed nursing assistant (NA) staff to not contradict R3's delusions of items being missing or stolen. Staff were directed to inform R3 their daughter has taken them to be repaired. R3's Kardex lacked interventions to support R3's mood and to minimize self-isolation, lethargy, and refusals of care.

When interviewed on 7/17/24 at 11:51 a.m., nursing assistant (NA)-B stated the Kardex should have information to let staff know what distractions or redirections worked for residents who were in an "off mood" or had behaviors. NA-B further stated R3 had good and bad days. Some days she was out and involved in activities and other times remained in her room. R3 also had days where she was sleepy or lethargic at times. NA-B encouraged R3 to get out for activities and to sit in the sunshine. NA-B further stated R3 liked to read. NA-B was not aware of any verbal behaviors or thinking items were stolen from her room.

When interviewed on 7/17/24 at 1:24 p.m., licensed practical nurse (LPN)-A stated if a resident was having increased anxiety or delusions, they would review the care plan and chart for guidance on what interventions worked for the resident. LPN-A further stated what works for one resident may not work for another one and how to address the behavior and be successful and decreasing it was important. LPN-A was not aware of any behaviors or refusal

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F 656	Continued From page 8 of cares. LPN-A further stated R3 had no verbal or aggressive behaviors and was generally calm. LPN-A verified the only individualized intervention listed in the care plan was to let R3 know her family had items she thought were stolen. LPN-A stated she was not aware of that behavior and had not known R3 to think items were missing or stolen. When interviewed on 7/17/24 at 3:50 p.m., the interim Director of Nursing (DON) stated residents on psychotropic medications required monitoring of behaviors the medication was hopefully helping. If behaviors or mood changes were present, staff would provide interventions that were individualized and specific as possible to the resident. Interim DON reviewed R3's care plan and verified it lacked individualized interventions to support R3's mood and behaviors. Interim DON expected staff to review and revise the care plan quarterly and with identified changes to mood or behaviors. Furthermore, the interim DON expected staff to ensure individualized non-pharmacological interventions were in place.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		8/26/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 by: Based on observation, interview, and document review the facility failed to identify and monitor bruising for 1 of 1 residents (R37) observed for skin alterations and failed to ensure open wounds related to moisture associated skin damage (MASD, inflammation and skin deterioration due to moisture) were routinely assessed for healing for 1 of 1 residents (R22) reviewed for non-pressure wounds. Findings include: R37's quarterly Minimum Data Set (MDS) assessment, dated 7/2/24, indicated a diagnosis of dementia and severe cognitive impairment with behaviors of inattention, and disorganized thinking. It further indicated R37 required staff assistance with activities of daily living (ADL) and mobility. During observation on 7/15/24 at 7:55 a.m., R37 was sitting in her room and had a golf ball sized bruise (above her wrist) on her left forearm. During observation 7/16/24 at 12:56 p.m., R37 was laying in bed resting, R37 was sitting in her room and had a golf ball sized bruise (above her wrist) on her left forearm. R37's physician's orders dated 6/30/24, indicated complete weekly skin inspection progress note for resident skin check every day shift on Sunday. R37's care plan dated 1/3/23, indicated R37 had an ADL self-care performance deficit r/t Activity Intolerance, confusion, dementia, limited mobility, terminal diagnoses R37 requires a skin inspection weekly and as needed by nursing.	F 684	" Resident: (R37) weekly skin assessment was completed on 8/11 & (R22) weekly skin assessment were completed on 8/14/2024 and care plans and Kardexs updated. " Pressure Ulcer/Skin Policy and Procedure reviewed and updated " Education to the nursing staff on policy and procedure(s) " Implementation of a Skin Alterations Checklist with education on August 14, 2024 to the licensed staff. " Nurse Managers will audit daily during the week the 24-hour summary report and review all skin alterations for initiation and completion of Skin Alteration Checklist weekly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " Responsible party: Director of Nursing or Designee " Date of compliance: 8/26/2024	

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F 684	Continued From page 10 Daily by nursing assistant (NA) observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. R37's progress notes dated 7/14/24, indicated skin check was completed and there was no new skin issues. During interview on 7/16/24 at 1:26 p.m., nursing assistant (NA)-A stated NA's were responsible for bathing residents once a week and the nurses were responsible for completing skin checks on bath day. The nurses were also responsible for documenting the skin checks. If the NA's noticed skin alterations in between bath days they should report it to the nurse so they can document and monitor it. NA-A verified the bruise on R37's left wrist. During interview on 7/16/24 at 1:41 p.m., licensed practical nurse (LPN)-B stated NA's bathe the residents at least once a week and on bath day, the nurses complete skin checks even if the resident refuses to take a bath. The nurses were also responsible for documenting the skin check in a progress note. The NA should report skin alterations to the nurse so they can document and monitor it until it was resolved. The nurses should also let the nurse manager know. LPN-B verified the bruise on R37's arm and stated she had never seen it before. LPN-B also stated it looked like it's new and the NA's should've reported that to her. It was not documented anywhere in the medical record. During interview on 7/16/24 at 3:12 p.m., the registered nurse (RN)-A stated NA's were responsible for giving residents a bath once a week and the nurses were responsible for	F 684		

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F 684	Continued From page 11 completing skin checks on bath day. The nurses were also responsible for documenting the skin checks. If the NA's noticed skin alterations in between bath days they should report it to the nurse so they can try to determine the cause, document it, and monitor it to make sure it doesn't get worse or until it's resolved. During an interview on 7/17/24 at 2:07 p.m., the director of nursing (DON) stated stated NA's were responsible for giving residents a bath once a week and the nurses were responsible for completing skin checks on bath day. The nurses were also responsible for documenting the skin checks. If the NA's noticed skin alterations in between bath days they should report it to the nurse so they can try to determine the root cause, document it, and monitor it to make sure it doesn't get worse or until it's resolved. There may also need to be a call to the provider. It's important to document and monitor skin alterations in order to keep the residents safe. A facility policy on skin alteration was asked for and received, however it did not address the monitoring and documentation of bruises. R22's quarterly MDS dated 5/29/24, indicated R22 was cognitively intact and had diagnoses of diabetes weakness and chronic non-pressure skin breakdown to left buttock. Furthermore, R22's MDS indicated R22 had MASD. R22's skin care area assessment (CAA) dated 9/7/23, indicated R22 had limited physical mobility, had MASD to buttock and was at risk for skin breakdown.	F 684		

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F 684	Continued From page 12 R22's care plan revised 9/7/23, indicated R22 had MASD due to immobility and refusal of assistance with personal cares. Interventions included to follow facility protocols for treatment of injury. R22's nursing progress note dated 4/17/24 at 11:24p.m., indicated a weekly skin inspection was completed and abrasions on bilateral buttocks and left posterior upper thigh were present. No further assessment or measurements were obtained. R22's nursing progress note dated 6/5/24 at 14:08p.m., indicated R22 had bleeding from the open areas on bilateral buttock. The note further indicated measurements of open areas will be obtained during wound cares the following day. R22's situation background assessment recommendation (SBAR) note dated 6/24/24 at 9:52 p.m., indicated R22 had a wound on the left and right buttocks with some drainage. R22's SBAR requested a treatment plan. R22's SBAR lacked any further description of the wounds or measurements. R22's medical record lacked indication a R22's open areas were assessed or measured since identification of them. An observation on 7/17/24 at 9:47 a.m., licensed practical nurse (LPN)-A entered R22's room to provide wound care. R22 was assisted to their side and after performing hand hygiene, gown and glove, LPN-A removed the foam dressing that was in place on R22's bottom. R22 had blanchable reddened excoriated area on bilateral buttocks. On the right side there were 2 small open areas with slight bleeding. On the left upper	F 684		

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F 684	Continued From page 13 thigh/bottom buttock were several scattered open areas that were slightly bleeding. LPN-A completed wound cares without taking any measurements of R22's open areas. When interviewed on 7/15/24 at 8:23 a.m., R22 stated he had some wounds on his bottom that were bleeding all over the place a few weeks ago. R22 stated the provider was trying to get things healed and had been dealing with this off and on for over a year now. When interviewed on 7/17/24 at 10:25 a.m., LPN-A R22's wounds were looking better and had much less bleeding. LPN-A stated an SBAR was placed to the provider a few weeks back when there was so much drainage occurring. LPN-A further stated the initial wound assessment/measurements should be included in the SBAR. LPN-A reviewed the SBAR and verified there were no measurements taken. LPN-A further stated the provider would determine if any further assessments or measurements were needed in addition to the treatment orders. Since there is no order for assessment or wound measurements that was not completed. LPN-A stated description and measurements could be placed in a progress note, but there was no other place to document that. When interviewed on 7/17/24 at 12:05 p.m., registered nurse (RN) stated not all open areas were reviewed during weekly wound rounds. MASD skin issues were assessed by the bedside nurses. RN stated nurses could not do a skin/wound assessment note as it needed to be completed capturing a photo. However, nurses were expected to assess the area and document	F 684		

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F 684	Continued From page 14 any open areas. When interviewed on 7/17/24 at 3:50 p.m., the interim DON expected staff to assess and document any open areas. Not all residents were seen during wound rounds, and bedside nurses need to ensure wound assessments and measurements are completed. If there are not monitoring orders in place, the interim DON expected staff to obtain them. A facility policy titled Pressure Ulcer/Skin breakdown- clinical protocol revised 3/2018 directed staff to initiate a skin form (pressure or non-pressure) when a skin alteration was found. Furthermore, assessment should include the wound and surrounding skin for edema, redness, drainage, healing progress and wound stage.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		8/26/24

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F 690	Continued From page 15 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper catheter management for 1 of 1 resident (R207) reviewed for catheters. Findings include: R207's admission Minimum Data Set (MDS) assessment, dated 7/4/24, indicated intact cognition, had an indwelling catheter, a trial of a toileting program had not been attempted, and was dependent on staff for toileting hygiene, and toilet transferring. R207's care area assessment (CAA) dated 7/10/24, indicated R207 had a diagnosis of urinary retention requiring foley catheter placement and was treated for a urinary tract infection upon admission with antibiotic therapy completed and her goal was to avoid	F 690	" R207 Indwelling Catheter was discontinued per MD order on 7/23/24. " All residents with an Indwelling Catheter have the potential to be affected. " All current residents with Indwelling Catheter have been reviewed for appropriate rationale. All residents admitted with a Indwelling Catheter will be assessed for appropriate rationale. Orders for residents with Indwelling catheter will be reviewed for all necessary components and verified correct. " All current residents with catheters have had their Care plan reviewed and revised. As warranted. " Policy and Procedure on Urinary Catheter Care reviewed and updated. " Education to the licensed nursing staff on Urinary Catheter Care policy including rationale, assessment, and orders will be	

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F 690	Continued From page 16 complications such as infection. R207's Medical Diagnosis form identified the following diagnoses: retention unspecified, acquired absence of left leg above the knee, disorientation, contracture of the right knee, osteoarthritis to the right knee, pain in right hip, and rheumatoid arthritis. R207's Physician's Orders Summary form identified the following orders: 7/15/24, contact precautions due to a history of CDIFF (Clostridiodes difficile, a bacteria that causes infection of the colon), MRSA (methicillin resistant staphylococcus aureus, an infection that has become resistant to many antibiotics) in left lower quadrant/left groin wound. Resident also has a urinary catheter. 6/29/24, urinary output every shift. The orders lacked information indicating when the catheter was last changed, when it should be removed, type of catheter and when to change the catheter. R207's medication administration record (MAR) and treatment administration record (TAR) for July 2024, was reviewed and lacked information regarding when catheter should be removed, and information regarding the type of catheter and when to change it. R207's care plan dated 6/28/24, indicated R207 had an indwelling catheter related to urinary retention and the goal indicated R207 would show no signs or symptoms of urinary infection through the review date. Additionally, R207's sole intervention indicated to monitor, record, report to MD (medical doctor) for signs and symptoms of a	F 690	completed. " Indwelling Catheter Audit will be completed on all residents with Indwelling Catheter weekly x 4 weeks, then monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " All staff education provided on 8/14/2024 " Responsible party: Director of Nursing or Designee " Date of compliance 8/26/2024	

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F 690	Continued From page 17 urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The care plan lacked information on the type of catheter used, when it should be changed, when it should be removed, education provided on the risks and benefits for the use of the catheter, and interventions to restore as much urinary function as possible without the use of a catheter. R207's history and physical dated 7/1/24, indicated R207 had urinary retention in the past and currently had a Foley catheter in place and recently completed cefdinir (an antibiotic) for Klebsiella UTI. The note further indicated R207 denied urinary symptoms, and did not see a voiding trial. Additionally, R207 wished to keep the catheter as she worked on transfers with therapy and was open for a trial of voiding once transfers improved. Additionally, the foley catheter had been placed during a prolonged hospitalization January 2024. A follow up visit was requested for one week to reassess the need for the catheter and if transfers improved would plan to remove the catheter and implement post void residual (PVR) monitoring given reported retention in the past. R207's faxed order scanned in the Documents tab in the electronic medical record (EMR) dated 7/8/24, indicated to encourage removal of the indwelling catheter in the next 1 to 2 weeks as R207 regains function. R207's care conference note dated 7/1/24,	F 690		

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F 690	Continued From page 18 indicated the physician proposed removing the catheter, however R207 was not ready and physical and occupational therapy was working with R207 on a slide board transfer with therapy and a hoyer with nursing staff. R207's care conference note dated 7/11/24, indicated R207 was not in agreement to remove the catheter. Additionally, R207 was working with physical and occupational therapy and was close to switching from a full body mechanical lift to a slide board, but had since refused to get up. R207's progress notes were reviewed from 6/28/24, to 7/17/24, and indicated the catheter was in place for urination. The progress notes lacked evidence of any counseling to assist R207 in understanding clinical implications and risks associated with the use of the catheter. During interview and observation on 7/15/24 at 1:15 p.m., R207 stated she did not know why she had a catheter. During interview on 7/17/24 at 1:00 p.m., physical therapist assistant (PTA)-D stated she was working with R207 on slide board transfers and leg strengthening and R207 was doing well this week. PTA-D further stated she had been working with R207 since admission and was still using a hoyer lift with nursing staff due to pain and was mainly using a bed pan. PTA-D further stated she had not seen bladder retraining completed here and did not have experience in bladder retraining. During interview on 7/17/24 at 11:42 a.m., LPN-D stated they looked to the care plan or the MAR and TAR to know what cares a resident required.	F 690		

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F 690	Continued From page 19 During interview on 7/17/24 at 1:05 p.m., LPN-D stated they documented whether they provided education to a resident in a progress note and stated sometimes the MAR and TAR would identify what they needed to provide education on. LPN-D stated R207 had an indwelling catheter and it was up to the physician to determine whether or not R207 still needed the catheter and stated if there was an order to remove the catheter, they would do a bladder scan and remove the catheter and educate R207 if she refused on the risks and document in the progress notes. LPN-D further stated she was not aware R207 declined to have the catheter removed and viewed the medical record and stated she did not see an order regarding the catheter, and verified documentation lacked evidence of education completed regarding the catheter and stated she should ask R207 why she wanted to keep the catheter. LPN-D stated it would be important to educate R207 the catheter can cause an infection and further stated she could talk to R207 and determine R207's reasoning for why she was not ready to remove the catheter. During interview on 7/17/24 at 1:33 p.m., the director of nursing (DON) stated if a catheter was placed for retention, they would try to check a post void residual to try to eliminate unnecessary catheter placement and stated she expected staff provide education to the resident and stated she would enter education in R207's care plan and further stated education was important because a foreign body increased the risk for infection and catheters need to be medically necessary. A policy, Catheter Care Protocol, undated, lacked	F 690		

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F 690	Continued From page 20 information regarding removal of catheters as soon as possible when no longer necessary, care plan interventions for resident education, and documentation in the medical record of implications of continued use.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure supplemental oxygen was delivered according to physician orders, and failed to ensure oxygen tubing was properly maintained per professional standards for 1 of 1 resident (R17) reviewed for respiratory care. Findings include: R17's admission Minimum Data Set (MDS) assessment, dated 7/1/24, indicated moderate cognitive impairment, did not have behaviors, did not reject cares, did not have SOB (shortness of breath). R17's Medical Diagnosis form indicated the following diagnoses: acute systolic congestive heart failure, disorientation, unspecified dementia,	F 695	" Resident #17 resident O2 order was d/c□d " Residents receiving supplemental oxygen have the potential to be affected. " All residents receiving Oxygen had their orders reviewed and updated. " Policy and Procedure on Oxygen Administration reviewed and updated accordingly. " Education to the nursing staff on Oxygen Administration policy and procedure on August 14, 2024. " All residents on O2 will have their O2 tubing changed per policy and procedure. • All residents on O2 will have treatment orders added to MAR to check flow rate every shift. " Oxygen Audit will be completed on 4 residents on each unit (Unit 200-400, Unit	8/26/24

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F 695	Continued From page 21 anemia, and chronic obstructive pulmonary disease. R17's physician orders dated 7/11/24, indicated supplemental oxygen at 2 to 3 liters via nasal cannula every shift to maintain oxygen saturations of 90% or higher. The orders lacked information when to change the oxygen tubing. R17's medication administration record (MAR) and treatment administration record (TAR) for July 2024, were reviewed and lacked information when oxygen tubing was changed. R17's care plan was reviewed and lacked information R17 required oxygen. R17's progress notes dated 7/13/24 at 11:41 a.m., indicated R17 had 2 liters per minute (LPM) of oxygen on. R17's progress notes dated 7/15/24 at 8:53 p.m., indicated R17 had oxygen on at 1 lpm. R17's progress notes dated 7/15/24 at 10:51 p.m., indicated R17 was on 2 lpm of oxygen. R17's progress notes dated 7/16/24 at 12:37 p.m., indicated R17 was on 1 lpm of oxygen. During interview and observation on 7/15/24 at 8:17 a.m., R17 stated she started oxygen over the weekend but was not currently wearing oxygen and stated she has had trouble breathing from smoking and no longer smoked and denied any difficulty breathing at time of interview. R17 had a cart with an oxygen tank inside in her room along with a concentrator. The nasal cannula	F 695	500, & Unit 600) weekly x 4 weeks, then monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " All staff education provided on 8/14/2024 " Responsible party: Director of Nursing or Designee " Date of compliance 8/26/2024	

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F 695	Continued From page 22 piece of oxygen tubing that goes into the nares was located on the floor and the tubing was connected to the concentrator. During observation on 7/16/24 at 11:38 a.m., R17 was in her recliner chair and her oxygen on. During observation on 7/16/24 at 3:00 p.m., R17 was brought back to her room and had the oxygen on and was connected to the O2 tank on her wheelchair. During observation on 7/16/24 at 5:24 p.m., R17 was sitting up in her wheelchair with the oxygen on. During observation on 7/16/24 at 7:00 p.m., R17 was in her wheelchair and the oxygen tank in the back of the wheelchair indicator amount was in the red. R17's oxygen tubing was attached to her concentrator which was on at 1 liter per minute. During observation on 7/17/24 at 9:24 a.m., R17 was not in her room and the oxygen tubing including the nasal cannula was located on the floor. During observation on 7/17/24 at 9:28 a.m., staff brought R17 to her room and R17 did not have oxygen on and left the room and the nasal cannula was still located on the floor. During observation on 7/17/24 at 10:30 a.m., R17 was in bed and the nasal cannula was located on the floor and the concentrator was on but R17 was not wearing oxygen. During interview on 7/17/24 at 10:33 a.m., registered nurse (RN)-C stated she had been at	F 695		

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F 695	Continued From page 23 the facility a few weeks and guessed oxygen tubing was changed when residents got a new tank and if they had a concentrator. RN-C verified R17's concentrator was on and running at 1 liter per minute (LPM) and verified the nasal cannula was located on the floor and stated she expected staff to follow up to see if oxygen was needed if oxygen was turned on and follow up for new tubing because the nasal cannula should not be located on the floor. RN-C reviewed R17's medical record and verified the record lacked information on when to change the tubing. At 10:44 a.m., RN-C checked R17's oxygen and stated she would try 2 liters of oxygen because R17's oxygen saturations were not consistently staying above 90%. During interview on 7/17/24 at 10:50 a.m., the director of nursing stated if the nasal cannula was located on the floor she expected the tubing be changed and expected staff follow oxygen orders and stated it was important for infection control. A policy, Oxygen Administration and Cleaning of O2 Equipment, dated 4/2022, indicated oxygen tubing needs to be stored off the ground when not in use by a resident. Oxygen tubing and cannula set up must be changed weekly, do this every Thursday on the night shift. Chart on treatment sheet in the MAR. Concentrator filters are to be cleaned weekly with baby shampoo and rinsed with water.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		8/26/24

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F 698	Continued From page 24 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure collaboration with the dialysis facility for 1 of 1 resident (R14) reviewed for dialysis. Findings include: R14's admission Minimum Data Set (MDS) assessment, dated 6/16/24, indicated intact cognition, required substantial assist for dressing, and was dependent for transfers, was frequently incontinent of bowel and bladder, and received dialysis. R14's Medical Diagnosis form indicated the following diagnoses: acute kidney failure unspecified, chronic kidney disease stage 3, anemia in chronic kidney disease, arthrosclerosis of native arteries of left leg with ulceration of other part of foot, arthrosclerosis of native arteries of right leg with ulceration of heel and midfoot, type 2 diabetes mellitus, unspecified open wound of abdominal wall unspecified quadrant without penetration into peritoneal cavity, and peripheral vascular disease. R14's physician's orders included the following orders: 6/12/24, administer all a.m. medications after dialysis in the morning every Tuesday, Thursday, and Saturday. 6/10/24, complete pre-dialysis assessment and send with resident to dialysis. Complete	F 698	" R14□s dialysis binder and care plan have been updated to contain name of dialysis company, address, and phone number, days, access site location, p/u time, transportation company name and phone number. " All residents receiving dialysis have the potential to be affected. " All residents receiving dialysis had their dialysis binder and care plan reviewed and updated as needed. " Dialysis Policy reviewed and updated accordingly. " Education to the licensed nursing staff on Dialysis policy and procedure, and on expectation that dialysis facility is called when resident is not going to attend dialysis, when there are med changes or status changes, (protocols added to binder for nursing reference) occurred on August 14, 2024. " Residents on dialysis will be audited weekly x 4 weeks, then monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " Responsible party: Director of Nursing or Designee	

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F 698	Continued From page 25 post- dialysis assessment once resident returns to facility one time a day every Tuesday, Thursday, Saturday post-dialysis assessment. 6/10/24, complete pre-dialysis assessment and send with resident to dialysis. Complete post- dialysis assessment once resident returns to facility one time a day every Tuesday, Thursday, and Saturday pre-dialysis assessment. 6/10/24, monitor hemodialysis catheter to the right chest wall for signs and symptoms of infection daily and complete SBAR (a communication framework) if signs and symptoms are present every day and evening shift. R14's physician orders lacked information on how to contact dialysis and which dialysis facility R14 used and when to contact dialysis. R14's medication administration record (MAR) and treatment administration record (TAR) indicated R14 was taking amoxicillin-pot clavulanate (an antibiotic) oral tablet 875-125 milligram tablets twice a day for infection for 14 days that started on 7/4/24. R14's MAR and TAR lacked information on how to contact dialysis, which dialysis company R14 used, and when to contact dialysis. R14's Profile form in the electronic medical record (EMR) lacked information regarding the contact number and where R14 went for dialysis and when to contact dialysis. R14's Dashboard form in the EMR lacked information regarding the contact number and where R14 went for dialysis and when to contact	F 698	" Date of compliance 8/26/2024	

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F 698	Continued From page 26 dialysis. R14's care plan dated 6/10/24, indicated R14 needed hemodialysis due to renal failure and R14's goal was to have no signs or symptoms of complications from dialysis through the review date. The care plan included the following interventions: do not draw blood or take blood pressure in the arm with the graft, encourage resident to go for the scheduled dialysis appointments, R14 receives dialysis Tuesday, Thursday, and Saturday, monitor, document, and report to physician as needed any signs or symptoms of infection to the access site: redness, swelling, warmth, or drainage, monitor, document, and report to the physician as needed signs and symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds, obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure immediately. R14's care plan dated 7/15/24, indicated R14 had altered kidney function related to chronic kidney disease, required dialysis, and R14's site of graft was the right chest wall. R14's intervention indicated if bleeding occurs at the access site, apply direct pressure to site for 10 minutes and alert nursing, physician/nurse practitioner, and the dialysis facility. The care plans lacked information on how to contact dialysis, and which dialysis facility R14 used. R14's progress notes dated 6/21/24 at 4:26 p.m., indicated orders were received for Keflex (an antibiotic) 500 milligrams (MG) every 12 hours for	F 698		

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F 698	Continued From page 27 7 days. Documentation lacked evidence the dialysis facility was notified. R14's progress notes dated 6/22/24 at 6:34 a.m., indicated R14 chose not to go to dialysis due to not feeling well and had started on antibiotics the previous evening. Documentation lacked evidence the dialysis facility was notified. R14's progress notes dated 6/22/24 at 11:47 a.m., indicated R14 refused dialysis due to not feeling well. Documentation lacked evidence the dialysis facility was notified. R14's progress notes dated 6/24/24 at 10:31 a.m., completed by registered nurse (RN)-B indicated the clinic was notified that R14 canceled dialysis on 6/22/24. R14's progress notes dated 7/6/24, indicated R14's right lower extremity was bleeding heavily, saturating the dressing and spilling onto the floor. The on call physician was notified after a pressure dressing was applied and resident was in transportation to dialysis when transportation contacted the facility to report R14 was bleeding through reinforced dressings and R14 decided to go to the emergency department. The progress note lacked information that the dialysis facility was notified. During interview on 7/15/24 at 12:33 p.m., R14 stated she started dialysis at 6:30 a.m., on Tuesdays, Thursdays, and Saturdays and stated her access site was on her right chest. During interview on 7/16/24 at 5:54 p.m., registered nurse (RN)-D stated R14 went to dialysis three times a week and was not sure	F 698		

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F 698	Continued From page 28 which dialysis facility R14 went to. RN-D stated would update the nurse manager, RN-B at the nursing facility if the dialysis facility needed to be notified. RN-D viewed R14's medical records and could not identify which dialysis facility R14 attended and stated it was important to know because sometimes they needed to call the dialysis facility and the last time they needed to contact them, the dialysis facility contacted RN-D. At 6:52 p.m., RN-D stated she contacted RN-E who would update the information in R14's chart to include who to contact for dialysis. During interview on 7/16/24 at 6:35 p.m., RN-E stated they located which dialysis facility R14 attended and stated they added the information in the binder including the phone number, the address, and stated the director of nursing added the dialysis facility in the care plan. During interview on 7/17/24 at 9:59 a.m., a call was placed to the given dialysis facility phone number and the receptionist stated the phone number was the main phone number to the clinic and the dialysis facility was a different number. During interview on 7/17/24 at 10:02 a.m., RN-F from the dialysis facility stated the facility communicated with the dialysis facility via a form that was sent with R14 on dialysis days. RN-F stated the facility should contact the dialysis facility via phone if there was anything out of the baseline, transportation updates, and stated they expected a phone call if a resident started a new antibiotic or if a resident declined to go to the dialysis facility. RN-F stated R14 did not show up for dialysis on 6/22/24, and the dialysis nurse had to contact the nursing facility and reviewed R14's chart and found out R14 started on Keflex. RN-F	F 698		

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F 698	Continued From page 29 further provided the number the nursing facility should call for the dialysis facility. During interview on 7/17/24 at 10:56 a.m., the director of nursing stated a booklet had the dialysis information, but the nurse didn't read down far enough and stated nobody took time to rewrite in the location they indicate the name of the dialysis. DON contacted the number per the care plan and verified it was not the number indicated per the dialysis facility. During interview on 7/17/24 at 11:18 a.m., the DON stated she was able to speak with dialysis and confirm the correct number and updated the care plan and stated it was important to have this information in case R14 needed to reschedule and further stated antibiotics can affect R14's labs and to help R14 remain medically stable and was important for the dialysis facility to be aware. The care plan was updated to reflect the phone number identified by RN-F. A policy Care of a Resident with End Stage Renal Disease, dated 2010, indicated residents with end stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed including: how the care plan will be developed and implemented, how information will be exchanged between the facilities; and responsibility for waste handling, sterilization and disinfection of equipment. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. A policy Dialysis Care, dated 3/12/20, indicated	F 698		

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F 698	Continued From page 30 dialysis should be contacted for low blood pressures, discuss lab parameters with the dialysis clinic and physician, and communicate electrolyte levels to the dialysis facility. The policy lacked information on contacting dialysis with medication changes and appointment cancellations.	F 698		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		8/26/24

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F 756	Continued From page 31 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the pharmacist failed to identify and report a psychotropic medication (medication to stabilize mood) was increased without implementing non-pharmacological interventions and without indication the increased dose was clinically significant after a gradual dose reduction (GDR) for 1of 2 residents (R3) reviewed who required psychotropic medications. R3's quarterly Minimum Data Set (MDS) assessment, dated 4/23/24, indicated R3 had mild cognitive impairment and diagnoses of bipolar disorder (mood disorder that caused intense shifts in mood and behaviors). R3 had no behaviors, delusions, or refusal of cares. Furthermore, R3's MDS indicated R3 received psychotropic medications on a routine basis. R3's psychotropic care area assessment (CAA) dated 11/3/23, indicated R3 currently received psychotropic medications and directed monitoring of R3's behaviors and mood was required. R3's care plan revised 4/23/24, indicated R3 required the use of Depakote (psychotropic medication) related to behavior management of depression and delusional disorder.	F 756	" (R3) Pharmacist recommendation was completed 8/13/2024 and forwarded to Psychiatrist for review. " All residents receiving psychotropic medications have the potential to be affected. " All residents receiving psychotropic medications will be reviewed for Gradual Dose Reduction. " Medication Monitoring and Management policy was reviewed and updated as warranted. " Care plans of residents receiving psychotropic medication were reviewed and will be addressed to contain nonpharmacological interventions. Kardex□s will be updated accordingly. " Will review the communication process between the Primary MD and Other Providers at QAPI meeting on August 23, 2024. " Education to licensed nurses on Medication Monitoring and Management policy and procedure on 8/14/2024. " Psychotropic Medication Committee will be developed and begin meeting monthly in September to review GDRs. " All residents have audited for	

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F 756	Continued From page 32 Non-pharmacological interventions last revised on 7/26/2020, directed staff to discuss ongoing need of medication with provider and family, consult with pharmacy, provider, and family to consider GDR, monitor delusions of items stolen or missing from room, refusal of cares, and increased self-isolation and monitor/document mood or behavior changes, and provide assurance daughter has perceived missing or stolen items. R3's medication regimen review (MRR) notes to attending provider dated 9/7/23, requested R3's provider to assess R3 for possible GDR for or Seroquel 25 milligrams (mg) every morning and 225mg at bedtime, Depakote 125mg in the morning and 250mg each evening, and Lexapro 5mg daily. Nurse Practitioner (NP)-A responded and agreed with the recommendation and reduced Depakote 250mg every evening to 125mg every evening. NP-A signed R3's MRR note to attending provider on 9/29/23. R3's MRR's dated 10/2023- 6/2024, indicated R3 had no medication irregularities. A review of R3's provider and nursing orders showed: -on 5/11/23, R3 required Depakote 125 mg each morning and 250mg each evening. -on 9/29/23, R3 required Depakote 125 mg each morning and 125mg each evening. -on 11/29/23 R3 required Depakote 375mg daily in the evening. A review of R3's medical record dated 9/15/2023 - 7/14/2024, lacked indication R3 had exhibited behaviors of delusions of items stolen or missing from room, refusal of cares, or increased self-isolation.	F 756	appropriateness of GDR. Any resident due for GDR, Pharmacist and Provider will be updated accordingly. Going forward Psych Med Committee will be responsible for tracking and trending this data and reporting to QAPI. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " Responsible party: Director of Nursing or Designee " Date of compliance 8/26/2024	

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F 756	Continued From page 33 When interviewed on 7/17/24 at 1:59 p.m., NP-B stated they were not aware of R3's GDR of Depakote last fall and R3's mood and behaviors had been stable for about a year. NP-B stated they referred R3 back to a psychiatrist for medication management as there had been some concerns of increased drowsiness during the daytime and had not realized R3's Depakote was then increased by the psychiatrist in 11/2023. NP-B stated they had not received any communication from the clinical pharmacist (CP) or nursing staff about the medication changes. If this information was known, NP-B would have followed up to ensure the medication dose was appropriate. This communication was important to ensure minimize risk of residents receiving psychotropic medications unnecessarily. When interviewed on 7/17/24 at 2:52 p.m., CP stated MRR's were completed monthly. CP verified R3's Depakote GDR was ordered in 9/2023, however was not aware of R3's Depakote being increased after the visit with the psychiatrist. CP reviewed the psychiatrist note dated 11/29/23, and felt the psychiatrist was not aware the Depakote dose was being increased and therefore no clinical indication. CP further stated the increased dose was missed in subsequent MRR's and if known, CP would have brought it forward to the team to clarify. When interviewed on 7/17/24 at 3:50 p.m., the interim Director of Nursing (DON) was not sure of the details around when R3's Depakote was increased. Interim DON stated the nurse managers on the unit review changes to medications and are involved in the medication review process. Interim DON further stated there was leadership changes at the time that may	F 756		

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F 756	Continued From page 34 have contributed to the lack of awareness R3's Depakote was increased. Interim DON expected nursing, pharmacy, and providers to be aware when a resident's psychotropic medication dose was changed, and this was important to ensure psychotropic medications were given appropriately.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		8/26/24

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F 758	Continued From page 35 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an increased dose of a psychotropic medication (medication to stabilize mood) was clinically indicated after a gradual dose reduction (GDR) after a for 1 of 2 residents (R3) reviewed who required psychotropic medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated 4/23/24, indicated R13 had mild cognitive impairment and diagnoses of bipolar disorder (mood disorder that caused intense shifts in mood and behaviors). R3 had no behaviors, delusions, or refusal of cares. Furthermore, R3's MDS indicated R3 received psychotropic medications on a routine basis.	F 758	R3) Pharmacist recommendation was completed 8/13/2024 and forwarded to Psychiatrist for review. " All residents receiving psychotropic medications have the potential to be affected. " Policy and Procedure on Medication Monitoring and Management reviewed and updated. " Education to licensed nurses on Medication Monitoring and Management including PRN orders for anti-psychotic medications limited to 14 days on August 14, 2024. " All residents receiving psychotropic medications will be reviewed. " Psychotropic Medication Committee was developed and meets monthly to review GRD□s.	

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F 758	Continued From page 36 R3's psychotropic care area assessment (CAA) dated 11/3/23, indicated R3 currently received psychotropic medications and directed monitoring of R3's behaviors and mood was required. R3's care plan revised 4/23/24, indicated R3 required the use of Depakote (psychotropic medication) related to behavior management of depression and delusional disorder. Non-pharmacological interventions last revised on 7/26/2020, directed staff to discuss ongoing need of medication with provider and family, consult with pharmacy, provider, and family to consider GDR, monitor delusions of items stolen or missing from room, refusal of cares, and increased self-isolation and monitor/document mood or behavior changes, and provide assurance daughter has perceived missing or stolen items. R3's medication regimen review (MRR) notes to attending provider dated 9/7/23, requested R3's provider to assess R3 for possible GDR for or Seroquel 25 milligrams (mg) every morning and 225mg at bedtime, Depakote 125mg in the morning and 250mg each evening, and Lexapro 5mg daily. Nurse Practitioner (NP)-A responded and agreed with the recommendation and reduced Depakote 250mg every evening to 125mg every evening. NP-A signed R3's MRR note to attending provider on 9/29/23. A review of R3's provider and nursing orders showed: -on 9/29/23, R3 required Depakote 125 mg twice daily in the morning and in the evening. This order was discontinued on 11/29/23 and replaced with an order to increase R3's Depakote to	F 758	" All residents have audited for appropriateness of GDR. Any resident due for GDR, Pharmacist and Provider will be updated accordingly. Going forward Psych Med Committee will be responsible for tracking and trending this data and reporting to QAPI. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " Psychotropic Medication Committee will be developed and begin meeting monthly in September to review GDRs. " Responsible party: Director of Nursing or Designee " Date of compliance 8/26/2024	

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F 758	Continued From page 37 375mg daily in the evening. -on 8/6/20, R3 required behavior monitoring for use of Depakote. Behaviors to be monitored included delusions of items stolen or missing from room, refusal of cares, and increased self-isolation. A review of R3's medical record dated 9/15/2023 - 7/14/2024, lacked indication R3 had exhibited behaviors of delusions of items stolen or missing from room, refusal of cares, or increased self-isolation. R3's psychiatry provider progress note dated 11/29/23, indicated NP-B had referred R3 back to a psychiatry for medication management due to use of high-risk medications and increased sedation. The progress note indicated concern R3 had increased sleeping/drowsiness during the day and R3's mood was overall stable. Furthermore, the note indicated a plan to change the timing of R3's Depakote order from 125mg each morning and 250mg each evening to a combined dose of 375mg each evening. R3's psychiatric progress note lacked acknowledgement of the R3's recent GDR review on 9/29/23, which lowered R3's daily Depakote dose from 375mg to 250mg and lacked indication of why R3's Depakote was increased back to a total of 375mg daily. R3's psychiatric progress note dated 1/26/24, indicated R3's mood was stable and indicated no medication changes. R3's primary provider progress note dated 6/11/24, indicated R3 had stable bipolar disorder and was followed by psychiatry for medication	F 758		

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F 758	Continued From page 38 management. When interviewed on 7/17/24 at 1:24 p.m., licensed practical nurse (LPN)-A stated they were not aware of R3 having delusions or refusal of cares. LPN-A stated when residents who received psychotropic medications had orders to monitor behaviors. When behaviors occurred, it would be documented in the treatment record and then a progress note would be made. LPN-A further stated R3 did not require any redirection or distractions. When interviewed on 7/17/24 at 1:59 p.m., NP-B stated R3 had not seen a psychiatrist for some time prior to 11/2023 as R3's mood and behaviors had been stable. NP-B stated they referred R3 back to a psychiatrist for medication management as there had been some concerns of increased drowsiness during the daytime. NP-B reviewed R3's pharmacy recommendation for a GDR and verified NP-A had made a dose reduction on 9/29/23 but was not aware of it until now. NP-B stated NP-A was another provider within their provider group and was not sure why the dose reduction was made. NP-B verified there was no progress note or communication note from NP-A about R3's dose reduction. NP-B reviewed R3's psychiatrist progress notes from 11/29/23 and verified R3's Depakote order reflected the discontinued dose of 125mg every morning and 250mg every evening. Furthermore, NP-B verified the psychiatrist had not intentionally made a dose increase with R3's medications but only moved them to the evening in attempt to reduce daytime sleepiness. NP-B stated when a provider makes a medication change, they must reconcile the medication list in R3's EPIC record (the clinic electronic medical record) to ensure it was	F 758		

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F 758	Continued From page 39 current. NP-B further stated since NP-A had not reconciled the medications in EPIC or made a progress note about the change the psychiatrist likely was not aware of the GDR. NP-B further stated when a GDR was attempted, they would have increased communication with nursing staff pharmacy and psychiatry about behaviors and symptom monitoring. This communication was important to ensure minimize risk of residents receiving psychotropic medications unnecessarily. When interviewed on 7/17/24 at 2:52 p.m., clinical pharmacist (CP) stated they track when GDRs become due and then send out a request to the resident's provider. CP verified R3's Depakote GDR was ordered in 9/2023. CP was not aware of R3's Depakote being increased after the visit with the psychiatrist. CP reviewed the psychiatrist note dated 11/29/23, and verified it indicated risks of a GDR and opted to start with R3 taking the medications in the evening. CP stated the note indicated the psychiatrist was not aware the dose was being increased. CP further stated this was missed in subsequent medication regimen reviews and if known, CP would have brought it forward to the team to clarify. When interviewed on 7/17/24 at 3:50 p.m., the interim Director of Nursing (DON) was not sure of the details around when R3's Depakote was increased. Interim DON stated the nurse managers on the unit review changes to medications and are involved in the medication review process. Interim DON further stated there was leadership changes at the time that may have contributed to the lack of awareness R3's Depakote was increased. Interim DON expected nursing, pharmacy, and providers to be aware	F 758		

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F 758	Continued From page 40 when a resident's psychotropic medication dose was changed, and this was important to ensure psychotropic medications were given appropriately.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a high temperature sanitizing dishwasher reached the rinse temperature required to sanitize of dishware used for resident service . Furthermore, the facility failed to ensure resident water/ice machines and the high temperature dishwasher were cleaned in 2 resident care units. This had the potential to impact all 29 residents who reside in the 500 and 600 care units.	F 812	" 7/16/2024 500 Called ecolab to address issue, scheduled to come out next day. Pulled all dishes and washed in main kitchen until machine was fixed. " Eco Lab on site on 7/17/24 at 9:00 am and noted that EcoLab failed to recalibrate the rinse temp controller on the machine after they were out on 7/12/2024. Machine calibrated on 7/17/2024, temp is up to code at 186. EcoLab reviewed with	8/26/24

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F 812	Continued From page 41 Findings include: Hobart AM15T dishwasher manual no date, directed the high temperature sanitization washers were required rinse temperatures to reach temperatures to be at 180 degrees Fahrenheit (F) to ensure dishes were properly sanitized. A facility document titled Dish Machine Temperature Daily log sheet dated 7/2024, indicated the shift temperature checks completed by staff. At the bottom of the document indicated the rinse cycle was required to be a minimum of 180 degrees F and directed staff not use the machine if incorrect temperatures were noted. Three of the 36 documented entries had rinse temperatures at 180 degrees F. or above. The remainder temperatures documented ranged between 161 degrees F and 177 degrees F. The document lacked indication any follow up or communication had occurred about the low rinse temps. An observation on 7/16/24 at 1:37 p.m., dietary aide (DA)-A was washing dishes in the 500/600 wing kitchenette. DA-A started a load and the rinse temperature reached 170 degrees F. DA-A pushed the rack of dishes through to the clean side and proceeded to start another load. The second load rinsed at a temp of 172 degrees F. The electronic temperature gauge on the wall had not alarmed to alert staff of the low rinse temperatures. When the dishwasher door was lifted, the inside dishwasher frame, door and sprayers had large amounts of white crusty mineral-like substances. The same white substance was on the bottom of the dishwasher	F 812	surveyor on 7/17/2024. " documentation of temperature checks of dishwashers prior to use. " Education in-service completed with dietary staff, re: dishwasher temps, cleaning the dishwasher. Staff are not to use the machine and let Dietary Director or Justin from Ecolab know if temps are off. " On 7/17/2024 communication posted in 2 kitchens (500 and main) for staff re: dish machine temperatures instructions. " Dishwasher temperatures in main kitchen checked to verified accurate temperatures on 7/17/24 " Created dishwasher policy 7/17/2024 " Both dishwashers cleaned on 7/17/2024 " Reviewed cleaning logs for dishwashers and ice makers and ensured placement for easy documentation once task completed. " Reviewed and updated Cleaning and Disinfection Kitchen Equipment policy 7/22/2024 " Audits of temperature documentation, daily (Mon-Fri) for 2 weeks and then weekly for 2 months. Action will be taken immediately if trends for improvement are identified and staff education and coaching will be provided if indicated. Audit results and actions will be reported to the monthly QAPI Committee. " Audits of dish machine and ice machine cleaning to be done monthly for 3 months. Action will be taken immediately if trends for improvement are identified and staff education and coaching will be provided if indicated.	

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F 812	Continued From page 42 door. When interviewed on 7/16/24 at 1:54 p.m., DA-A stated the dishwasher temperatures were checked during each shift and wrote on the temperature log sheet. DA-A stated they were not sure what the temperature should be and further stated the temperature gauge on the wall alarmed if the water was not hot enough and if it didn't alarm, it was ok to use. When it alarms, maintenance is notified, and dishes were then brought to the main kitchen if needed. DA-A further stated rinse temperatures needed to get to 180 degrees F. once a shift and the lower temperatures were ok to use. DA-A was not aware of another way to check the temperatures of the rinse cycle. DA-A verified the white crusted substance on the dishwasher and stated another shift was responsible to complete the de-liming process. DA-A showed the cleaning schedule and stated it should have been done 5 days prior, however stated it looked like it wasn't done in a while. When interviewed on 7/16/24 at 3:13 p.m. The culinary director verified the dishwasher required high temperature rinse to ensure sanitization. They acknowledged the documented low rinse temperatures and had not been notified of those readings. The culinary director expected staff to notify maintenance of low temperatures and move dishes to the main kitchen to be cleaned until the sanitization temperature was correct. The culinary director further stated recently the de-liming process was recently changed from the dietary team to the maintenance team. The white substance on the dishwasher was due to the lime scale and further stated it likely needed to be done and coordination with the maintenance	F 812	Audit results and actions will be reported to the QAPI Committee. " All staff education provided on 8/14/2024 " Dietary Director is responsible for compliance with Administrator responsible for overall compliance. " Date of compliance 8/26/2024	

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F 812	Continued From page 43 team needed to be worked on. When interviewed on 7/17/24 at 9:30 a.m., the Ecolab technician acknowledged the machine had been reset to the factory settings and the temperature gauge's factory settings to alarm with a rinse temperature below 160 degrees F. The technician further stated it had not alarmed as the temperatures were above 160 degrees F. The machine was now running around 180-190 degrees F. and the temperature gauge was set to alarm when below 180 degrees F. On 7/15/24 at 8:55 a.m., the 500-unit kitchenette was observed. The ice/water machine had white mineral buildup on the shoot where the ice/water came out as well as the tray below. On 7/15/24 at 10:09 a.m., the 600-unit kitchenette was observed. The ice/water machine had whitish brownish mineral build up on the shoot where the ice/water came out. Streaks of white went down the stainless-steel back splash and onto the tray below. When interviewed on 7/16/24 at 1:54 p.m., DA-A verified the 500-unit ice/water machine had white crusty buildup. DA-A stated the dietary staff was not responsible for the ice/water machine cleaning and thought maintenance completed it. When interviewed on 7/17/24 at 8:27 a.m., maintenance-A stated the maintenance team was responsible for cleaning the ice/water machines. He was unaware of the last time the cleaning was completed and stated cleaning was done quarterly. Cleaning included de-liming of the machine and ensuring the spout, tray and outside were cleaned.	F 812		

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F 812	Continued From page 44 When interviewed on 7/17/24 at 4:30 p.m., the covering administrator expected staff to ensure dishwashers ran at temperatures needed to ensure dishes were sanitized. The dishwashers and ice/water machines were expected to be cleaned regularly to ensure cleanliness and minimize any risk of infection to the residents. A facility policy titled Dish Machine All Units dated 7/2024, directed staff to not use machine if rinse temp was not reaching 180 degrees F. Staff were further directed to notify the supervisor and maintenance aware of problem. A facility policy titled Cleaning and Disinfection of Kitchen Equipment revised 9/2022, directed maintenance staff to de-lime dish machines once a week and ice/water machines monthly. All cleaning will be logged.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		8/26/24

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F 880	Continued From page 45 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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	F 880		

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	245359	A. BUILDING _____ B. WING _____	C 07/17/2024

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F 880	Continued From page 46 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff donned (put on) appropriate personal protective equipment (PPE) for enhanced barrier precautions (EBP), and contact precautions for 2 of 3 residents (R207, R48), and failed to ensure a clean laundry area was maintained. Additionally, the facility failed to ensure resident ice packs were stored separately from food storage on 2 of 4 unit refrigerators. This had the potential to impact the 29 residents who reside on those units. Findings include: R207's admission Minimum Data Set (MDS) assessment, dated 7/4/24, indicated intact cognition, had an indwelling catheter, a trial of a toileting program had not been attempted, and was dependent on staff for toileting hygiene, and toilet transferring. R207's Medical Diagnosis form indicated R207 had the following diagnoses: unspecified wound to left lower leg, atherosclerosis of native arteries of the right leg with ulceration of the ankle, atherosclerosis of native arteries of the left leg	F 880	" All residents on infection precautions have the potential to be affected. " All residents on EBP and Contact Precautions have had their care plans and kardex□s updated to reflect EBP and Contract Precautions. " Signage on the doors were reviewed for those on Precautions and are correct. " Policies and Procedures titled Enhanced Barrier Precautions and Contact Precautions reviewed and updated to correlate with accepted standards of practice as necessary. " Staff education was completed on 8/14/2024 which included education on the appropriate time to DONN and DOFF PPE. " Six (6) Staff members, were audited on the appropriate use of PPE when caring for a resident on precautions weekly x 4 weeks, then monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for	

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F 880	Continued From page 47 with ulceration of the ankle, non-pressure chronic ulcer of other part of right foot limited to breakdown of skin, enterocolitis due to clostridium difficile, and retention of urine, R207's physician orders dated 7/15/24 at 11:06 a.m., indicated R207 was on contact precautions due to a history of clostridium difficile, and methicillin resistant staphylococcus aureus (MRSA) in the left lower quadrant and left groin wound, additionally, R207 had a urinary catheter. R207's care plan lacked evidence R207 was on any kind of precautions. During interview and observation on 7/15/24 between 9:47 a.m., and 9:56 a.m., nursing assistant (NA)-D entered R207's room without first donning gloves or a gown. NA-D closed the privacy curtain by the door. There was signage on the wall next to R207's room that indicated R207 was on contact precautions and everyone must clean their hands including before entering and when leaving the room. Additionally, signage indicated providers and staff must also put on gloves before room entry and discard gloves before room exit, put on a gown before room entry and discard the gown before room exit. Do not wear the same gown and gloves for the care of more than one person. use dedicated or disposable equipment and clean and disinfect reusable equipment before use on another person. All equipment and wheels must be wiped down with bleach wipes immediately after leaving this room. At 9:54 a.m., R207 told NA-D thank you and at 9:56 a.m., NA-D asked R207 if she needed anything else and then walked out of the room. NA-D did not know why equipment needed to be cleaned with bleach and verified she did not	F 880	trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " All staff education provided on 8/14/2024 " Responsible party: Director of Nursing or Designee " Ice packs were immediately removed from freezer and other freezers checked for non food items on 7/17/2024. " Signs placed on 7/17/2024, on all resident fridges with reminders of what is allowed and not allowed in resident freezer/fridges " Education in-service completed with dietary staff on removing all non resident items if found in fridge, including ice packs on 7/17/2024. " Food storage□fridge/freezer policy reviewed and updated as necessary. " Immediate education provided in Point Click Care on communication page re: no non food items should be kept in resident refrigerators on the units for all affected staff on 7/18/2024 " Written communication to all staff posted on all unit fridges. " On going audits of resident fridges weekly for 3 months. Action will be taken immediately if trends for improvement are identified and staff education and coaching will be provided if indicated. Audit results and actions will be reported to the monthly QAPI Committee. " All staff education provided on 8/14/2024 " Dietary Director is responsible for compliance with Administrator responsible	

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F 880	Continued From page 48 donn a gown and stated she was told she had to donn PPE when completing catheter cares and stated she would restock the gowns after looking in the bin to find one gown left. NA-D stated R207 was incontinent of stool and NA-D changed R207's brief. During interview on 7/15/24 at 10:05 a.m., licensed practical nurse (LPN)-C stated R207 was not on contact precautions and was required by the state to donn PPE when emptying drainage from catheters or when completing a dressing change and stated she would not expect staff to donn a gown when changing a brief and stated it was mostly for nurses when changing a dressing. LPN-C further stated she knew someone was on contact precautions because it was identified in the electronic medical record and verified R207 had contact precautions signage located outside the door and stated R207 was not on contact precautions. LPN-C could not state why equipment needed to be wiped down with bleach and added they just wiped down equipment before going in with other residents. During interview on 7/15/24 at 10:23 a.m., trained medication aide (TMA)-B stated if a resident was on EBP or contact precautions, they had signage located outside the door and stated contact precautions was something skin wise that could be transmitted by touching and EBP was used as a precautionary measure for residents with wounds, ostomies, or catheters to limit their exposure to our germs and further verified the electronic medical record lacked information R207 was on any type of precautions. During interview on 7/15/24 at 10:26 a.m., registered nurse (RN)-B stated R207 had an	F 880	for overall compliance. " The laundry area was immediately cleaned and dust removed, including the fan. " linen exposed to any dust was rewashed " laundry and housekeeping staff were educated on cleaning expectations in areas where clean laundry resides. " All staff education provided on 8/14/2024 " On going audits of the laundry area cleaning has been set up to be completely weekly for 1 month and then monthly for 3 months. Action will be taken immediately if trends for improvement are identified and staff education and coaching will be provided if indicated. Audit results and actions will be reported to the monthly QAPI committee. " Environmental Services Director is responsible for compliance with Administrator responsible for overall compliance. " Date of compliance: 8/26/2024	

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F 880	Continued From page 49 indwelling catheter and wounds and would have to find out whether R207 was on contact or EBP. During interview on 7/15/24 at 10:30 a.m., RN infection preventionist (IP)-H stated R207 should be on contact precautions because R207 had a history of e-coli and placed R207 on full contact precautions instead of EBP and stated staff should donn PPE anytime when going into the room and would have expected staff donn PPE. R48 R48's admission Minimum Data Set (MDS) dated 5/29/24, indicated R48 had an indwelling catheter, an ostomy, was not on a toileting program, required moderate assist with toileting hygiene, and transfers and had diagnoses of colon cancer, and benign prostatic hyperplasia (BPH). R48's physician orders indicated the following orders: 7/15/24, catheter 16 French 10 cc (cubic centimeter) balloon changed at urology. 7/15/24, resident on enhanced barrier precautions due to urinary catheter. R48's medication administration record (MAR) and treatment administration record (TAR) indicated R48 was on EBP due to having a urinary catheter. R48's care plan was reviewed and identified R48 had an indwelling catheter, and an ileostomy, but lacked evidence R48 was on EBP. During interview and observation on 7/16/24 between 11:50 a.m., and 11:57 a.m., R48 stated	F 880		

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F 880	Continued From page 50 he wanted to lie down and nursing assistant (NA)-E transferred R48 to his bed without donning a gown. R48 had signage outside his door that indicated he was on EBP. NA-E stated he should have had a gown on and stated he thought they were supposed to with regulations passed in the beginning of the year and stated R48 had a catheter and verified he did not have a gown on when transferring R48 to bed. During interview on 7/16/24 at 3:04 p.m., RN-B stated R48 was on EBP because R48 had a catheter and staff should donn PPE during a transfer and further stated she would complete coaching because it was important to protect residents from further infections. During interview on 7/17/24 at 2:09 p.m., IP-H stated RN-B updated her on lack of PPE for R48 and stated she completed coaching and expected staff to gown and wear appropriate PPE during a transfer. Linens During interview and observation on 7/16/24 at 12:29 p.m., a fan with gray particles was blowing on clean laundry and towards clean linens and the clean linen storage room. Additionally, a shelf below the fan was covered with gray particles and a buildup of the particles was clinging onto all three window screens behind the fan, some of the particles measured approximately 2 inches long. Additionally, the pipes behind the washing machine and under the shelf contained a thick layer of gray particles. Housekeeping and environmental services (HE)-A stated the gray particles hanging off the fan was dust and lint, and stated the shelf below the fan contained 1/4	F 880		

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F 880	Continued From page 51 inches of dust and lint and stated it was "pretty bad" and further stated the pipes had a build up of dust. During interview on 7/17/24 at 2:09 p.m., IP-H stated environmental services was responsible for cleaning the lint and dust and stated it should not blow onto clean linens. Additionally, IP-H stated it was important not to store ice packs in the freezers because the ice packs were on a person's body and was placed in an area where food was stored and was an infection control issue. During interview on 7/17/24 at 3:19 p.m., the director of nursing stated they completed on the spot coaching with staff related to the contact and EBP and stated they needed to complete in-house education because it was important not to spread infection and stated all the ice packs were removed from the freezers and would be further addressed. Further, DON stated they got rid of the dust and it was important to have a clean environment and they needed a clean space and did not want a fire hazard. A policy was requested for laundry and cleanliness, but the facility did not have a policy. A policy, Infection Control Transmission/Isolation Precautions, dated 3/2024, indicated transmission based precautions, are actions that are implemented in addition to standard precautions based on the particular means of transmission. Equipment necessary to carry out precautions/isolation may include gowns, goggles, mask, and gloves. Contact precautions examples included, residents with norovirus, Clostridiodes difficile (C. Diff) wounds, and diarrhea. Hand hygiene, gloves, and gowns are	F 880		

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F 880	Continued From page 52 donned upon entry into the room and hand hygiene is completed according to standard precautions when in the room. Remove gloves and gown and perform hand hygiene before exiting the room. Some organisms require hand hygiene to be performed with soap and water after exiting the room and will be designated on the signage. Additionally, EBP expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (MDROs) to staff hands and clothing. EBP apply to residents with any of the following: infection or colonization with a novel or targeted MDRO when contact precautions do not apply, wounds, and or indwelling medical devices such as central lines, urinary catheters, and wounds. Examples of high contact resident care activities requiring gown and glove use included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care and wound care. An observation on 7/15/24 t 8:55 p.m., the 500-wing resident food refrigerator was reviewed. The freezer contained three blue ice packs and one white cloth ice pack with a blue clip. Along side the ice packs were individual containers of ice cream. The ice packs were not labeled with who they belonged to. An observation on 4/15/24 at 10:09 a.m., the 600-wing resident food refrigerator was reviewed. The freezer contained blue gel ice packs. The ice packs were not labeled. Along side the ice	F 880		

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F 880	Continued From page 53 packs and on the same shelf were individual cups of ice cream and yogurt. When interviewed on 7/16/24 at 3:13 p.m., the culinary director stated dietary aides reviewed the unit fridges weekly. The culinary director further stated ice packs should not be stored in the freezers of the unit fridge as only food was stored there. Storing resident items with food is a risk for contamination. The culinary director further stated diary aides review the fridges they should notify nursing staff to remove ice packs if found in the unit refrigerators. When interviewed on 7/16/24 at 6:18 p.m., nursing assistant (NA)-C stated if a resident wanted an ice pack, there were blue packs that were in the freezer that can be used. NA-C stated the ice packs were stored in the freezer in the medication room and could not be stored in the fridge in the kitchenettes. NA-C verified the refrigerators in the kitchenette were for food items only. A policy titled food storage- fridge/freezer no date, directed staff to maintain procedures to maintain safe food storage and prevent contamination.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		8/26/24

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F 883	Continued From page 54 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

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F 883	Continued From page 55 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 2 of 5 residents (R48, R36) were offered or received pneumococcal vaccination in accordance to Center for Disease Control (CDC) recommendations. Findings include: The CDC Pneumococcal Vaccine Timing for Adults undated, indicated adults aged 65 years and older who have had no prior pneumococcal vaccinations could either have option A which indicated PCV20, or option B, give PCV15 and follow with PPSV23 after at least one year of giving PCV15. If only the PPSV23 vaccination was administered prior at any age, option A indicated PCV20 could be administered after 1 year or option B indicated PCV15 could be administered after 1 year. If only the PCV13 vaccination was administered at any age, option A indicated PCV20 could be administered after 1 year, or PPSV23. If PCV13 was administered at any age, and PPSV23 was administered prior to 65 years of age, option A indicated PCV20 could be administered after five years, or option B indicated PPSV23 could be administered after 5 years. Additionally, for those who already completed PCV13 at any age, and PPSV23 at age 65 or greater, together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than 65 years old who	F 883	" Addressed vaccination status of R48 and R36 " Other residents having potential to be affected: All residents have the potential to be affected. " Pneumococcal Vaccine Program Policy and Procedure reviewed and updated to align with CDC recommendations. " All current resident pneumovac vaccination records were reviewed and vaccinations offered if needed. " Vaccine consent form updated to include PVC20. " All staff education provided on 8/14/2024 " All new admissions pneumovac vaccinations will be reviewed weekly x 4 weeks, then monthly for 3 months. Action will be taken immediately if trends for improvement are identified, and staff education and coaching will be provided if indicated. Audit results and actions taken will be reported to the MONTHLY QAA/QAPI Committee for trends and determination of areas of improvement. The Committee will provide recommendations if indicated. " Responsible party: Director of Nursing or Designee " Date of compliance: 8/26/2024	

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F 883	Continued From page 56 have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of 65 years old. R48's admission Minimum Data Set (MDS) dated 5/29/24, indicated R48 was 78 years old, admitted to the facility on 5/23/24, had intact cognition, and pneumococcal vaccinations were up to date. R48's Medical Diagnosis form indicated the following diagnoses: malignant neoplasm of colon, anemia unspecified, and hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left non dominant side. R48's Minnesota Immunization Report dated 7/17/24, indicated R48 received the PPSV23 on 10/19/2012, and received Prevnar 13 on 1/12/2017. R48's Immunization form indicated R48 received the PPSV23 on 10/19/2012, and Prevnar 13 on 1/12/2017. R48's Vaccination Consent form dated 5/23/24, indicated R48 would like the following vaccinations if overdue or not up to date: the list contained the following items: COVID-19 vaccine, herpes zoster, pneumococcal vaccines PCV13, or PPSV23, Tetanus, Diphtheria, and Pertussis, hepatitis B, influenza, and I do not wish to receive any vaccinations. an "X" was marked in front of the options: pneumococcal vaccines PCV13, or PPSV23, Tetanus, Diphtheria, and Pertussis, and I do not wish to receive any vaccinations. The consent form lacked any information regarding PCV20.	F 883		

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F 883	Continued From page 57 R48's medication administration record (MAR) and treatment administration record (TAR) dated May 2024, June 2024, and July 2024, was reviewed and lacked evidence PCV20 was offered or administered. R48's medical record was reviewed and lacked evidence PCV20 was administered or that shared clinical decision making occurred. A form, Short Term Resident Quality Measures Vaccination Report 2023-2024, indicated R48 had the PPSV23 vaccine on 10/19/2012, and PCV13 on 1/12/2017, and indicated "N/A" for PCV15 or PCV20. R36 R36's admission MDS dated 6/24/24, indicated R36 was 77 years old, had intact cognition, and pneumococcal vaccinations were up to date. R36's Medical Diagnosis form indicated the following diagnoses: hypertensive chronic kidney disease stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, chronic kidney disease stage 3, and type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage). R36's Minnesota Immunization Report dated 7/17/24, indicated R36 received PCV13 (Prevnar 13) on 9/17/2015, PPSV23 on 5/31/2011, and 9/29/2016. R36's Immunization form indicated R36 received PPSV23 on 2/28/2011 and PCV13 on 9/17/2015. R36's Vaccination Consent form dated 6/18/24,	F 883		

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	245359	A. BUILDING _____ B. WING _____	C 07/17/2024

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F 883	Continued From page 58 indicated R36 would like the following vaccinations if overdue or not up to date: the list contained the following items: COVID-19 vaccine, herpes zoster, pneumococcal vaccines PCV13, or PPSV23, Tetanus, Diphtheria, and Pertussis, hepatitis B, influenza, and I do not wish to receive any vaccinations. An "X" was marked in front of the options: COVID-19, herpes zoster, pneumococcal vaccines (PCV13 or PPSV23), tetanus, diphtheria, and Pertussis (TDAP), hepatitis B, and influenza. The consent lacked information on PCV20. R36's medical record was reviewed and lacked evidence PCV20 was administered, or that shared clinical decision making occurred. A form, Short Term Resident Quality Measures Vaccination Report 2023-2024 indicated R36 had PPSV23 on 5/31/2011, and again 9/29/2016, and had PCV13 on 9/17/2015, and indicated "N/A" for PCV15 or PCV20. During interview on 7/17/24 at 2:09 p.m., the infection preventionist (IP) stated the consent forms indicated which vaccination a resident wanted. IP further stated they were working with the medical director and offering PCV20 if a resident was eligible when a resident had a recertification and stated clinical decision making was documented under immunizations. Additionally, IP verified consent forms lacked information for PCV20 and stated R48 had not been offered PCV20 nor had there been a discussion on clinical decision making and stated it should have been completed the first couple of weeks of admission since he was a short term resident and further stated she had to clarify what R48's wishes were based on the conflicting	F 883		

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F 883	Continued From page 59 response on the consent form. Additionally, IP stated R36's medical record contained no documentation regarding PCV20 or whether a shared clinical decision making discussion occurred and stated they utilized the CDC Pneumococcal Vaccine Timing for Adults form and stated it was important to administer vaccinations according to the CDC recommendations because of safety for residents and others in the building. During interview on 7/17/24 at 3:19 p.m., the director of nursing stated they had to establish a short term program for pneumovaccines due to the risk of pneumonia. A policy, Influenza and Pneumococcal Immunizations, dated 2/2020, indicated the facility followed the CDC guidelines for pneumococcal and influenza vaccinations. all residents, 65 years of age or older, and those younger than age 65 as recommended by the CDC, should receive the pneumococcal vaccine both the conjugate PCV13, and the polysaccharide PPSV23, if not already immunized, medically contraindicated or refused by resident or responsible party. These vaccines are administered under facility standing orders. All residents on admission will be screened to determine if they are current on influenza and both pneumococcal immunizations. Documentation of the resident's immunization status will be maintained in the medical record. Prior to administration, consent for all vaccinations will be obtained from the resident or a responsible party after current education is provided and documented in the medical record. The facility will follow the CDC guidelines for administration of PCV13 and PPSV23 vaccines	F 883		

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F 883	Continued From page 60 for those residents aged 65 or older. The policy lacked information regarding providing shared clinical decision making, or information on PCV20.	F 883		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/17/2024. At the time of this survey, PINE HAVEN CARE CENTER - BLDG 01 was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 08/16/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. PINE HAVEN CARE CENTER - BLDG 01 is a one-story building with partial basement. The building was constructed at 3 different times. A one-story building with partial basement was constructed in 1964 and determined to be Type II (111). In 1970, an addition to the North Wing was	K 000		

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K 000	Continued From page 2 constructed and determined to be Type II (111). In 1991, an addition was added to the West Wing and determined to be Type II (111). Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to PINE HAVEN CARE CENTER - BLDG 02 which was determined to be of Type V (111) construction. There is a 2-hour fire rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 70 beds and had a census of 56 at the time of the survey.	K 000		
K 345 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by: Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		8/26/24

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K 345	Continued From page 3 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to secure and maintain documentation per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was present to confirm that semi-annual testing of the fire alarm system is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	Semi-annual fire alarm testing was completed on 2/14/2024. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Fire alarm testing will be scheduled before 8/26/2024 Audits will be completed twice per year for one year and then as needed to ensure compliance with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		8/26/24

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K 353	Continued From page 4 _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2, 5.2.1.1.2, 5.2.2.2, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section 8.5.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that no sprinkler system quarterly inspection is occurring. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that sprinkler head(s) located in the Kitchen / Dishwashing areas exhibiting signs of being foreign debris loaded and/or oxidation.	K 353	The sprinkler system will be checked by Olympic on 10/3/2024. During that inspection, training of the maintenance personnel will occur so that they will begin doing quarterly system inspections in house. maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. A new sprinkler system check form was implemented on at that time. The form will include the date the system was checked, who provided the system test, the water system supply source and comments. A new maintenance schedule will be created to ensure quarterly inspections are completed. The sprinkler heads in the laundry room were cleaned on 7/18/24 The sprinkler heads in the employee break room, and kitchen will be replaced by the end of August. The items stacked vertically in Room 218 were moved to a different location to ensure 18 inch clearance from the sprinkler head on 7/18/24. Audits will be completed monthly for six months to ensure compliance with fire alarm system testing and sprinkler head compliance with results reported to the monthly QAPI Committee for further	

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K 353	Continued From page 5 3. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that sprinkler head(s) located in the Employee Break Room exhibiting signs of foreign debris loading. 4. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that sprinkler head(s) located in the Laundry Area exhibiting signs of foreign debris loading. 5. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that in RM 218 - Storage Closet that items were vertically stacked closer than 18 inches to the sprinkler head. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.5. This deficient finding could have a widespread impact on the residents within the facility.	K 355	All facility fire extinguishers will be properly inspected and documentation maintained by 8/26/2024. Fire extinguisher monthly checks will be added to the maintenance schedule. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed monthly for three months to ensure fire extinguisher checks are completed with results reported to the monthly QAPI Committee for further review	8/26/24

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K 355	Continued From page 6 Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was presented to demonstrate that at least the last 12 monthly inspections had been performed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 374	The Wing 200 smoke barrier door will be serviced by 8/26/2024. To ensure that it will self-close and seal. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed quarterly for one year to ensure that all smoke barrier doors self-close and seal properly with results reported to the monthly QAPI Committee	8/26/24

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K 374	Continued From page 7 On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that in Wing 200 the smoke barrier doors did not self-close and seal the opening. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction:8/26/2024.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the laundry chute assembly per NFPA 101 (2012 edition), section 19.5.4.5, 9.5, and NFPA 82 (2012 edition),	K 541	The laundry chute self-closing door assembly will be repaired by 8/26/2024. Maintenance personnel have been educated on 8/13/2024 on this Ktag and	8/26/24

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K 541	Continued From page 8 section 5.2.3.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that the bottom of the laundry chute, located in the Basement of the facility, exhibited a fusible link with chain attached to the chute but was absent of an approved automatic closing -or- self-closing door assembly. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	POC. Semi-annual audits will be completed to ensure the laundry chute door assembly works properly with results reported to the monthly QAPI Committee for review and further recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document or conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7 These deficient findings could have a widespread impact on the residents within the facility.	K 712	Quarterly fire drills will be completed on On all 3 shifts at varying times before 8/26/2024. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Quarterly drills will be clearly documented. Audits will be completed monthly for six months to ensure fire drills	8/26/24

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	245359	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 9 Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that no documentation presented for review to confirm that a fire drill was conducted for: 1st and 2nd shift - Q1; 3rd shift - Q3; and 1st, 2nd, 3rd shifts - Q4. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that documentation presented for review indicated patterning as 2nd and 3rd shift drills for Q2 were conducted on the same day, with 1st shift drill for Q2 being conducted on the following day. 3. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that fire drill log sheets were incomplete in data capture and signature(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	are completed quarterly on each shift at random times with results reported to the monthly QAPI Committee for further review and recommendations. The Maintenance Director will be responsible. Date of Correction:8/26/2024.	
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 901		8/26/24

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K 901	Continued From page 10 Based on a review of available documentation and staff interview, the facility failed to maintain and have available for review the current hazard vulnerability analysis documentation per NFPA 99 (2012 edition), Health Care Facilities Code, section 12.5.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that the most current hazard vulnerability analysis documentation presented for review was dated 2016. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 901	The Hazard Vulnerability Assessment was updated 8/12/2024. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed annually to ensure the Hazard Vulnerability Assessment is reviewed and updated at least annually and as needed with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12	K 914		8/26/24

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K 914	Continued From page 11 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that no documentation was presented for review of a fully completed electrical outlet testing of the facility. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that documentation presented for review of the in-process 2024 outlet testing (initiated in April 2024) was found to be generic in format and content, not providing specific findings and outcomes of testing of individual outlets. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Recepticle testing was started on 8/14/2024 and will be completed on 8/26/2024. Recepticle testing was added to the maintenance schedule to completed every 12 months. maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed quarterly for one year to ensure recepticle testing is completed with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		8/26/24

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K 918	Continued From page 12 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section	K 918	Monthly generator testing was last done for Generator 1, 2, and 3 on 12/11/2023 by Ziegler. A new monthly generator testing form was created. Ziegler will be out in	

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K 918	Continued From page 13 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that the Monthly Log Sheets for the three (3) generators were incomplete in data capture. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that for the CATERPILLAR (diesel) generator: there was no monthly load testing calculation to identify if 30% load is being achieved; the most recent 2hr load bank test was completed on 12/14/2022; and there was no document presented to confirm that 36 month - 4-hour load bank testing is occurring. 3. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that for the GENRAC (diesel) generator: there was no monthly load testing calculation to identify if 30% load is being achieved; and there was no document presented to confirm that 36 month - 4-hour load bank testing is occurring. 4. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that for the KATO (natural gas) generator there was no document presented to confirm that 36 month - 4-hour load bank testing is occurring.	K 918	September 2024 to complete annual testing of all 3 generators and provide training to maintenance personnel on monthly generator testing. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed monthly for six months to ensure generator testing is completed with results reported to the monthly QAPI Committee for further review and recommendations. The Maintenance Director of designee will be responsible. Date of Correction: 8/26/2024	

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K 918	Continued From page 14 5. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that the KATO (natural gas) generator remote annunciator panel failed upon lamp-test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of extension cords and power taps in accordance with NFPA 99 (2012	K 920	The power strips in Rooms 305 & 309 were removed and the oxygen contentrators were plugged directly into the	8/26/24

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K 920	Continued From page 15 edition), Health Care Facilities Code, sections 10.2.3.6, 10.2.4, 10.5.2.3, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that in RM 309 a medical device (Med Gas (O2) Concentrator) was found connected to a to relocatable power strip. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that in RM 305 a medical device (Med Gas (O2) Concentrator) was found connected to a to relocatable power strip. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	wall outlets on 7/17/2024. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed monthly for three months to ensure oxygen concentrators are plugged directly into a wall outlet with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible	K 923		8/26/24

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K 923	Continued From page 16 construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.5.3, 11.6.5, 11.3.2.3, These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that Med Gas (O2) Storage Room 100L was found to have storage of	K 923	The combustibles in Room 100L were removed on 7/17/2024 and relocated. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. All staff were educated on 8/14/2024. Audits will be completed weekly for three months to ensure that combustibles are stored correctly with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction:8/26/2024.	

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K 923	Continued From page 17 combustible(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to confirm qualification and training of personnel per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that, initial medical gas qualification and training of personal, is generic in content. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was present to confirm the most recent medical gas continuing education	K 926	Staff responsible for the application, maintenance, and handing of medical gases attended training on 8/14/2024. Annual training provided through Educare for all staff, last done in first quarter 2024. Continuing education will be provided for staff annually. The training will include specific information on the the application, maintenance, and storage of medical gases. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be one time per year for one year to ensure staff are adequately trained with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/24/2024.	8/26/24

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K 926	Continued From page 18 was conducted. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926		

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	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**07/17/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/17/2024. At the time of this survey, PINE HAVEN CARE CENTER - BLDG 02 was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 08/16/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 6. A detailed description of the corrective action taken or planned to correct the deficiency. 7. Address the measures that will be put in place to ensure the deficiency does not reoccur. 8. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 9. Identify who is responsible for the corrective actions and monitoring of compliance. 10. The actual or proposed date for completion of the remedy. PINE HAVEN CARE CENTER - BLDG 02 is a one-story building with no basement. The building was constructed in 2016 and determined to be Type V (111).	K 000		

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	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**07/17/2024**

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K 000	Continued From page 2 Because of the date of construction, the building was surveyed per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to PINE HAVEN CARE CENTER - BLDG 01 which was determined to be of Type II (111) construction. There is a 2-hour fire rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 70 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain means of egress	K 211	The 500 Wing Dining Room entrance/exit slab will be repaired on by end of	8/26/24

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K 211	Continued From page 3 requirements per NFPA 101 (2012 edition), Life Safety Code sections 18.2.1, 7.1.6, 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed in the 500 Wing Dining Room that concrete slab servicing the exit was degraded and spalling, presenting a trip / fall hazard. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	September. Facility has received 1 of 2 bids required before job approval can be done. Sign placed at exit communicating safety concerns. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits of all entrance/exit areas will be completed monthly for three months to ensure they are in good repair and there are not trip hazards with the results reported to the monthly QAPI Committee for review and further recommendations. The Maintenance Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to secure and maintain documentation per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5. This deficient finding could have a widespread impact on the residents within the facility.	K 345	Semi-annual fire alarm testing was completed on 2/14/2024. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Fire alarm testing will be scheduled before 8/26/2024 Audits will be completed twice per year for one year and then as needed to ensure compliance with results reported to the	8/26/24

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K 345	Continued From page 4 Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was present to confirm that semi-annual testing of the fire alarm system is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life	K 353	The sprinkler system will be checked by Olympic on 10/3/2024. During that inspection, training of the maintenance personnel will occur so that they will begin	8/26/24

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K 353	Continued From page 5 Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2, 5.2.1.1.2, 5.2.2.2, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section 8.5.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that no sprinkler system quarterly inspection is occurring. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that sprinkler head(s) located in the 500 / 600 Serving Kitchen exhibiting signs of foreign debris loading. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	doing quarterly system inspections in house. maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. A new sprinkler system check form was implemented on at that time. The form will include the date the system was checked, who provided the system test, the water system supply source and comments. A new maintenance schedule will be created to ensure quarterly inspections are completed. The sprinkler heads in the laundry room were cleaned on 7/18/24 The sprinkler heads in the employee break room, and kitchen will be replaced by the end of August. The items stacked vertically in Room 218 were moved to a different location to ensure 18 inch clearance from the sprinkler head on 7/18/24. Audits will be completed monthly for six months to ensure compliance with fire alarm system testing and sprinkler head compliance with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed	K 355	All facility fire extinguishers will be properly inspected and documentation	8/26/24

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K 355	Continued From page 6 to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 18.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was presented to demonstrate that at least the last 12 monthly inspections had been performed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	maintained by 8/26/2024. Fire extinguisher monthly checks will be added to the maintenance schedule. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed monthly for three months to ensure fire extinguisher checks are completed with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document or conduct fire drills per NFPA 101 (2012 edition), Life	K 712	Quarterly fire drills will be completed on On all 3 shifts at varying times before 8/26/2024. Maintenance personnel have	8/26/24

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K 712	Continued From page 7 Safety Code, sections 18.7.1, 4.7 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that no documentation presented for review to confirm that a fire drill was conducted for: 1st and 2nd shift - Q1; 3rd shift - Q3; and 1st, 2nd, 3rd shifts - Q4. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that documentation presented for review indicated patterning as 2nd and 3rd shift drills for Q2 were conducted on the same day, with 1st shift drill for Q2 being conducted on the following day. 3. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that fire drill log sheets were incomplete in data capture and signature(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	been educated on 8/13/2024 on this Ktag and POC. Quarterly drills will be clearly documented. Audits will be completed monthly for six months to ensure fire drills are completed quarterly on each shift at random times with results reported to the monthly QAPI Committee for further review and recommendations. The Maintenance Director will be responsible. Date of Correction:8/26/2024.	
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		8/26/24

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K 901	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and have available for review the current hazard vulnerability analysis documentation per NFPA 99 (2012 edition), Health Care Facilities Code, section 12.5.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that the most current hazard vulnerability analysis documentation presented for review was dated 2016. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 901	The Hazard Vulnerability Assessment was updated 8/12/2024. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed annually to ensure the Hazard Vulnerability Assessment is reviewed and updated at least annually and as needed with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the	K 914		8/26/24

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K 914	Continued From page 9 LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that no documentation was presented for review of a fully completed electrical outlet testing of the facility. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by review of available documentation that documentation presented for review of the in-process 2024 outlet testing (initiated in April 2024) was found to be generic in format and content, not providing specific findings and outcomes of testing of individual outlets. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Recepticle testing was started on 8/14/2024 and will be completed on 8/26/2024. Recepticle testing was added to the maintenance schedule to completed every 12 months. maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed quarterly for one year to ensure recepticle testing is completed with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/26/2024.	

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K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff	K 918	Monthly generator testing was last done	8/26/24

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K 918	Continued From page 11 interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that the Monthly Log Sheets for the three (3) generators were incomplete in data capture. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that for the CATERPILLAR (diesel) generator: there was no monthly load testing calculation to identify if 30% load is being achieved; the most recent 2hr load bank test was completed on 12/14/2022; and there was no document presented to confirm that 36 month - 4-hour load bank testing is occurring. 3. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that for the GENRAC (diesel) generator: there was no monthly load testing calculation to identify if 30% load is being achieved; and there was no document presented to confirm that 36 month - 4-hour load bank testing is occurring. 4. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that for the KATO (natural gas) generator there	K 918	for Generator 1, 2, and 3 on 12/11/2023 by Ziegler. A new monthly generator testing form was created. Ziegler will be out in September 2024 to complete annual testing of all 3 generators and provide training to maintenance personnel on monthly generator testing. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be completed monthly for six months to ensure generator testing is completed with results reported to the monthly QAPI Committee for further review and recommendations. The Maintenance Director of designee will be responsible. Date of Correction: 8/26/2024	

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K 918	Continued From page 12 was no document presented to confirm that 36 month - 4-hour load bank testing is occurring. 5. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that the KATO (natural gas) generator remote annunciator panel failed upon lamp-test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room,	K 923		8/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**07/17/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 13 where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.5.3, 11.6.5, 11.3.2.3, These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that Med Gas (O2) Storage Room 541 was found to have storage of combustible(s). 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by observation that in resident room RM 613 a free-standing oxygen cylinder (E-size) was observed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	The combustibles in Room 100L were removed on 7/17/2024 and relocated. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. All staff were educated on 8/14/2024. Audits will be completed weekly for three months to ensure that combustibles are stored correctly with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction:8/26/2024.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101	K 926		8/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING **02 - PINE HAVEN CARE CENTER** B. WING _____	**07/17/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926	Continued From page 14 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to confirm qualification and training of personnel per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that, initial medical gas qualification and training of personal, is generic in content. 2. On 07/17/2024 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was present to confirm the most recent medical gas continuing education was conducted. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926	Staff responsible for the application, maintenance, and handing of medical gases attended training on 8/14/2024. Annual training provided through Educare for all staff, last done in first quarter 2024. Continuing education will be provided for staff annually. The training will include specific information on the the application, maintenance, and storage of medical gases. Maintenance personnel have been educated on 8/13/2024 on this Ktag and POC. Audits will be one time per year for one year to ensure staff are adequately trained with results reported to the monthly QAPI Committee for further review and recommendations. The EVS Director or designee will be responsible. Date of Correction: 8/24/2024.	