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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on observation, interview, and document review the facility failed to ensure safety and protect residents from physical and verbal abuse, during resident to resident altercations. This resulted in an immediate jeopardy (IJ) when resident (R) 1 who had a history of aggression would become abusive towards others. The Immediate Jeopardy began on 6/5/21, when the facility failed to protect R2 and other residents after R1 aggressively yelled and swung at her. There was 8 other residents (R2, R3, R4, R5, R6, R7, R8, and R9) identified to have had known suffering by either physical abuse, verbal abuse, or physical aggression. The IJ was identified on 7/19/21. The administrator and director of nursing (DON) were notified on 7/19/21, at 5:12 p. m. The IJ was removed on 7/22/21, at 2:58 p.m. after it could be verified the facility had implemented an acceptable removal plan, however, non-compliance remained at E severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's hospital discharge summary dated 10/12/21, indicated R1 had a psychiatric hospital stay related to worsening agitation and behavioral disturbance with aggression in the setting of major neurocognitive disorder (probable Alzheimer's and Lewy body dementia). The summary indicated R1 was prescribed medications for behavior/mood management. R1's face sheet dated 7/22/21, indicated R1 was admitted to the facility on [DATE] with diagnoses that included diagnoses of dementia with behavioral disturbance and insomnia. R1's Behavioral Care Area assessment dated [DATE], included R1 is new to Pine Haven, he is here for respite care, he likes to walk, he is confused and used to be home with his wife. and was not fully completed. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R1 had severe cognitive impairment, had signs and symptoms of delirium that was continuously present, had physical and verbal behavioral symptoms directed towards others 1 to 3 days during the assessment period, and rejection of care behaviors 1 to 3 days during the assessment period. R1 also had wandering behaviors daily. The MDS indicated R1 required supervision for transfers, limited assistance from staff to walk in room and in corridor, and supervision for locomotion on and off the unit. (continued on next page)

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.

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

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's behavioral care plan dated 6/24/21, included, R1 had alteration in memory, judgement, decision making and thought process related to diagnosis of dementia. R1 had behaviors of wandering, attempting to enter other residents rooms, exit seeking, threats of physical harm to staff, actual physical aggression to staff and residents, saying play with him/it and gestures to groin, yelling out Help me! Let's go! Where are you! Family reports resident becomes agitated when he sees mirrors/his reflection. Interventions included: -Mirrors removed from room [ROOM NUMBER]/21/21. -Give medication as per physician orders (start date 2/11/2021) -Break activities into manageable subtasks. Give one instruction at a time to resident (start date 3/5/2021) -Ensure staff introduce themselves and are wearing name tags at initiation of each interaction with resident (start date 3/5/2021) -Use only one staff member for cares, multiple staff around me make me agitated (start date 3/5/2021) -[NAME] responds well to praise. When participating in cares, acknowledge that he is participating well (start date 3/5/2021) -If resident has behaviors, it may be due to not understanding what is being done, use soft gentle tone, soothing words. (start date 3/5/2021) -If I enter other resident's rooms, do not tell me I can't be in there. Tell me See you later [R1] or We should go into this room instead (start date 3/5/2021) -Allow R1 to assist with simple tasks, like carrying his snack back to his room, and say things like Good job [R1] (start date 5/26/2021) -I am easily over stimulated by too much noise or too many people (start date 5/28/2021) -Keep resident away from mirrors when possible to avoid agitation (start date 6/18/2021) R2's quarterly MDS dated [DATE], identified R2 did not have cognitive impairment (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During observation and interview on 7/19/21, 3:34 p.m. R2's room had a Velcro mesh netting with a STOP sign strung across her doorway. R2 sat up in her chair. When asked what is the stop sign for? R2 replied, it was to stop R1 from entering; he goes up and down the hallways looking for his wife. R2 stated she was aware of R1's behaviors of wandering into residents' rooms and yelling at other residents. R2 stated before the stop sign was placed, (R2 could not recall the date), R1 came in the room, R2 put on her call light right away, she was scared and shaking, she then told R1 he was in the wrong room. R2 stated R1 became hostile, walked over to where she was sitting in her chair and got 2 inches from her face, started yelling back at her but could not recall what his words were. R2 stated she thought he was going to hit her. R2 stated she couldn't get up without assistance from staff. R2 indicated R1 left on his own and shut the door behind him, stated R1 had been in her room for about 5 minutes and staff had not responded while he was in her room. R2 stated she reported the incident and concerns to staff. staff were aware of how scared she is of him. R2 stated R1 had not been back in her room since then but continues to be very frightened, R1 continued to stand behind the stop sign and looks in, I just fall to pieces when I see him, I tremble in fear. R2 stated she didn't know what he would do, one day he was standing out there and he was trying to take the sign down. He just scares me. R2 stated, she did not feel very safe and even though she continues to report fear to staff, she doesn't think they have done anything about his behaviors. R9's admission MDS dated [DATE], identified R9 had moderate cognitive impairment. During an interview on 7/19/21, at 3:44 p.m. R9's room had a Velcro mesh netting with a STOP sign strung across her doorway. When asked what the stop sign was for, R9 stated it was to prevent R1 from entering his room. R9 stated R1 had entered his room recently, (could not recall the date) R1 started going through his drawers, when R9 told him to get out, R9 walked over to him and swatted me in the head. R9 stated R1 hit him with an open hand however, it really hurt. R9 stated he had put on his call light as soon as R1 had entered his room, however, staff did not respond to prevent him from getting hit. R9 indicated after R9 had hit him, he left the room, and soon after staff responded, R9 reported the incident, and staff came back with that stop sign. R9 indicated R1 had not come in his room again, however does linger outside his door, I hope I never get in his way! R1's progress notes included: 5/29/21, at 3:10 p.m. Resident [R1] was wandering into others rooms with another resident. Staff attempted to redirect, resident who became agitated very quickly and was giving a strangling motion to another resident. Resident was given a snack at the nurse's station. 6/2/21, at 2:02 p.m. Resident [R1] was wandering halls around 1300 [1:00 p.m.] and walked into [number of a resident's room] room when staff attempted to redirect him and he became aggravated swinging his fists around. Another resident, [initial of a resident] in [room number of that resident], was also walking down that hall and attempted to speak to [R1] and redirect him from entering said room when he grabbed onto her wrist and swung it away from him. Staff unable to remember which wrist. The two were separated by staff and walked their separate ways. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6/5/21, at 10:29 p.m. Resident [R1] was yelling at a female resident very aggressively. Female resident did not say anything to him. He then swung at her quite hard and missed her by less than an inch because she flinched backwards. A resident asked to go to her room because she was scared of that man, he is so angry, he is going to hurt someone Staff had to remove him from other resident's room's multiple times. One time in particular, the other resident, whose room it was, was screaming because she was scared and this resident was screaming back at her to shut up and let's go he was also trying to get over to her in her recliner. This is when he grabbed this nurses arm and squeezed it very hard. He also punched and slapped this nurse trying to get to the scared resident. This resident hit and slapped this nurse and other nurses multiple times when he walked by. For no reason what so ever. 6/6/2021, at 9:40 p.m. Resident [R1] intruding into many residents rooms this shift. Yelling at several residents which has made them afraid to come out of their rooms due to this behavior. Resident went into [room number of a victim] room and [victim] yelled at him to get out. This resident [R1] got very angry and began to yell. Staff was able to redirect him away from the room. [Victim] was told to talk to him calmly if he comes into their room. During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, one of the residents was identified as R2 and the other resident(s) were not able to be identified. DON stated the incident was not reported to the State Agency. 6/7/21, progress note indicated new orders were given to increase R1's antipsychotic medication. 6/8/21, at 11:30 p.m. Resident [R1] entered a female resident's room and would not get out when she asked him and it was difficult to remove him with the help of staff as well. Female resident cannot move herself and was scared and crying. This agitated and angered this resident more. Resident came out of the room and soon was distracted by something else. Female resident is requesting a Velcro stop sign to be placed in her doorway to help prevent this resident from entering again. R1's physician visit note dated 6/9/21, did not address aggressive behaviors toward other residents. The note included, Updates obtained from nursing and patient. He has had some refusal of cares. He has also had behaviors of urinating inappropriate places. To help ensure he is safe in redirectable his Seroquel (antipsychotic) has been titrated. It was noted that he was sleeping more yesterday, but has been up and witnessed ambulating around building again today. He often wonders [sic] throughout the building. The note also included, Difficulty and risks with staff providing cares is indication for this dose being titrated up. Will be monitored closely and adjusted appropriately. R1's progress note dates on 6/13/21, at 2:34 p.m., indicated R1 attempted to elope from the facility. The note then included, This writer and another nurse tried to bring resident inside which agitated him even more and was grabbing and pushing staff members while another resident was watching and crying because she was scared. Staff members were eventually able to bring resident back inside and lie him down in bed. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's physician visit note dated 6/15/21, did not address the behavior noted 6/13/21. Note included, On 6/7/21 patient was noted to have increased behaviors during bedtime regimen including agitation grabbing at wrists of staff and difficult to redirect. Seroquel medication regimen was readjusted to providing him with a dose of Seroquel at bedtime. The note indicated since then he has been directable with less behaviors. Staff continues to educate numerous staff on approach with [R1] which seems to be the most effective. 6/16/21, at 8:12 p.m. Resident [R1] easily agitated this shift. Resident noted to be restless (wandering halls) throughout the shift. Resident displayed verbal and physical aggression towards staff and verbal aggression towards other residents. Resident would wave fist in air and yell unintelligible sounds/garbled speech at other residents. Resident would attempt to move others in wheel chairs if they were in the path of resident. 6/17/2021, at 12:20 p.m. Resident [R1] has been aggressive towards staff and other residents today. Resident was easily directed at times with food. However, there were situation where he needed to directed away from the scene. Cooperative with mediation administration. 6/17/21, at 12:45 p.m. Resident [R1] walking down to DR [dining room] by the windows. [R4] said hi. [R1 name] went behind her and punched her in the back and called her an asshole. Staff intervened and removed this resident from the scene. Resident remained agitated despite agitation. 6/18/21, at 8:22 a.m., note indicated DON, and administrator aware of the situation between R1 and another resident on 6/17/21. The note indicated the care plan would not be changed and staff would continue to redirect the resident to a more calm environment. 6/26/21, at 2:39 p.m. Resident [R1] wandered into [R5's] room. [R5] asked him to leave in which he started yelling and acting like he was going to hit resident. Staff escorted resident out of room and redirected him into own room. 6/30/21, at 3:15 p.m. At 1515 [3:15 p.m.] on 6/30/21 Resident [R1] slapped another resident on their left arm. Resident had been arguing with another resident moments before and was upset r/t [related to] that. 7/12/21, at 3:15 p.m. Resident [R1] asked another resident [R7] a question and the other resident didn't hear him and said, what did you say. This angered resident and he hit the other resident twice with the back of his right hand on the side of the other resident's upper left arm. This nurse got in between the two residents and took the other resident down the hall to use the bathroom. 7/13/21, at 4:30 p.m. Resident [R1] was walking up and down the halls and passed in front of a couple of ladies watching a program on TV One of the ladies [victim not identified] who has dementia yelled, Why don't you get out of the way. This resulted in an argument and resident 2 [R1] grabbed resident 1 [victim] by her right forearm with his left hand squeezing and twisting. He let go of her arm as this writer ran toward the situation. Resident one [sic] walked away. Resident 2 [sic] started crying and saying, He twisted my arm. Both resident's forgot about this altercation shortly after it happened. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7/16/21, at 3:55 p.m. progress note indicated leadership team discussed resident's continued behaviors and agitation. Indicated increased agitation typically in afternoon beginning at 1:30 p.m. and continuing until 5:00 p.m. He becomes agitated easily and at times hits staff members and has hit residents. Area of concern is the common area on 200/300/400 units. Resident is having acute visit on 7/19/2021 to addressed continued and increased behaviors. Updated care plan and kardex for staff to walk with resident on 500/600 units as he previously enjoyed this when his room was on the 600 unit. Writer updated hall nurse and communication page. Observations on 7/19/21: -At 11:30 a.m. during the initial facility tour, multiple resident rooms were observed to have mesh netting with a stop sign strung between the door frames. -At 12:06 p.m. R1 walked out of the dining room. Registered nurse (RN)-A assisted R1 back into the dining room. -At 12:21 p.m. R1 was wandering in and out of the dining room calling out for his wife. An unidentified staff member informed R1 his wife was not here and walked away. -At 12:27 p.m. R1 was sitting at the dining room table and began walking out of dining room, unidentified nursing assistant (NA) asked if he wanted a cookie and returned R1 to the dining room table. -At 1:20 p.m. R1 wandered up and down the hallway in front of the nursing station, residents were in the vicinity. -At 3:15 p.m. R1 sat in the front entry way eating a snack, other residents were near R1. Observation on 7/21/21: -At 7:55 a.m. it was observed that some rooms that had stop signs up on 7/20/21, were not in place. -At 9:32 a.m. R1 sat in a chair down the 200 hallway. At 9:34 a.m. R1 was wandering in the hallway without supervision. The stop signs continued to be down. -At 11:21 a.m. multiple stop signs continued to be down. -At 12:25 p.m. multiple stop signs continue to be down in most resident rooms -At 12:35 p.m. administrator stated stop signs were supposed to be up at all times whether residents were in their rooms or not. Administrator was informed stop signs had not been up since first observation made. -At 1:08 p.m. stop signs continued to not be in place. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-At 4:25 p.m. stop signs continued to not be in place. R1 was observed wandering down the 300-hallway unsupervised, R1 entered 2 residents rooms that previously had stop signs on them, one resident was in her bed sleeping. An unidentified nursing assistant was walking with another resident in front of R1. NA asked R1 to follow them, R1 stated no, dietary assistant (DA)-1 attempted to redirect R1 to follow her to the dining room several times, however R1 became agitated and slapped DA-1 on the shoulder. -At 4:35 p.m. administrator was made aware of the observations. Observations on 7/22/21: -At 7:25 a.m. stop signs were not up on residents rooms. -At 7:41 a.m. R1 came out of his room and urinated on the doors that lead to the 500/600 unit, after several minutes licensed practical nurse (LPN)-A responded to the scene. -At 8:44 a.m. stop signs to resident's rooms continued to be not in place. Administrator inquired with LPN-A where the stop signs were. Administrator supervised R1 until other staff were nearby to supervise resident. -At 9:24 a.m. R1 finished his snack and wandered unsupervised down the 200 hallways, R1 stopped and entrances to resident rooms and looked inside. At 9:25 a.m. a staff member walked passed him and said hi and kept walking. -At 11:11 a.m. director of nursing (DON) indicated an awareness that staff were not monitoring/supervising R1 when R1 was wandering in order to keep residents safe. -at 12:29 p.m. all stop signs to resident rooms were observed to be in place. During an interview on 7/19/21, at 11:37 a.m. licensed practical nurse (LPN)-A stated R1 had aggressive behaviors and got agitated with redirection. LPN-A stated R1 would hit you, indicated when R1 demonstrated aggressive behaviors, staff were supposed to leave him alone and reproach him, offer him food, or toilet him. LPN-A stated if a resident tried to tell him something he didn't want to do, R1 would get agitated/aggressive toward them too. LPN-A stated R1's behaviors of aggression were unpredictable. During an interview on 7/19/21, at 11:41 a.m. LPN-C indicated she was not aware of all of the R1's incidents of physical/verbal abuse against residents. LPN-C stated if R1 was agitated we would remove him away from other residents and offer a snack. LPN-C indicated R1 had very short-term memory loss, he would forget what he was doing in seconds. LPN-C stated R1 would get agitated with noise and a lot of people, behaviors started to increase around 1:30 p.m., staff were supposed to take him to a different unit when he got agitated. LPN-C stated R1 calms down as fast as he got agitated, no rhyme or reason for his behaviors, and his aggression was very unpredictable. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/19/21, at 12:05 p.m. LPN-B stated R1 wandered a lot. LPN-B stated R1 got agitated and aggressive, he didn't always comprehend what staff are telling him. LPN-B stated R1 has pretended to take a swing at her. LPN-B indicated R1 was not always supervised when he wandered, residents would tell him to get out and he would get frustrated. When asked how residents are protected from R1 if he wandered into a residents room and became frustrated, LPN-B stated I like to keep a close eye on him LPN-B stated R1 didn't have a lot of behaviors on the day shift, R1 had more behaviors on the evening shift, around shift change is when behaviors started. LPN-B stated R1 was triggered by a lot of commotion and visitors coming into the building. During an interview on 7/19/21 at 1:52 p.m. medical doctor (MD)-A stated an awareness of R1 history of aggressive behaviors. MD-A indicated nurse practitioner had increased his antipsychotic medications on 6/7/21, for an increase in behaviors; at the follow-up visit around 6/15/21, there had been an improvement. MD-A stated an unawareness of increase of physical/verbal aggressive behaviors after the NP had evaluated him. MD-A stated staff should have notified him/NP when R1 demonstrated physical/verbal/threatening behaviors toward other residents and/or with increase in behaviors after the medication dose adjustment. MD-A indicated an expectation non-pharmacological behavioral intervention be utilized and evaluated for effectiveness. MD-A indicated because R1 was ambulatory, difficult to redirect, limited successful non-pharmacological approaches, elements of behavioral unpredictability, and concerns with stress on residents and their safety, medication management was warranted in addition to good behavioral approaches. During an interview on 7/20/21, 7:51 a.m. nursing assistant (NA)-A stated R1 had aggressive behaviors toward staff and residents. NA-A stated his behaviors are unpredictable and doesn't like to be told what to do. NA-A stated when he is agitated we offer him something to eat, bathroom, or take him for a walk to the other unit where it is quieter, and he likes being told he does a good job. During an interview on 7/20/21 at 8:11 a.m. registered nurse (RN)-A indicated she was the nurse manager of the unit in which R1 resided. RN-A reviewed R1's progress notes that identified incidents of physical/verbal abuse and threatening behaviors towards residents. RN-A verified immediate interventions to protect residents were not developed and/or implemented after each occurrence and the care plan had not been revised. RN-A stated any incidents of abuse or threatening behaviors toward other residents should be immediately reported to the administrator or the DON. RN-A stated it should have been made clear who those residents were and that they were safe, and immediately protected from R1. RN-A confirmed R1's physician was not notified of the physical/verbal abuse inflicted on other residents, confirmed physicians of the residents who suffered abuse were not notified, and confirmed psychosocial assessments, monitoring, or services were offered to those victims. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/21/21, at 11:10 a.m. NA-C indicated R1 had aggressive behaviors and he had good days and bad days. NA-C stated he would get agitated when he was not ready to be helped with something or if there was too much commotion. Staff could tell if he was agitated if he wandered around looking for his wife. NA-C stated when R1 was agitated, staff offered him food, or take him away from the commotion. NA-C indicated R1 wandered around the unit. When asked how were staff aware if R1 had wandered into a residents' room, NA-C responded the resident would put on their call light. NA-C stated R1's behaviors were sometimes unpredictable, if R1 was having a bad day and a resident told him to get out, he would not leave unless directed by staff. NA-C stated recently she had to step in-between him and R3 because they were having words back and forth and he looked like he was going to hit her. NA-C stated she redirected R1, and removed him from the location. NA-C stated R1 has grabbed and hit her before, and R1 would probably have the same aggressive behaviors towards residents. During an interview on 7/21/21, at 11:56 a.m. licensed social worker (LSW) indicated her assistant covered the unit in which R1 resided however, had awareness of R1's aggressive behaviors towards residents because every morning the leadership team had a meeting to review/discuss progress notes/events from the previous day. R1's record was reviewed with LSW, when asked how the facility was protecting residents from R1, LSW stated residents were provided with stop signs, I know staff don't always do that, we have provided education on ensuring they were up. LSW indicated all residents who resided on the same unit had not been interviewed and/or evaluated after R1's documented abusive incidents. LSW indicated the facility had not completed a comprehensive assessments and/or monitoring of residents who suffered R1's abusive behaviors, indicated the residents were checked on, but the checks were not documented or evaluated. LSW indicated nursing was supposed to be documenting behaviors, however the documentation did not reflect how may occurrences of each behavior occurred on each shift and the effectiveness of the intervention used. During an interview on 7/21/21, at 1:08 p.m. DON confirmed the lack of documentation and/or incident report completion. DON stated that the notes that indicated verbal aggression were not reported to the State agency because they were deemed as arguments between residents even though the documentation indicated residents were fearful of R1. DON indicated after further investigation on 7/20-7/21, residents who were affected were identified after further investigation and vulnerable adult reports were submitted to the state agency for those that were not previously reported. When asked how residents were being protected from R1, DON indicated residents that resided on the same unit were protected by putting stop signs up that prevented R1 from entering and staff were supposed to take R1 for a walk to the 500/600 hallway when he demonstrated agitation, however, could not articulate how long R1 was supposed to be walked and if R1 was supposed to be monitored after the walk. DON stated R1's agitation was unpredictable. DON stated as of 7/21/21, all residents who resided on R1's unit had not been interviewed in order to determine if R1 had demonstrated verbal/physical aggression towards them. DON indicated that interventions including medication should be monitored and evaluated for effectiveness, confirmed the record lacked analysis of the effectiveness of interventions. DON stated stop signs on resident rooms should be up at all times and staff had been provided education. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Facility policy Pine Haven Abuse and Neglect Policy and Reporting dated 1/2021, included the following definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical charm, pain or mental anguish. Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It is the policy of Pine Haven Care Center, that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The policy also outlined reporting and investigation requirements including the protection of the vulnerable adults during the investigation. The immediate Jeopardy was removed on 7/22/21, at 2:58 p.m. when it could be determined the facility had completed the following: 1) All staff were educated on the abuse policy, monitoring interventions for effectiveness, completing a comprehensive abuse assessment, and completing root cause analysis leading to the alleged abuse, and implementing immediate interventions to protect residents from abuse. 2) R1's behaviors and interventions were comprehensively assessed, and interventions were developed, care planned, and implemented to protect facility residents from further abuse. 3) Facility residents who sustained alleged abuse were evaluated for any impact on mental well-being and facility residents. 4) Facility conducted abuse investigations to determine root cause analysis including interviewing all residents residing on same unit in order to determine if any other residents were affected. 5) An auditing system for compliance with the abuse policy, comprehensive assessments, root cause analysis, and implementation of interventions was developed and implemented.

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on interview and document review the facility failed to report allegations of resident to resident physical and verbal abuse and threatening behaviors from R1 to the State Agency within 2 hours for 9 of 9 residents (R2, R3, R4, R5, R6, R7, R8) reviewed for allegations of abuse. Findings include R1's progress note dated 5/29/21, at 3:10 p.m. Resident [R1] was wandering into others rooms with another resident. Staff attempted to redirect, resident who became agitated very quickly and was giving a strangling motion to another resident. Resident was given a snack at the nurse's station. R1's progress note dated 6/2/21, at 2:02 p.m. Resident [R1] was wandering halls around 1300 [1:00 p.m.] and walked into [number of a resident's room] room when staff attempted to redirect him and he became aggravated swinging his fists around. Another resident, [initial of a resident] in [room number of that resident], was also walking down that hall and attempted to speak to [R1] and redirect him from entering said room when he grabbed onto her wrist and swung it away from him. Staff unable to remember which wrist. The two were separated by staff and walked their separate ways. R1's progress note dated 6/5/21, at 10:29 p.m. Resident [R1] was yelling at a female resident very aggressively. Female resident did not say anything to him. He then swung at her quite hard and missed her by less than an inch because she flinched backwards. A resident asked to go to her room because she was scared of that man, he is so angry, he is going to hurt someone Staff had to remove him from other resident's room's multiple times. One time in particular, the other resident, whose room it was, was screaming because she was scared and this resident was screaming back at her to shut up and let's go he was also trying to get over to her in her recliner. This is when he grabbed this nurses arm and squeezed it very hard. He also punched and slapped this nurse trying to get to the scared resident. This resident hit and slapped this nurse and other nurses multiple times when he walked by. For no reason what so ever. During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, the residents was identified as R2 and R3. DON stated the incident was not reported to the State Agency. R1's progress note dated 6/6/2021, at 9:40 p.m. Resident [R1] intruding into many residents rooms this shift. Yelling at several residents which has made them afraid to come out of their rooms due to this behavior. Resident went into [room number of a victim] room and [victim] yelled at him to get out. This resident [R1] got very angry and began to yell. Staff was able to redirect him away from the room. [Victim] was told to talk to him calmly if he comes into their room. During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, one of the residents was identified as R2 and the other resident(s) were not able to be identified. DON stated the incident was not reported to the State Agency. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's progress note dated 6/8/21, at 11:30 p.m. Resident [R1] entered a female resident's room and would not get out when she asked him and it was difficult to remove him with the help of staff as well. Female resident cannot move herself and was scared and crying. This agitated and angered this resident more. Resident came out of the room and soon was distracted by something else. Female resident is requesting a Velcro stop sign to be placed in her doorway to help prevent this resident from entering again. During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON stated after further investigations were completed on 7/20/21, the resident was identified as R2. DON stated the incident was not reported to the State Agency. R1's progress note dated 6/13/21, at 2:34 p.m. Note indicated R1 attempted to elope from the facility. The note then included, This writer and another nurse tried to bring resident inside which agitated him even more and was grabbing and pushing staff members while another resident was watching and crying because she was scared. Staff members were eventually able to bring resident back inside and lie him down in bed. During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident the progress note referred to, DON indicated upon further investigations completed on 7/20/21, the resident was not identified. The DON stated the incident was not reported to the State Agency. R1's progress note dated 6/16/21, at 8:12 p.m. Resident [R1] easily agitated this shift. Resident noted to be restless (wandering halls) throughout the shift. Resident displayed verbal and physical aggression towards staff and verbal aggression towards other residents. Resident would wave fist in air and yell unintelligible sounds/garbled speech at other residents. Resident would attempt to move others in wheel chairs if they were in the path of resident. R1's progress note dated 6/17/2021, at 12:20 p.m. Resident [R1] has been aggressive towards staff and other residents today. Resident was easily directed at times with food. However, there were situation where he needed to directed away from the scene. Cooperative with mediation administration. 6/17/21, at 12:45 p.m. Resident [R1] walking down to DR [dining room] by the windows. [R4] said hi. [NAME] went behind her and punched her in the back and called her an asshole. Staff intervened and removed this resident from the scene. Resident remained agitated despite agitation. During an interview on 7/21/21, at 1:08 p.m. DON indicated records did not identify which resident(s) the progress note referred to on 6/17/21 at 12:20 p.m., DON indicated upon further investigations completed on 7/20/21, it could not be determined which resident(s) the progress note at 12:20 p.m. referred. DON indicated the incidents were not reported to the State Agency. R1's progress note dated 6/26/21, at 2:39 p.m. Resident [R1] wandered into [R5's] room. [R5] asked him to leave in which he started yelling and acting like he was going to hit resident. Staff escorted resident out of room and redirected him into own room. During an interview on 7/21/21, at 1:08 p.m. DON stated the incident was not reported to the State Agency. (continued on next page)

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/12/21, at 3:15 p.m. Resident [R1] asked another resident [R7] a question and the other resident didn't hear him and said, what did you say. This angered resident and he hit the other resident twice with the back of his right hand on the side of the other resident's upper left arm. This nurse got in between the two residents and took the other resident down the hall to use the bathroom. During an interview on 7/21/21, at 1:08 p.m. (DON) stated the incident was not reported to the State Agency. Facility policy Pine Haven Abuse and Neglect Policy and Reporting dated 1/2021, included G. REPORTING AND RESPONSE: It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported per Federal and State Law. The facility will ensure that all alleged violation involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation do not involve abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property and do not result in serious bodily injury are reported no later than 24 hours to the administrator of the facility and to other officials

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on document review and interview, the facility failed to ensure a Level I preadmission screening (PAS) was completed prior to long term care admission to determine whether residents with mental illness or intellectual disability qualified for additional services. This had the potential to affect 1 of 1 resident (R1) reviewed for preadmission screening. Findings include R1's hospital discharge summary dated 10/12/21, indicated R1 had a psychiatric hospital stay related to worsening agitation and behavioral disturbance with aggression in the setting of major neurocognitive disorder (probable Alzheimer's and Lewy body dementia). The summary indicated R1 was prescribed medications for behavior/mood management. The summary included the primary diagnosis of Major Neurocognitive disorder with Behavioral Disturbance. R1's physician letter dated 1/28/21, indicated R1 had dementia, and required temporary respite care at the facility. R1's physician letter dated 2/15/21, indicated R1's primary physician was writing the letter on behalf of R1. The letter included, [R1] has dementia and is going to be entering long term care at Pine Haven Care Center today. This letter should serve as an order for long term care placement. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severely impaired cognitive skills for daily decision making, had signs and symptoms of delirium that was continuously present, had physical and verbal behavioral symptoms directed towards others 1 to 3 days during the assessment period, and rejection of care behaviors 1 to 3 days during the assessment period. R1 also had wandering behaviors daily. R1's record identified the Initial Pre-Admission Screening was not submitted to the Senior Linkage Line until 6/2/21. The PAS indicated R1 had an actual admitted [DATE], and the anticipated length of stay was 91+ days. During an interview on 7/21/21, at 11:56 a.m. licensed social worker (LSW) reviewed R1's record and verified the PAS was not completed until 6/2/21, and indicated the PAS should have been completed prior to admission to the facility. During an interview on 7/21/21, at 1:08 p.m. director of nursing (DON) reviewed R1's record and confirmed the PAS was not completed until 6/2/21, and indicated the PAS should have been completed prior to admission to the facility. Facility policy Admission Criteria dated 3/2019, included the following: 9) All new admissions and readmissions are screened for Mental disorders, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review process.

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	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on interview and document review the facility failed to obtain physician ordered laboratory tests according to the hospital discharge summary for 1 of 1 residents (R12) reviewed for gastrointestinal bleeding. Findings include R12's hospital discharge summary dated 7/9/21, indicated R12 was hospitalized related to diagnosis of acute on chronic congestive heart failure on 6/29/21, and required intravenous diuresis, Recommend BMP [basic metabolic panel) on 7/12/21. The summary also indicated R12 was found to be anemic in the hospital and was transfused with two doses of iron. The summary section Consults and Follow-up Appointments included Recommendations: BMP/CBC [complete blood count]. The discharge summary indicated R12 was discharged from the hospital on 7/9/21 to the facility. R12's face sheet dated 7/22/21, identified R12 was admitted to the facility on [DATE], with diagnoses that included acute on chronic heart failure, atrial fibrillation, presence of a cardiac pacemaker, long term use of anticoagulants, and chronic wasting disease. R12's record lacked evidence the recommended labs according to the hospital discharge summary were collected and/or completed. During an interview on 7/22/21, at 2:00 p.m. registered nurse (RN)-B stated she was the nurse manager for the transitional care unit, however did not complete R12's admission. RN-B reviewed R12's hospital discharge summary and confirmed the labs were not obtained. RN-B indicated the discharging hospital should have called and arranged for the lab blood draws. RN-B stated the admission nurse would transcribe the order into the treatment administration record. During an interview on 7/21/21, at 1:08 p.m. director of nursing (DON) reviewed R12's hospital discharge summary and confirmed the orders for the follow-up lab testing for BMP/CBC were not completed. DON indicated the nurse manager who does the admission was responsible for making sure all follow-up appointments and labs were ordered. DON indicated it was missed. Facility policy Lab and Diagnostic Test Results-Clinical Protocol dated 11/2018 included, 1) The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2) The staff will process test requisitions and arrange for the test.