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	12/24/2024

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

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 - Few	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** 38685 Based on interview and record review the facility failed to ensure allegations of staff to resident physical abuse were immediately reported to the State Agency (SA) no later than 2 hours after the knowledge of the allegation of abuse, for 1 of 1 residents (R1) reviewed for abuse. Findings include: Facility reported incident (FRI) submitted on 12/18/24 at 9:27 p.m., identified that on 12/18/24 at 4:10 p.m., the facility was notified by registered nurse (RN)-D that R1 stated her leg was sore because someone had kicked her in the leg and pinched her in the groin area. Two finger sized bruises noted to inner thigh. In addition, R1 stated she had been slapped in the cheek and her glasses were knocked off of her face. R1 identified it was a staff member from 2 weeks ago and had not seen staff member since. R1's quarterly, Minimum Data Set (MDS), dated [DATE], indicated R1's cognition was moderately impaired. R1's diagnoses included dementia. R1's progress note dated 12/18/24 at 6:12 p.m., identified R1 made an accusation of abuse that happened 'a couple weeks ago'. R1 stated it was a female and it happened in the morning. R1 stated the caregiver slapped her on the cheek, knocking her glasses off. The person purposely kicked her in the left leg and pinched at the left inner thigh. At 6:17 p.m., identified R1 had relayed the abuse accusation at 6:05 p.m. Writer called the on-call manager phone at 6:10 p.m., and 6:15 p.m., without connecting to anyone in person. Writer left a voice message describing the basic situation and left a phone number to call back. At 6:22 p.m., R1 was unable to identify her accuser. During an interview on 12/23/24 at 3:29 p.m., RN-D (agency nurse) stated on 12/18/24, at around 6:00 p.m. R1 reported a nurse aide kicked her in the left ankle and pinched her inner thigh a few weeks prior. Shortly after he called the DON, but she did not answer the phone, so he left a message. RN-D could not recall the exact time he had left the message. RN-D stated at 7:00 p.m., the DON called back with the instructions to obtain more information and get a description of the nursing assistant involved. RN-D stated at 7:45 p.m., he spoke with DON to inform her of the description that R1 gave. RN-D thought allegations were reported within 2 hours; RN-D asked surveyor Does this mean the 2-hour timeframe would be from 2 hours of being reported by the resident or would it be 2 hours when we report it to management? (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/24/24 at 11:06 a.m., director of nursing (DON) indicated on 12/18/24, RN-D called her phone at 6:13 p.m. and left a voice message. DON had missed the call and did not get the message. At 8:14 p.m. she talked to RN-D, had him collect more information, then reported to the SA. DON indicated RN-D had told her R1 had reported the allegation to him at 4:10 p.m. however was documented in the record a little after 6:00 p.m. When asked what the time period of reporting abuse to the SA was, DON stated, immediately but within 24-hours. DON verified R1's allegation of abuse was reported to the SA on 12/18/24, at 9:27 p.m. which was more than 2-hours of when the allegation was made by R1. During an interview on 12/24/24 at 1:19 p.m., director of social services (DOS)-A stated all abuse allegations should be reported to the SA no later than 2 hours. DOS-A stated she provides all staff upon hire during orientation and staff were required to do abuse training annually. DOS-A indicated she does not educate agency staff of abuse reporting. During an interview on 12/24/24 at 1:47 p.m., administrator stated all allegations of abuse should be reported to the SA no later than 2-hours and verified R1's abuse allegation was reported late. Administrator indicated when the DON had called her on 12/18/24, she had informed the DON allegations of abuse needed to be reported to the SA immediately. During an email correspondance on 12/27/24, at 12:03 p.m., DON indicated she had made an error in the reporting time and stated she had put 4:10 p.m., for the initial report in error and should have been 6:12 p.m. On 12/30/24 at 8:45 a.m., via phone DON stated the report would still be late. Facility policy, ABUSE, NEGLECT, MISTREATMENT AND MISAPPROPRIATION OF RESIDENT PROPERTY, policy revised 1/2021 identified it is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation .The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements .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 violations 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. 51576

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 51576 Based on observation, interview, and document review the facility failed to assess and monitor non-pressure related skin injury (bruises) for changes until resolved for 1 of 1 resident (R1), reviewed for abuse. Findings include: R1's admission, Minimum Data Set (MDS), dated [DATE], indicated R1's cognition was moderately impaired. R1's care plan dated 4/9/24, identified a focus of R1 had history of potential for/actual impairment to skin integrity however did not identify and/or direct a monitoring plan for the potential or actual impairment. R1's progress note dated 12/17/24 at 10:31 p.m., included R1's skin issues on arms and back still present. Facility reported incident (FRI) submitted on 12/18/24 at 9:27 p.m., identified that on 12/18/24 at 4:10 p.m., the facility was notified by registered nurse (RN)-D that R1 reported allegations of physical abuse. Two finger sized bruises noted to inner thigh. R1's record was reviewed between 12/18/24 through 12/24/24, and did not include a comprehensive skin assessment and monitoring of the bruises identified in the FRI dated 12/18/24. During an interview on 12/23/24 at 3:29 p.m., RN-D stated R1 informed him on 12/18/24 of being pinched on inner thigh and kicked on her leg. RN-D indicated he had observed two small bruises on R1's left inner thigh that were about 1/2 inch in diameter and dark purple in color but he did not measure or record the information into R1's medical record. During an observation and interview on 12/23/24 at 12:10 p.m., R1 indicated a staff member had pinched her leaving bruises. She lifted the blanket to show her left inner thigh where there was two purple oval bruises in proximity to each other. The two bruises were each approximately 1.0 cm in diameter. During an interview on 12/23/24 at 1:28 p.m., nursing assistant (NA)-A stated she cared for R1 today and stated around 11:30 a.m., the director of nursing was in R1's room with her looking at R1's two bruises to her inner thigh. NA-A indicated she was not aware of where the bruises came from or how long they had been there. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/24/24 at 8:29 a.m., registered nurse (RN)-C indicated she was the nurse responsible for R1. RN-C explained she was aware R1 had two bruises on her inner thigh becasue someone told her two days ago (12/22/24). RN-C reviewed R1's record and reported there was nothing that identified R1 had bruises or that directed monitoring. RN-C stated she was agency staff and was unaware of the facility process for documenting skin impairments such as bruises. At 11:51 a.m RN-C stated she had just obtained measurements of R1's bruises on left inner thigh today. Measurements were 1.25 cm x 1.25 cm (purple/maroon in color) and 1.5 cm x 1.25 cm purple/maroon in color. During an interview on 12/24/24 at 11:06 a.m., director of nursing (DON) stated RN-D initially found R1's two bruises on her left inner thigh on 12/18/24. DON further stated that no comprehensive skin assessment or monitoring of R1's bruises for healing were in R1's medical record and there should be. A follow-up email correspondance sent by the DON on 12/27/24, at 12:03 p.m., included a a skin ulcer policy. On 12/30/24 at 8:45 a.m., via phone DON indicated the facility did not have a non pressure skin policy, however the skin ulcer policy did direct monitoring of residents skin integrity. Facility policy, Skin Ulcers, reviewed 7/2022, identified D.Monitor Skin Integrity: Skin will be observed daily during cares done by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits on the bath/shower day will be performed by the Licensed Nurse. The Care Plan for Skin Integrity is to be evaluated and revised by Nurse Manager based on response, outcomes, and needs of the resident. E.Identified risk factors and problems will be care planned . Review of Skin ulcer Policy did not address the facility process for monitoring and assessing for non-pressure skin integrity concerns.