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	05/20/2022

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 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44650 Based on interview and document review, the facility failed to ensure staff were aware of resident food allergies for 1 of 3 residents (R3) reviewed for food allergies. R3 was served a [NAME] Bar Cheesecake dessert which contained chopped Reese's Peanut Butter Cup and Butterfingers candies causing an anaphylaxis reaction requiring Benadryl and an EpiPen at treatment at the facility, and R3 was sent to the emergency department (ED) for treatment. The deficient practice was identified as an immediate jeopardy (IJ). The IJ began on 5/18/22, at lunch time when R3 was served a lunch tray which included a [NAME] Bar Cheesecake dessert containing Reese's Peanut Butter Cup and Butterfingers candies. R3 unknowingly ate approximately half of the dessert which contained peanut allergens and this caused a severe allergic reaction requiring immediate interventions including: 50 milligrams (mg) of Benadryl (antihistamine), use of an EpiPen (an auto-injectable device that delivers the drug epinephrine, used when someone is having an allergic reaction) and ultimately R3 was sent to the emergency department (ED) due to progressing anaphylaxis (a severe, potentially life-threatening allergic reaction). The administrator and director of nursing (DON) were informed of the IJ on 5/19/22, at 5:07 p.m. The IJ was removed on 5/20/22, at 1:20 p.m. but scope and severity remained at a level E, no actual harm with potential for more than minimal harm. Findings include: R3's Diagnosis List printed on 5/20/22, indicated R3 diagnoses included muscle weakness, atrial fibrilation (an irregular, often rapid heart rate that commonly causes poor blood flow), and syncope (commonly known as fainting). R3's significant change Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact. R3's Care Plan printed on 5/20/22, indicated R3's allergies included allergies to nuts and peanut-containing products. Review of R3's progress notes on 5/18/22 revealed the following: -5/18/22, at 1:01 p.m. R3 was served a cream cheesecake for dessert which carried risks of peanut contamination. The progress note indicated R3 was given 50 mg of Benadryl and had his EpiPen in hand. R3 had a tight throat, and frequent checks were to be made to monitor his condition. (continued on next page)

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

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-5/18/22, at 2:11 p.m. indicated epinephrine (EpiPen) had been given and was ineffective. 911 was called at approximately 1:25 p.m. due to progression of anaphylaxis. On 5/19/22, at 11:39 a.m. R3 was interviewed and stated on 5/18/22, he was served his lunch which included a dessert cake. R3 stated he ate some of the dessert, and it turned out to have peanut butter in it. R3 stated he had to use his EpiPen, but it didn't relieve his symptoms, and he was eventually sent to the hospital via ambulance. On 5/19/22, at 1:16 p.m. C-B and C-C were interviewed. C-B and C-C both stated they were not aware R3 had an allergic reaction on 5/18/22. C-C stated all the desserts were made from scratch, and she would produce the recipe book. On 5/19/22, at 1:20 p.m. C-A was interviewed. C-A stated the meal ticket did not include a list of the menu ingredients on the ticket, it was the dietary aide's (DA) responsibility to look at the ingredients in the recipe book. C-A stated the prep cook dished up the desserts each day. C-A stated a dietary aide dished up the dessert onto R3's tray without knowing it contained peanut butter. C-A provided a copy of the recipe which showed a list of the allergens used in making the candy bar cheesecake and listed peanuts, soy, gluten, wheat, and milk as allergens. On 5/19/22, at 2:02 p.m. C-D was interviewed. C-D stated she was the one who put the dessert on R3's tray. C-D stated meal tickets have residents' allergies typed in red. C-D stated she delivered the meal tray to R3. C-D stated when she was done with the lunch meal service, she went to eat lunch. C-D stated she took a bite of the dessert and knew immediately there was peanut butter in it. C-D stated she ran to stop R3 from eating it, but he had already eaten it; nurses and aides were already there. C-D stated she felt dietary staff should not have to look through the cookbook for allergens in a food, the food should be labeled. On 5/19/22, at 2:30 p.m. the DON stated whoever dished up the cheesecake candy dessert didn't know it contained the peanut allergen. The DON stated staff knew of R3's severe allergy and called 911 immediately. The DON's stated R3 was her son, and she was trying to remain neutral and allow the investigation to move forward without her providing bias. On 5/19/22, at 2:56 p.m. the administrator stated R3 had an allergic reaction to his dessert. The administrator stated staff told him R3 was given a dessert that contained a peanut allergen. Kitchen staff had initially told the administrator the recipe was new which was not true, he knows as he does the food orders himself and knows the ingredients have been ordered for some time. The administrator stated the facility used a [NAME] Brothers computer system which has the recipes in the computer system which prints the meal tickets. The administrator stated the [NAME] Brothers computer system should have been set up to automatically remove foods with allergens from R3's meal ticket, or any other residents meal ticket when an allergen is served. R3's meal ticket dated 5/18/22, for the noon meal, included [NAME] Bar Cheesecake. R3's meal ticket listed R3's food allergies: peanuts, tree nuts, all nuts. The facility Tray Identification Policy revised on 4/2007, directed the Food Services Manager or supervisor will check trays for correct diets before the food carts are transported to their designated areas. Nursing staff shall check each food tray for the correct diet before serving the resident. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility implemented corrective action to remove the IJ on 5/20/22, when all resident allergies were reviewed by the DON and administrator, staff were educated on food allergies and intolerance, the facility updated their tray identification policy, the facility updated the [NAME] Brother system to ensure foods containing allergens were removed from the residents food labels, menus, and meal tickets. Food allergy audits were completed and will continue daily for 10 days, weekly for four weeks, and then monthly thereafter. This was verified through interview and document review.