STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 Heartwood Drive Crosby, MN 56441

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the medications section of the Minimum Data Set (MDS) was accurately coded for 1 of 5 resident (R6) reviewed for unnecessary medications.Findings include:R6's admission Minimum Data Set (MDS) dated [DATE], identified R6 had intact cognition and included a diagnosis of type 2 diabetes. R12 received an injection of insulin one day per week.R6's Order Summary Report dated 6/30/25, identified semaglutide (a GLP-1 receptor agonist used primarily for managing type 2 diabetes and aiding in weight loss, with significant effects on appetite regulation and blood sugar control.) subcutaneous solution pen-injector 2 milligram (MG)/3 milliliter (ML) inject 0.5 mg subcutaneously one time a day every Monday for type 2 diabetes.An email from the coding department director dated 7/23/25 at 1216: p.m., identified R6's semaglutide was coded as insulin in error.During an interview on 7/23/25 at 12:37 a.m., the director of nursing (DON) stated MDS assessments should be coded correctly to ensure correct payment was received and to ensure the residents received the care they required.The facility policy Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission revised 3/25, identified the facility would complete the RAI in accordance with the utilization guideline set forth in the current MDS 3.0 RAI User's Manual.Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2024, identified the steps for assessment included:1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).2. Determine if the resident received insulin injections during the look-back period.3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period.4. Count the number of days insulin injections were received and/or insulin orders changed.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively assess for trauma informed care and identify potential triggers, to avoid potential re-traumatization for 1 of 1 resident (R6) reviewed for trauma informed care.Findings include:R6's admission Minimum Data Set (MDS) dated [DATE], identified R6 had intact cognition and included a diagnosis of post traumatic stress disorder (PTSD).R6's medical record failed to identify a Trauma-Informed Care Assessment was completed.R6's care plan revised 5/9/25, did not include R6's PTSD triggers and/or interventions specific to his PTSD.During an interview on 7/21/25 at 2:22 p.m., R6 was lying in bed in her room. R6 spoke with a flat affect and stated she liked to keep to herself in her room. R6 stated she was unaware of any traumatic events in her life and could not recall anything that would make her upset specifically. During an interview on 7/23/25 at 9:05 a.m., registered nurse (RN)-B and nursing assistant (NA)-C stated they were both unaware of R6's PTSD diagnosis. RN-B stated she heard R6 had had a rough childhood but didn't know any details. Neither were aware of any triggers for R6, but NA-C stated R6 was very withdrawn. Staff did offer activities and opportunities for R6 to get out of her room but R6 never wanted to. R6 did not like her blinds open until later in the day when R6 up and moving around. When R6's family called R6, R6 was very quiet afterwards but R6 never told why. Neither could say if there was anything that made R6 uncomfortable or anything that should be avoided.During an interview on 7/23/25 at 10:08 a.m., RN-A stated social services was responsible to complete the Trauma Informed Care Assessment and would make care plan revisions if the assessment identified a problem. RN-A stated R6 was very stoic and had never told RN-A anything about any traumatic life events. R6 knew she was on medications but could not explain to you why she was on those medications. It would be important for staff to know those things because staff wanted to keep R6 comfortable and feeling secure and safe.During an interview on 7/23/25 at 12:37 p.m., the director of nursing (DON) stated R6 was admitted at the time the facility was changing ownership and electronic medical records. Because of this, R6 was missed, and a trauma informed care assessment was not completed. The DON stated the assessment should have been completed for staff to identify and care plan triggers and interventions for R6's psychosocial needs. The facility Trauma Informed Care Policy revised 12/22, identified the facility would ensure staff assessed a resident who displayed or was diagnosed with mental disorder or psychological adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder and facilitate appropriate treatment and services to manage the assessed problem to attain the highest practicable mental and psychological well-being. The intent of this requirement was to ensure that the facility delivered care and services which, in addition to meeting professional standards, were delivered using approaches which were culturally competent and account for experiences and preferences and addressed the needs of trauma survivors by minimizing triggers and/or re-traumatization.