STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	1633 Delton Avenue NW Bemidji, MN 56601

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to notify the physician of a change in condition for 1 of 3 residents (R1) who was sleeping more than usual, not eating and not taking medications. Findings include: R1's Resident Face Sheet identified diagnosis that included dementia with behavioral disturbance, depression, hypertensive kidney disease, open wound and agitation. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated she displayed no rejection of care behaviors during the basement period. The MDS indicated R1 was able to eat independently after set up and weighed 116 pounds. R1's care plan dated 3/25/24, identified a self care deficit related to dementia and decreased physical mobility. The care plan indicated R1 did not ambulate and required assist of two staff for transfers. The care plan identified an alteration in nutrition related to a poor appetite at times, pain and cognitive dysfunction. The care plan indicated R1 was able to feed herself after set up and directed staff to assist with eating and cues as needed, weigh as ordered and protein shakes with every meal. R1's Resident Progress Notes indicated the following: -5/24/24, R1's family member (FM)-A called in regard to R1 and her medications. FM-A stated she did not like the way R1 was on her current medication (Zyprexa) and would like to have it discontinued or changed to something else. FM-A stated that she was not able to understand R1's speech, and that she was not eating. Discussed in morning meeting where it was stated that they should probably have a care conference for R1 with FM-A to discuss further. Spoke to administrator who said next week. (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/25/24, R1's FM-A was in to visit and left immediately upset that she was in her room sleeping. Spoke to all staff about it and it was reported that she had been sleeping most of the day. Staff reported that the day staff said R1 wouldn't wake up even during cares and licensed practical nurse said R1 wouldn't wake up to take her medication that morning and it had been attempted multiple times. R1 was not up for lunch. When writer went in with staff R1 woke up and was cooperative with her brief change which had a small BM and the brief was dry. She had not received any medications due to sleepiness. 5/26/24, received order from physician to send R1 for evaluation, lethargic and not eating. R1's Resident Transfer Form dated 5/26/24, indicated unscheduled discharge to hospital due to level of consciousness decline. Hospital paperwork dated 5/26/24 indicated R1 presented to the emergency department after FM noted she was more somnolent and deconditioned. FM stated the nursing home told her R1 had been significantly more drowsy over the last several days/weeks, had been sleeping longer and refusing to eat or drink any water. The History and Physical identified encephalopathy likely secondary to chronic hypernatremia as well as deconditioning and sever calorie protein . and UTI. Urinalysis showed many bacteria, significant change from prior. The following lab work was performed: Sodium level of 162 milliequivalents per liter (mEq/L), A normal blood sodium level is between 135 and 145 (mEq/L). (Symptoms of hyponatremia can include nausea and vomiting, loss of energy and confusion. Serious hyponatremia can cause seizures, coma and even death.) Acute Kidney Injury (AKI), which is significant for her (AKI is defined as an abrupt (within hours) decrease in kidney function, which encompasses both injury (structural damage) and impairment). During interview on 5/31/24 at 11:31 a.m., FM-A said at baseline R1 could communicate and said she was not always accurate but could be understood and R1 could eat independently. FM-A said she had called the facility and kept saying something wasn't right. FM-A stated she felt R1 was not feeding herself because of the medication and the facility had not been feeding her. FM-A stated last Thursday (5/23/24) she went to the facility and R1 looked near death and said she looked so bad FM-A knew something wasn't right. FM-A said that was in the evening and nobody knew anything so she called Friday and was told they would do a care conference on Tuesday. FM-A said she she went back to the facility on Saturday evening and R1 was in bed and said the staff told her R1 had been in bed since the staff member had gotten there at 2:00 p.m. FM-A stated she went back again on Sunday and R1 was in her chair and could not hold her own head up. FM-A said she told the nurse something was wrong and the nurse asked her if she wanted R1 sent to the hospital, then told her the hospital would just say it was R1's dementia causing the decline. FM-A said when R1 got to the hospital she was seriously dehydrated and her sodium level was through the roof. During interview on 6/4/24 at 7:31 a.m., physician (P)-A stated the last time she had seen R1 was on 4/9/24 for a hospital discharge follow up and said her lab work was fine at that time. P-A stated R1's labs always seemed to be perfect and said in general R1 slept in the mornings because her nighttime routine was a little skewed. P-A reviewed R1's hospital record and said all her labs were skewed and she could tell she was severely dehydrated. P-A said typically when R1 was up she was very social and said when R1 was healthy she saw her eat. P-A stated maybe the facility had been seeing a decline but it didn't give them the okay to not address safety, not getting up and not eating or drinking. P-A said she had not heard anything about R1's status since she had last seen her in April other than behaviors. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/4/24 at 1:56 p.m., trained medication aide (TMA)-A stated R1's intake was poor and she only took bites here and there but she received a supplement that she was good about drinking. TMA-A said recently R1 had been sleeping a lot more and not waking for her medications. During interview on 6/4/24 at 2:20 p.m. registered nurse (RN)-A stated R1 had been declining over the last month and said, more behaviors. RN-A said R1 was sleepy but sated that was not abnormal. RN-A stated FM-A had come to the facility on Sunday and had also been there the day before. RN-A said staff had been utilizing an as needed medication regularly and said she felt like it may have been making R1 a little more sleepy. RN-A stated she felt FM-A was so upset because she had a hard time coming to terms with the health decline. On 6/4/24 at 4:36 p.m. the director of nursing (DON) and administrator were interviewed. The DON stated RN-A had noticed R1 had a change of condition on Friday and asked what she should do. The DON said she had said they should set up a care conference. The administrator stated RN-A talked about R1 pouring her drinks in her food and said it was unusual and said R1 was discussed in the morning interdisciplinary team meeting. The administrator stated she had been seeing a big change in R1 also. The DON stated when staff identified R1's change of condition they should have updated the provider. Facility policy Notification to Physician/Family/Responsible Representative, dated 10/17/21, indicated physicians, responsible family members or legal representatives shall be notified, in a timely manner, of any changes in the resident's condition. The policy indicated when there is a change in resident status or condition, the charge nurse must evaluate the resident, obtain vital signs, and document findings in the resident's electronic medical record. The charge nurse will notify the assistant director of nursing or DON on call of the situation or change in condition as soon as possible. The physician will be notified as follows: If the change requires the immediate care of a physician, attempts will be made at contacting the primary care provider or on call Provider for treatment recommendation or, an order to transfer to the ER if the resident change in not life threatening.

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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 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** 35569 Based on interview and document review, the facility failed to identify and assess for a change of condition for 1 of 3 residents (R1) who began sleeping more, missing medications due to sleep and not drinking/eating regularly. Additionally, R1's family member had to voice concerns regarding deteriorating health condition for initiation of hospital transfer. Findings include: R1's Resident Face Sheet identified diagnosis that included dementia with behavioral disturbance, depression, hypertensive kidney disease, open wound and agitation. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated she displayed no rejection of care behaviors during the basement period. The MDS indicated R1 was able to eat independently after set up and weighed 116 pounds. R1's care plan dated 3/25/24, identified a self care deficit related to dementia and decreased physical mobility. The care plan indicated R1 did not ambulate and required assist of two staff for transfers. The care plan identified an altered thought process and directed staff to encourage family to voice questions and concerns. The care plan further identified and alteration in nutrition related to a poor appetite at times, pain and cognitive dysfunction. The care plan indicated R1 was able to feed herself after set up and directed staff to assist with eating and cues as needed, weigh as ordered and protein shakes with every meal. R1's Resident Progress Notes indicated the following: -5/24/24, R1's family member (FM)-A called in regard to R1 and her medications. FM-A stated she did not like the way R1 was on her current medication (Zyprexa) and would like to have it discontinued or changed to something else. FM-A stated that she was not able to understand R1's speech, and that she was not eating. Discussed in morning meeting where it was stated that they should probably have a care conference for R1 with FM-A to discuss further. Spoke to administrator who said next week. -5/25/24, R1's FM-A was in to visit and left immediately upset that R1 was in her room sleeping. Spoke to all staff about it and it was reported that R1 had been sleeping most of the day. She did have cares completed and was dressed on top but had her brief on the bottom. Staff reported that the day staff said R1 wouldn't wake up even during cares and licensed practical nurse said R1 wouldn't wake up to take her medication this morning and it was attempted multiple times. R1 was not up for lunch. When writer went in with staff R1 woke up and was cooperative with her brief change which had a small BM and the brief was dry. She had not received any medications due to sleepiness. -5/26/24, received order from physician to send R1 for evaluation, lethargic and not eating. R1's Resident Transfer Form dated 5/26/24, indicated unscheduled discharge to hospital due to level of consciousness decline. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Conference Review dated 5/28/24, indicated family member (FM)-A was frustrated because R1 had significantly declined in the past two weeks and she had received very little communication. FM-A advocated for R1 to be sent to the emergency department on Saturday and felt the staff working didn't think she should send her. R1's Hospital Admission History and Physical Note dated 5/26/24, indicated R1 presented to the emergency department after FM noted she was more somnolent and deconditioned. FM stated the nursing home told her R1 had been significantly more drowsy over the last several days/weeks, had been sleeping longer and refusing to eat or drink any water. The H and P identified encephalopathy likely secondary to chronic hypernatremia as well as decondition and sever calorie protein . and UTI. Urinalysis showed many bacteria, significant change from prior. The following lab work was performed: Sodium level of 162 milliequivalents per liter (mEq/L), A normal blood sodium level is between 135 and 145 (mEq/L). (Symptoms of hyponatremia can include nausea and vomiting, loss of energy and confusion. Serious hyponatremia can cause seizures, coma and even death.) Acute Kidney Injury (AKI), which is significant for her (AKI is defined as an abrupt (within hours) decrease in kidney function, which encompasses both injury (structural damage) and impairment). During interview on 5/31/24 at 11:31 a.m. FM-A stated for the past month facility staff had been claiming R1's behaviors were increasing and they wanted to put her on behavior medication. FM-A stated she told them she was concerned that R1 would be in a zombie state. FM-A said at baseline R1 could communicate and said she was not always accurate but could be understood and R1 could eat independently. FM-A stated the facility kept increasing her doses and R1 was not feeding herself. FM-A said she called the facility and kept saying something wasn't right. FM-A stated she felt R1 was not feeding herself because of the medication and said the facility had not been feeding her. FM-A stated last Thursday (5/23/24) she went to the facility and R1 looked near death and said she looked so bad FM-A knew something wasn't right. FM-A said that was in the evening and nobody knew anything so she called Friday and was told they would do a care conference on Tuesday. FM-A said she she went back to the facility on Saturday evening and R1 was in bed and said the staff told her R1 had been in bed since the staff member had gotten there at 2:00 p.m. FM-A stated she went back again on Sunday and R1 was in her chair and could not hold her own head up. FM-A said she told the nurse something was wrong and the nurse asked her if she wanted R1 sent to the hospital, then told her the hospital would just say it was R1's dementia causing the decline. FM-A said when R1 got to the hospital she was seriously dehydrated and her sodium level was through the roof. During interview on 6/4/24 at 7:31 a.m., physician (P)-A R1 was 80 some years old and had a significant wound on her hip. P-A stated the last time she had seen R1 was on 4/9/24 for a hospital discharge follow up and said her lab work was fine at that time. P-A stated R1's labs always seemed to be perfect and said in general R1 slept in the mornings because her nighttime routine was a little skewed. P-A reviewed R1's hospital record and said all her labs were skewed and she could tell she was severely dehydrated. P-A said typically when R1 was up she was very social and said when R1 was healthy she saw her eat. P-A stated maybe the facility was seeing a decline but said it didn't give them the okay to not address safety, not getting up and not eating or drinking. P-A said she had not heard anything about R1's status since she had last seen her in April other than behaviors. P-A said R1 weighed 106 pounds when she admitted to the hospital. During interview on 6/4/24 at 1:56 p.m., trained medication aide (TMA)-A stated R1's intake was poor and she only took bites here and there but she received a supplement that she was good about drinking. TMA-A said recently R1 had been sleeping a lot more and not waking for her medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/4/24 at 2:20 p.m. registered nurse (RN)-A stated R1 had been declining over the last month and said, more behaviors. RN-A said R1 was sleepy but sated that was not abnormal. RN-A stated FM-A had come to the facility on Sunday and had also been there the day before. RN-A said she told FM-A they could send R1 to the hospital but told her it may not change the outcome. RN-A said staff had been utilizing an as needed medication regularly and said she felt like it may have been making R1 a little more sleepy. RN-A stated she felt FM-A was so upset because she had a hard time coming to terms with the health decline. On 6/4/24 at 4:36 p.m. the director of nursing (DON) and administrator were interviewed. The DON stated RN-A had noticed R1 had a change of condition on Friday and asked what she should do. The DON said she had said they should set up a care conference. The administrator stated RN-A asked about R1 pouring her drinks in her food and said it was unusual and said R1 was discussed in the morning interdisciplinary team meeting. The administrator stated she had been seeing a big change in R1 also. The DON stated when staff identified R1's change of condition they should have updated the provider and said they had a hard time determining if it was her medication or her dementia that was causing the changes. The DON acknowledge there was no evidence of an assessment following the change of condition or after FM-A voiced concerns. Facility policy Notification to Physician/Family/Responsible Representative, dated 10/17/21, indicated when there is a change in resident status or condition, the Charge Nurse must evaluate the resident, obtain vital signs, and document findings in the resident's electronic medical record. The charge nurse will notify the assistant director of nursing or DON on call of the situation or change in condition as soon as possible.