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	08/07/2025

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (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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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a system to provide the correct physician ordered diet texture for 1 of 3 residents (R1) who was at risk for choking and had a history of dysphagia. This resulted in an Immediate Jeopardy (IJ) for R1 when she was provided lunch which was not cut up into bite sized pieces as ordered. As a result, R1 was observed to choke, requiring the Heimlich to clear obstruction, suctioning, and oxygen after she lost consciousness. R1 was transferred to the hospital, was intubated and placed on a ventilator.The IJ began on 7/30/25 at 12:10 p.m., when nursing assistant (NA)-A provided R1 with a lunch tray which included potato chowder with kielbasa pieces and a chicken salad sandwich that were not cut up per physician orders. This resulted in R1 choking and requiring the Heimlich Maneuver, was hospitalized and placed on a ventilator. The Administrator and director of nursing (DON) were notified of the IJ on 8/7/25 at 2:25 p.m. The IJ was removed on 8/7/25 at 6:23 p.m., but noncompliance remained at the lower scope and severity level D, with isolated actual harm that is not immediate. Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 with moderately impaired cognition, did not reject cares, impaired mobility of both lower extremities, required setup or clean up assistance with eating and substantial assistance with oral care. In addition, R1's active diagnoses include spastic paraplegia (progressive stiffness and contraction in the lower limbs), Parkinsonism and dysphagia (difficulty swallowing). Diet was identified as Mechanically altered diet (require change in texture of food or liquids).A Facility Reported Incident (FRI) report was submitted to the State Agency (SA) on 7/30/25 at 3:25 p.m. The report identified, on 7/30/25, at 12:10 p.m., R1 experienced a choking incident requiring the Heimlich Maneuver and was sent to the hospital for treatment/evaluation.R1's hospital noted dated 7/30/25, identified R1 was intubated for airway protection following out of hospital cardiac arrest and respiratory failure and [R1 with history] of COPD presented to the ER (emergency room) following a choking event. Per EMS (Emergency Medical Services) report, patient choked on a sausage while at the assisted living facility, stopped breathing, attempt was made at Heimlich maneuver and R1 was unresponsive.R1's care plan dated 11/21/21, identified Approach: Regular Diet/Dysphagia level 4 (regular texture) with honey thick liquids; Cut food into small pieces. Encourage small bites and to chew well before swallowing.R1's physician orders dated 4/16/24, identified Honey Thick for Thickened Liquid, and Special Instructions: Cut all foods into bite size pieces. Encourage small bites and to chew well.R1's speech language pathology (SLP) evaluation and plan of treatment dated 4/2/24, recommended moderately thick liquids and Regular diet cut into bite sized pieces. R1's lunch meal ticket for 7/30/25, identified menu of Kielbasa and Potato Chowder, Chicken Salad Sandwich, Pickled Beets and Fruit Salad. The ticket identified food to be cut into bite sized pieces. During interview with family member (FM)-A on 8/5/25 at 1:06 p.m., FM-A stated she was present in the dining room at the time of R1's choking episode. FM-A stated R1 was eating food off her meal tray and then raised her left hand up in a 'wave'. Then, FM-A stated, I think [R1] is choking aloud to staff. Then a staff member approached R1. FM-A stated R1's skin color turned from normal to a gray color. FM-A stated staff immediately took R1 out of the dining room.During interview with nursing assistant (NA)-B on 8/5/25 at 1:17 p.m., NA-B stated, she presented R1's lunch tray to her in the dining room on 7/30/25. NA-B confirmed she did not double check the meal ticket to ensure it was accurate. NA-B stated the process for following meal ticket was for dietary staff to lay out meal tickets on the dining room tables prior to each meal, then the aides or nurses would bring the meal ticket to the kitchenette [located in each dining room] and the dietary aide would dispense the food per meal ticket. The aide would then bring the meal and meal ticket back to the resident. NA-B stated, I should have checked the ticket and I could have cut her sandwich with a butter knife but I did not. Her meal was not bite-size pieces.During interview with licensed practical nurse (LPN)-A on 8/5/25 at 2:08 p.m., LPN-A stated when R1 was suctioned there was little pieces of food noted. LPN-A obtained R1's meal tray and observed the kielbasa was large sausages about a 50-cent piece is size. LPN-A stated there was not formal education provided to staff following the choking incident.During interview with NA-C on 8/6/25 at 5:16 p.m., NA-C stated R1 choked pretty easily and if she swallowed wrong there was a lot of clearing her throat.During interview with trained medication aide (TMA)-C on 8/6/25 at 6:11pm, TMA-C stated they did not know who ensured the food was cut up. TMA-C indicated sometimes the dietary aide completed the task and sometimes it was the nursing staff. TMA-C stated it was unclear who was responsible. During interview with NA-E on 8/6/25 at 6:37 p.m., NA-E stated they though it was a mix of both