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	10/22/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the correct administration of insulin per physician orders for 1 of 3 residents (R1) who received 20 units of Novolog (rapid acting used to lower blood sugar levels onset in 15 minutes) instead of the physician ordered Lantus (long-acting onset 3 to 4 hours and duration of 24 hours). Findings included: R1's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition with no behaviors. Her diagnoses include diabetes mellitus (DM) and received insulin injections 7 out of 7 days a week. R1's care plan dated 9/18/25, identified a potential for alteration in nutrition related to obesity, diabetes, and chronic pain. Staff were directed to offer snacks two times a day. Medicate as ordered. Follow diabetic protocols. Monitor continuous glucose monitoring (CGM) as ordered. Monitor for signs and symptoms of hypoglycemia/hyperglycemia (low blood/high blood sugars). R1's physician orders identified: -Start date 3/21/25, bedside glucose monitoring to be performed four times a day; call primary care provider or family provider if blood sugars (BS) are greater than 300 or less than 60 at 7:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. -Start date 3/21/25, Novolog (lowers blood glucose levels quickly after meals, typically starting to work within 5 to 10 minutes after injection, with a maximum effect after 1 to 3 hours, and a duration of action of 3 to 5 hours) U-100 insulin solution; 100 units/milliliter (ml) amount per sliding scale, if BS less than 70 call medical doctor. Blood sugar 200 to 250, give 2 units, if BS 251 to 300; give 4 units. If BS 301 to 350; 6 units. If BS 351 to 400; give 10 units. If BS greater than 400 all MD. Three times a day; 8:00 a.m., 12:00 p.m., 5:00 p.m. -Start date 4/1/25, Novolog U-100 insulin solution 100 unit/ml; amount 4 units subcutaneously (SQ) with meals; 8:00 a.m., 12:00 p.m. and 5:00 p.m. Special instructions: hold insulin if eats less than 25% of meal. -Start date 9/24/25, Lantus (long-acting insulin works over a 24-hour period to provide a steady, continuous release of insulin, helping to keep BS levels consistent between meals and overnight) U-100 insulin solution 100 unit/ml; amount 20 units; subcutaneously (SQ) at bedtime 8:00 p.m. R1's Electronic Medication Administration Record (EMAR) on October 16th, 2025, identified: -Lantus Units (U)-100 insulin solution; 100 units/milliliters (ml) administer 20 units subcutaneous (SQ) at bedtime. At 8:00 p.m. Documented as not administered by RN-A --Novolog U-100 insulin Rapid acting insulin; 100 U/ml administer 4 units SQ with meals and hold if eats less than 25 % of meal. BS 129 milligrams per deciliter (mg/dl) prior to meal and she ate 75% of supper. RN-A Charted late at 6:43 p.m. administered 4 U. -Novolog U-100 insulin per sliding scale; at 4:50 p.m. not administered BS 129 mg/dl. R1's progress notes from 10/16/25 through 10/17/25, identified: -on 10/16/25 at 9:26 p.m., R1 was given her short acting insulin at 8:37 p.m. when noted by writer immediately called DON and the on call for family practice. While she waited for the on-call writer called the ambulance for transport . sent to emergency room (ER) for evaluation and treatment. -on 10/16/25 at 12:38 a.m., writer called ER department and was notified she was given carbohydrates along with fluids. Last two blood sugars obtained were stable. While in ER, chest x-ray was completed for her wet, productive cough and diagnosed with pneumonia and placed on antibiotics. -on 10/17/25 at 4:32 a.m., ambulance transported R1 back to facility. R1's BS record on 10/16/25, identified: -documented at 4:49 p.m. 129 mg/dL -documented at 9:42 p.m. 182 mg/dL R1's Emergency Department (ED) visit dated 10/16/25 at 9:20 p.m. through 10/17/25 4:20 a.m., identified clinical impressions hypoglycemic (low blood sugar) reaction to insulin type 2 diabetes mellitus (DM), insulin overdose, accidental or unintentional, initial encounter, conjunctivitis of left eye, bronchitis, and bronchial pneumonia.- on 10/16/25 at 9:31 p.m., BS 127 mg/dl -on 10/16/25 at 10:13 p.m., glucose dropped despite having eaten. Will give some dextrose and continue to monitor closely. Neurological status remains intact. -on 10/16/25 at 10:15 p.m., dextrose 10% intravenous (IV) solution 250 milliliters (ml), glucagon injection 1mg vial, and glucose chewable tablet 16 grams (g) administered. -on 10/16/25 at 10:20 p.m., BS 89 mg/dl -on 10/16/25 at 11:14 p.m., BS 134 mg/dl -on 10/17/25 at 12:22 a.m., BS 141 mg/dl -on 10/17/25 at 12:23 a.m., Should have passed the peak effects of insulin she was given. Will check one more to ensure stability. -on 10/17/25 at 1:16 a.m., BS 173 mg/dl -on 10/17/25 at 1:18 am., Glucose has stabilized. Passed the peak effects of the insulin. At this time will discharge back to care center with new treatment for pneumonia and conjunctivitis as well. -on 10/17/25 at 4:15 a.m., BS 136 mg/dl. discharged from ED at 4:20 p.m. back to care center. Medication Error Report dated 10/16/25 at 9:00 p.m., R1 was given short acting insulin 20 units instead of Lantus 20 units by RN-A. R1 was sent to ER, no negative outcome. Plan to correct the problem: double check insulin prior to administration by another staff. During an interview on 10/21/25 at 11:15 a.m., RN-A stated on 10/16/25 just

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure medications were secured at all times in 1 of 3 medication carts used. This had the potential to affect 20 residents whose medications were stored in medication cart. Additionally, the facility failed to ensure medication was labeled with clear and unaltered administration instructions to prevent potential error for 1 of 3 residents (R4) observed to receive medication.Findings include:R4's admission Minimum Data Set (MDS) dated [DATE], diagnosis: multiple sclerosis (MS) (a chronic autoimmune disease affects the central nervous system damaging the protective covering of nerve fibers with symptoms of muscle weakness, spasms or stiffness, and problems with balance and coordination). R4's provider order dated 9/6/25, identified: -Baclofen (muscle relaxant) tablet 20 milligrams (mg); amount 1 1/2 tabs (30mg); oral twice a day 7:00 a.m. and 9:00 p.m. -Baclofen tablet 20 mg 1 tablet oral twice a day 12:00 p.m. and 5:00 p.m. Special instructions: please wake resident to give this medication if she is sleeping. She needs it. During an observation/interview on 10/21/25 at 8:20 am., medication cart was in the hallway of Walnut Grove, no staff were seen in the hallway. The computer screen was left open with R4's identifying information readable, medication cart unlocked, a small plastic cup 1/2 full of clear liquid with tongue blade in it, and 3 white pills in a medication cup were located on top of the cart. At 8:25 am., an unidentified resident pushed herself down the hallway in a wheelchair past the medication cart. At 8:30 a.m., trained medication assistant (TMA)-A opened R4's room door located rooms away from the medication cart and walked out into the hallway to the medication cart. TMA-A stated staff had requested assistance with a total lift for R4. She moved the medication cart closer to R4's room, left the computer screen open, cart unlocked with R4's medications left on top of the cart, unattended and was in R4's room for approximately five minutes. She verified the clear liquid in the cup was MiraLAX (laxative) prepared with water and the three white pills were Baclofen (muscle relaxant) 10mg each. TMA-A stated she was running late with the medications and was in a hurry. TMA-A stated this was not good practice and would have been expected to have locked the medication cart and computer screen, with all medications placed inside the cart prior to walking away. During an interview on 10/21/25 at 1:55 p.m., RN-B stated nursing staff were expected to protect all resident personal health information by locking the computer screen prior to leaving the area. A violation of Health Insurance Portability and Accountability Act (HIPPA) would mean that anyone walking by an open computer would have access to personal information. Medication cart should be locked and no mediations left on top when unattended. Anyone could have grabbed them, and it would be a safety hazard (syringes, oral/injectable medications). During a follow up interview on 10/22/25 at 10:45 a.m., TMA-A searched the medication cart and unable to locate R4's Baclofen 30 mg pills (labeled bottle on top 2) she had administered yesterday. She located one bottle of Baclofen label information included: R4's name, Baclofen 10 mg tablets, bottled filled on 6/9/25 by local pharmacy, instructions take 2 tablets by mouth (po) 8:00 a.m., 2 tablets at 12:00 p.m., 2 tablets at 4:00 p.m., and 3 tablets at 8:00 p.m. Handwritten on the bottle with a black marker, direction change refer to electronic medication administration record (EMAR) BAC 1 of 2. She verified the label was wrong. Yesterday she placed three pills into a pill cup, and a staff nurse split two of them in 1/2. The three half pills went back into the container so that they could be given later. She was unaware she had administered R4 the wrong doses of Baclofen yesterday and today until now and considered medication errors. Staff were expected to have placed an orange sticker on the medication bottle direction change refer to EMAR. She verified there was not an orange sticker on the bottle. She had been off work for 6 weeks and just returned yesterday. TMA-A verified located in the Baclofen pill bottle label 2 on top (10 mg tablets) were 73 whole pills and 5 half pills. She stated there had to be other staff that had made medication errors on this same medication, yesterday she had placed 3 half pills back into the medication bottle and now there were five. The pills were 10 mg each and there would be no reason to cut them in half. At 11:07 a.m. TMA-A placed an orange-colored label direction sticker printed, DIRECTIONS CHANGED REFER TO CHART, over the written directions on the pill bottle and back into the located medication cart. She notified the staff nurse and requested the half pills be destroyed, reported to the DON, a mediation error filed, to avoid further errors. During an interview on 10/22/25 at 11:46 a.m. director of nursing (DON) verified R4's Baclofen dose was increased on 8/28/25 to 30 mg twice a day 7:00 a.m. and 9:00 p.m. and the other dose remained the same 20 mg twice a day at 12:00 p.m. and 5:00 p.m. On 9/6/25, the pharmacy sent over enough pills for two weeks in a bubble pack each one had 1 1/2 tabs. They ran out of that dose on 9/20/25