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	04/05/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review, the facility failed to ensure nursing staff observed medication administration for 1 of 1 residents (R30) observed to self-administer a nebulizer treatment who was not assessed to be able to do so. Findings include: R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30's diagnoses included aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension), asthma, anxiety, depression, and morbid obesity. R30's MDS identified her as severely cognitively impaired, with behaviors (verbal/vocal symptoms, disruptive sounds), rarely/never was understood, and rarely understood others. R30's current Physician Order Report dated 4/5/24, identified R30 had an order for albuterol sulfate solution (used to treat wheezing and shortness of breath caused by breathing problems such as asthma) for nebulization 2.5 milligrams (mg) per 3 milliliters (ml) for inhalation for moderate persistent asthma three times daily started on 11/16/23. R30's care plan dated 11/29/21, did not address nebulizer treatments. R30 did not have an assessment for self administration of medications. During an observation on 4/3/24 at 10:05 a.m., trained medication aide (TMA)-A brought R30 to her room and prepared R30's nebulizer with albuterol sulfate. TMA-A placed the nebulizer mask onto R30's face and gave her the call light and said she would be back to check on her and exited the room. TMA-A did not stay with R30 while the nebulizer treatment was in progress. During an observation on 4/3/23 at 10:16 a.m., TMA-A returned to R30's room, removed the nebulizer mask, took it apart, rinsed it in the bathroom sink, and placed the nebulizer set up on a paper towel and left R30 seated in her wheelchair in her room. During an interview on 4/3/24 at 10:18 a.m., TMA-A stated she had been taught that it was okay to leave a resident alone during a nebulizer treatament as long as they had their call light within reach. TMA-A stated she was not sure if R30 had ever been assessed for self administration of medications. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/24 at 10:03 a.m., corporate registered nurse (CRN) stated R30 had not been assessed for self administration of medications. Self-Administration Medications dated 4/2015, identified residents who chose to self-administer medications would be assessed by the interdisciplinary team to determine if they were cognitively and physically able to self-administer medications. The policy further identified the facility would obtain a written order for self-administration of medications from the prescriber. The policy identified the ability to safely self-administer medications would be reviewed quarterly and as needed based on changes in the resident's condition.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to ensure conflicting directives for emergency care and treatment were clarified to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 15 residents (R28) reviewed for advanced directives. Finding include: R28's significant change Minimum Data Set (MDS) dated [DATE], identified R28 had diagnoses which included anxiety, depression, bipolar disorder, and secondary Parkinsonism (when symptoms similar to Parkinson disease are caused by certain medicines, a different nervous system disorder or another illness). In addition, R28's MDS identified she was cognitively intact, was understood by others and was able to understand others and further identified she had no rejections of care, delusions, or hallucinations. On [DATE] at 12:36 p.m., R28's electronic medical record (EMR) identified her as do not resuscitate (DNR) on her face sheet. On [DATE] at 12:37 p.m., a review of R28's Uniform Code Level Directions for Cardiopulmonary Resuscitation Havenwood Care Center dated [DATE], located in her EMR identified the following: Code Level 1: All available reasonable technology is used in the event of cardiac respiratory arrest. The facility document titled Resident Care Sheet dated [DATE], identified R28 as DNR. A progress note dated [DATE] at 4:25 p.m., identified the facility staff visited with R28 and she informed them she wanted to live and wanted her code status to be full code. During an interview on [DATE] at 1:12 p.m., R28 stated when she first got to the facility she didn't want anything done, but then changed her mind and would want them to do everything. During an interview on [DATE] at 3:48 p.m., licensed practical nurse (LPN)-A stated any staff who were cardiopulmonary resuscitation (CPR) trained could perform CPR. LPN-A stated in the event of an emergency he would check the face sheet in the computer to see what a resident's code status was. LPN-A checked R28's and verified the code status was listed as DNR, he then checked the scanned documents and verified the document titled Uniform Code Level for R28 dated [DATE], identified R28 as a code level 1 meaning CPR should be performed in the event of a cardiac respiratory arrest. LPN-A verified the documents did not match and had conflicting information. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:54 p.m., licensed social worker (SW)-A stated staff could look for code status on the nursing assistant care guides and the clipboards located next to the automated external defibrillators (AEDs). The assistant director of nursing (ADON) stated the code status was also located in the computer on the resident's profile page. SW-A verified R28's scanned document identified R28 wanted CPR performed in the event of a cardiac respiratory arrest. SW-A stated code status was reviewed at each care conference and if a resident changed their mind on code status the uniform code level document should have been updated, signed and scanned into the EMR. During an observation on [DATE] at 9:30 a.m., the clipboard next to the automated external defibrillator (AED) had a sheet dated [DATE], which identified R28 as DNR During an interview on [DATE] at 9:30 a.m., the assistant director of nursing (ADON) was updating the code clipboard and stated the night staff were supposed to run a report at least weekly, but would prefer it if they ran the report daily after midnight. R28 was now listed as full code, meaning All available reasonable technology is used in the event of cardiac respiratory arrest. The facility policy Code Status Auditing dated [DATE], identified the facility would assure residents' choices for their code status would be accurately communicated throughout the medical record/organization by completing audits upon new admission, hospital return and monthly. The policy further identified the code status would be addressed during the quarterly care conference. During the monthly audits medical records would run a report from Matrix (the electronic medical record) and would compare this with the orders , the care plan and the care sheet. Any concerns or discrepancies would be brought to the director of nursing and clarified with the resident and/or resident's representative.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to ensure allegations of abuse were reported for 1 of 6 residents (R28) reviewed for abuse. This had the potential to affect residents who he provided care for. Findings include: R28's significant change Minimum Data Set (MDS) dated [DATE], identified R28 had diagnoses which included anxiety, depression, bipolar disorder, and secondary Parkinsonism (when symptoms similar to Parkinson disease are caused by certain medicines, a different nervous system disorder or another illness). In addition, R28's MDS identified she was cognitively intact, was understood by others and was able to understand others, and further identified she had no rejections of care, delusions, or hallucinations. R28's care plan dated 4/20/20, identified R28 as a vulnerable adult, one of the listed interventions was to invite designated family to care conferences, encourage family and resident to voice question or concerns. During an interview on 4/1/24 at 3:32 p.m., R28 stated there was a guy who touched her inappropriately. R28 stated he rubbed her vagina too long and it made her uncomfortable. She thought this occurred about five months ago or less. R28 stated she told staff about it the next day. On 4/1/24 at 3:51 p.m., this allegation was reported to the administrator and director of nursing (DON). Both stated they would check the grievance log and stated this was the first they had heard about the allegation. The facility Grievance Log revealed on 12/12/23, R28 filed a resident care concern (activities of daily living/cares). It was not reported to the State Agency (SA) or the police department. During an interview on 4/3/24 at 2:09 p.m., social worker (SW)-A recalled the assistant director of nursing (ADON) was working a night shift in December of 2023, and a nursing assistant approached her and asked her to go talk to R28. SW-A told the ADON to ask the resident if she thought the allegation was abuse, she recalled R28 said it wasn't abuse but she no longer wanted that particular staff to do any cares for her. SW-A stated at the time of the event they did not further investigate or report the allegation. During an interview on 4/3/24 at 2:21 p.m., the ADON recalled the night in December and that she called SW-A during the night shift for advice regarding what was reported to her by R28. She recalled R28 said she thought the care she received from nursing assistant (NA)-A was inappropriate during peri-cares. R28 stated she no longer wanted that particular staff to do any cares for her. The ADON was not sure what NA-A was told about the matter but thought he was told not to go into R28's room after the reported allegation. SW-A stated the NA-A was not working the night it was reported but had worked the previous night. No one knew if NA-A was given any remedial training on performing cares. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of NA-A's personnel file did not reveal any education/training on performing cares after the allegation. During an interview on 4/3/24 at 3:30 p.m., NA-A stated he had recently been placed on a suspension related to an allegation regarding cares with a resident. NA-A stated previous to his suspension there were a few residents he was not allowed to provide cares for. NA-A stated his orientation was hands on training with another NA. NA-A listed four residents who did not want him to do any cares and added he thought they did not want any males to take care of them. When asked if he recalled an event in December of 2023, he stated he did recall he was not supposed to do any cares with R28. He recalled he was told she wasn't comfortable with him because of care he provided in December. When asked if he received any remedial training after December on providing personal cares he stated he had not. During an interview on 4/4/24 at 7:26 a.m., NA-B recalled R28 had complained about a staff touching her. NA-B recalled the resident didn't like how the person had changed her. NA-B stated she immediately contacted the ADON via the walkie talkie asking her to come to R28's room to talk to the resident. NA-B recalled R28 stated the staff was NA-A and R28 stated he touched her in a way she didn't like during cares and said it was uncomfortable to her. NA-B stated she didn't wait a minute and told the ADON right away. During an interview on 4/5/24 at 9:57 a.m. SW-A stated they did not investigate further in December because R28 said it wasn't abuse when she was asked that specific question. The facility policy Abuse Prevention/Prohibition Program dated 8/1/22, identified the facility would promptly and immediately report any incident or suspected incident of resident abuse or neglect. The policy identified allegation would be reported as required by Stated and Federal regulation as soon as possible but no later than two hours for suspected abuse.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to ensure allegations of abuse were investigated for 1 of 6 residents (R28) reviewed for abuse. This had the potential to affect residents who he provided care for. Findings include: R28's significant change Minimum Data Set (MDS) dated [DATE], identified R28 had diagnoses which included anxiety, depression, bipolar disorder, and secondary Parkinsonism (when symptoms similar to Parkinson disease are caused by certain medicines, a different nervous system disorder or another illness). In addition, R28's MDS identified she was cognitively intact, was understood by others and was able to understand others and further identified she had no rejections of care, delusions, or hallucinations. R28's care plan dated 4/20/20, identified R28 as a vulnerable adult, one of the listed interventions was to invite designated family to care conferences, encourage family and resident to voice question or concerns. During an interview on 4/1/24 at 3:32 p.m., R28 stated there was a guy who touched her inappropriately. R28 stated he rubbed her vagina too long and it made her uncomfortable, she thought this occurred about five months ago or less. R28 stated she told staff about it the next day. On 4/1/24 at 3:51 p.m., this allegation was reported to the administrator and director of nursing (DON). Both stated they would check the grievance log and stated this was the first they had heard about the allegation. The facility Grievance Log revealed on 12/12/23, R28 filed a resident care concern (activities of daily living/cares), it was not reported to the State Agency (SA) or the police department. During an interview on 4/3/24 at 2:09 p.m., social worker (SW)-A recalled the assistant director of nursing (ADON) was working a night shift in December of 2023, and a nursing assistant approached her and asked her to go talk to R28. SW-A told the ADON to ask the resident if she thought the allegation was abuse, she recalled R28 said it wasn't abuse but she no longer wanted that particular staff to do any cares for her. SW-A stated at the time of the event they did not investigate further or report the allegation. During an interview on 4/3/24 at 2:21 p.m., the ADON recalled the night in December and that she called SW-A during the night shift for advice regarding what was reported to her by R28. She recalled R28 said she thought the care she received from nursing assistant (NA)-A was inappropriate during peri-cares. R28 stated she no longer wanted that particular staff to do any cares for her. The ADON was not sure what NA-A was told about the matter but thought he was told not to go into R28's room after the reported allegation. SW-A stated the NA-A was not working the night it was reported but had worked the previous night. No one knew if NA-A was given any remedial training on performing cares. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of NA-A's personnel file did not reveal any education/training on performing cares after the allegation. During a telephone interview on 4/3/24 at 3:30 p.m., NA-A stated he had been placed on a suspension related to an allegation regarding cares with a resident. NA-A stated previous to his suspension there were a few residents he was not allowed to provide cares for. NA-A stated his orientation was hands on training with another NA. NA-A listed four residents who did not want him to do any cares and added he thought they did not want any males to take care of them. When asked if he recalled an event in December of 2023, he stated he did recall he was not supposed to do any cares with R28. He recalled he was told she wasn't comfortable with him because of care he provided in December. When asked if he received any remedial training after December on providing personal cares he stated he had not. During an interview on 4/4/24 at 7:26 a.m., NA-B recalled R28 had complained about a staff touching her. NA-B recalled the resident didn't like how the person had changed her. NA-B stated she immediately contacted the ADON via the walkie talkie asking her to come to R28's room to talk to the resident. NA-B recalled R28 stated the staff was NA-A and R28 stated he touched her in a way she didn't like during cares and said it was uncomfortable to her. NA-B stated she didn't wait a minute but told the ADON right away. During an interview on 4/5/24 at 9:57 a.m. SW-A stated they did not investigate further in December 2023, because R28 said it wasn't abuse when she was asked that specific question. The facility policy Abuse Prevention/Prohibition Program dated 8/1/22, identified the facility would complete a timely, thorough and objective investigation of all allegations of abuse, neglect or mistreatment. The policy identified the investigation would be conducted by the administrator or director of nursing but could be designated to another individual to complete the investigation if needed. The investigation would include the name of the resident involved, date and time of incident, nature of the injury/illness, circumstances, were event took place, observation of the environment, determination to further report, names of witnesses, injured persons account of event, notification of residents physician, notification of person's family, condition of resident, corrective action taken, review by quality assurance.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to ensure the long term care ombudsman was notified of resident transfers for 1 of 2 residents (R26) reviewed for hospitalization . Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], identified R26 had diagnoses which included dementia, hemiplegia (paralysis on one side of the body), seizure disorder, and depression. R26's MDS identified she was cognitively intact. R26's progress notes revealed the following: -11/16/23, identified R26 was sent to the hospital at approximately 7:05 p.m -1/13/24, identified R26 was sent to the hospital at approximately 4:15 p.m R26's medical record lacked evidence notification was sent to the state ombudsman's office regarding the transfers to the hospital. An email communication from the ombudsman dated 4/4/24, indicated the ombudsman's office had not received any communications regarding hospitalization s since 4/2021. During an interview on 4/4/24 at 1:56 p.m., social worker (SW)-A stated the facility did not notify the ombudsman's office of hospitalization s or discharges unless the hospitalization or discharge was contested . A policy on notifying the ombudsman's office of hospitalization s and/or transfers was requested but not provided.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to provide the resident or their representative a written bed hold notice for 1 of 2 residents (R26) reviewed for hospitalization . Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], identified R26 had diagnoses which included dementia, hemiplegia (paralysis on one side of the body), seizure disorder, and depression. R26's MDS identified she was cognitively intact. R26's progress notes revealed the following: -11/16/23, identified R26 was sent to the hospital at approximately 7:05 p.m -1/13/24, identified R26 was sent to the hospital at approximately 4:15 p.m R26's medical record lacked evidence written notification was given to the resident or the resident's representative for either hospitalization . During an interview on 4/4/24 at 12:46 p.m., nurse consultant (NC)-A stated residents would sign a bed hold on admission to designate if they would want their bed held in the future. During an interview on 4/4/24 at 1:38 p.m., social worker (SW)-A stated all residents sign a bed hold upon admission as the owner wants the residents to be able to return to the facility without worrying about any charges. SW-A stated residents and families are informed their bed will be held without a charge. They only ask residents and families to let them know if they are not planning to return to the facility. SW-A verified the bed hold form had language that identified the bed would be held with no charge for up to 18 consecutive days. SW-A verified the importance of having a resident or family member sign a bed hold is to notify them of potential charges to determine if they want their bed held. The Resident Handbook dated 6/2001, identified the following: BED-HOLD DURING ABSENCE FROM THE NURSING HOME- It is the responsibility of a resident receiving Medicare benefits, a private paying resident, or responsible party acting on their behalf, to pay the per diem rate during their absence from the facility in accordance with the current Minnesota Department of Human Services policy on reserve bed days. If the bed is to be held beyond 18 days a charge equal to one -half of the full per diem rate will be assessed. Until such time as the facility is notified that the room is no longer required, it will be reserved for the resident and billed accordingly. The facility will issue a notice of transfer or discharge, which outlines the bed-hold policy, when a transfer or discharge is to take place. The facility Bed Hold Policy dated 3/2005, identified the following: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When the facility transfers a resident to a hospital or a resident goes on a therapeutic leave, the facility will provide written information on the bed hold policy to the resident and / or responsible party.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review the facility failed to ensure residents who were at risk for pressure ulcers were repositioned timely as directed by the residents care plan for 1 of 2 residents (R30) reviewed for pressure ulcers. Findings include: R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30's diagnoses included aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension), asthma, anxiety, depression, and morbid obesity. R30's MDS identified her as severely cognitively impaired, with behaviors (verbal/vocal symptoms, disruptive sounds), rarely/never was understood, and rarely understood others. In addition, R30's MDS identified she was at risk for pressure ulcers and was always incontinent of bowel and bladder. R30's care plan dated 11/29/21, identified R30 had an alteration in elimination. Interventions included to check for incontinence every two to three hours. R30's care plan indicated R30 was at risk for alteration in skin integrity related to decreased physical mobility. R30's care plan identified she was unable to to turn and reposition herself. Interventions included staff to provide turning and repositioning every two to three hours. R30's resident care sheet dated 4/5/24, directed staff to check and change R30 every two to three hours and as needed. In addition, to reposition every two to three hours. On 4/3/24, R30 was continuously observed from 8:15 a.m. to 11:54 a.m. -at 8:15 a.m., R30 was observed seated in her wheel chair in the dining room seated at a table with one other resident. -at 8:19 a.m., R30 had her head down and staff gently woke her when she brought her the breakfast meal. -at 8:47 a.m., staff removed R30's clothing protector and brought her to an area with a television, there were several other residents in the area. -at 8:54 a.m., a staff member approached her and asked her if she wanted to go to her room and lie down, she declined. -at 9:54 a.m., an activities staff stated you usually like to hang out here and then left the area. -at 10:05 a.m., trained medication aide (TMA)-A brought R30 to her room for a nebulizer treatment. -at 10:16 a.m., TMA-A returned to the room removed the nebulizer treatment mask, did not offer to check and change or reposition her. R30 remained seated in her wheel chair in her room. -at 11:23 a.m., R30 had two visitors enter her room and visit with her. (continued on next page)

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	245397	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-at 11:44 a.m., one of the visitor asked R30 if she needed to use the bathroom before lunch and told R30 they should put the light on, but they did not. -at 11:54 a.m., staff were asked to check and change R30, nursing assistant (NA)-B stated sitting in one position for almost four hours was too long for R30. -at 11:56 a.m., visitors started to bring R30 out of her room, NA-B stated they wanted to change R30 prior to lunch and returned her to her room. -at 11:57 a.m., NA-B, NA-C, and licensed practical nurse (LPN)-B assisted R30 into bed by removing the foot rests, placing a transfer belt on R30 and instructing R30 to stand take a couple of steps, and then to sit on the bed. They assisted R30 by lifting her legs into bed. All three staff performed hand hygiene prior to putting gloves on. NA-B removed R30's brief wearing gloves, and NA-C wiped R30 front to back using pre-packaged wipes. R30 was rolled to her side and peri-care was performed again using different wipes, R30's brief was wet, a new brief was placed, R30 started to cough and voided in the new brief, the process was repeated ending with a new brief. R30's skin was intact with no open areas. During an interview on 4/3/24 at 1:30 p.m., NA-E verified R30 had not been repositioned since she got her up that morning and she should have been repositioned and checked and changed every two to three hours. During an interview on 4/5/24 at 10:05 a.m., nurse consultant (NC)-A verified R30 should have been checked and changed and repositioned every two to three hours as per the care plan. NC-A stated this would be important to prevent skin breakdown. Skin Care policy dated 6/2023, identified the resident care plan would be updated to address pressure relief, bowel and bladder incontinence, and treatment. The policy further indicated care plans would be individualized to address resident specific needs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review, the facility failed to ensure nebulizer and tubing were changed in a timely manner for 1 of 1 residents (R30) reviewed for respiratory care. Findings include: R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30's diagnoses included aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension), asthma, anxiety, depression, and morbid obesity. R30's MDS identified her as severely cognitively impaired, with behaviors (verbal/vocal symptoms, disruptive sounds), rarely/never was understood, and rarely understood others. In addition, R30's MDS identified she was receiving oxygen therapy. R30's care plan dated 11/29/21, did not address respiratory care and/or nebulizer treatments. R30's Physician Order report dated 3/5/24-4/5/24, did not address care and changing of nebulizer and tubing. R30's medical record lacked direction and/or documentation for nebulizer and tubing changes. During an observation on 4/2/24 at 12:08 p.m., R30's nebulizer set up was on R30's bedside table. The set up was all connected and the tubing was undated. During an interview on 4/3/24 at 10:18 a.m., trained medication aide (TMA)-A stated R30's nebulizer set up should be rinsed after each use and left to dry on a paper towel. She was unsure when the nebulizer set up and tubing was last changed but thought it came up as a task for the nurse. TMA-A verified the set up was undated. During an interview on 4/5/24 at 10:03 a.m. nurse consultant (NC)-A stated the nebulizer set up and tubing changes should have shown as being changed in the medication administration record. NC-A reviewed R30's record and verified there were no documented nebulizer and tubing changes for R30. NC-A stated it was important to change the tubing to prevent infection. The policy Quality of Care dated 10/2023, identified the following: Havenwood Care Center will ensure that a resident, who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive care plan, the residents' goals and preferences.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 42587 Based on document review and interview the facility failed to verify nurse aide registration for 1 of 5 nursing assistants (NA-A) prior to allowing the individual to serve as a nurse aide and work directly with residents in the facility after the 4 month training period. This had the potential to affect residents who he provided care for. Findings include: Review of NA-A's personnel file identified date of hire as 10/23/23, and placed on an investigatory suspension on 4/1/24. No verification of NA-A nursing assistant certification was located in the personnel file. A search of the nursing assistant registry revealed he was not currently registered. During an interview on 4/5/24 at 9:22 a.m., the administrator stated NA-A took his nursing assistant skills test on 12/22/23, but did not take his knowledge test related to a communication misunderstanding between the testing site and the facility. NA-A showed the facility proof of passing the skills test after the testing date. The administrator stated it was an expectation that after the four month training period a nursing assistant would take the test and become a registered nursing assistant. Abuse prevention/prohibition program dated 8/1/22, identified all applicants would be screened through the State of Minnesota Department of Human Services. In addition, prior to employment, all applicants for the position of Certified Nursing Assistant would be screened with the Minnesota Nursing Assistant Registry to ensure the applicant was eligible for employment in that capacity.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders for 2 of 6 residents (R30, R39) observed to receive medication. A total of two errors out of 27 opportunities were identified resulting in a facility error rate of seven percent. Findings include: R30: R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30's diagnoses included aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension), asthma, anxiety, depression, and morbid obesity. R30's MDS identified her as severely cognitively impaired, with behaviors (verbal/vocal symptoms, disruptive sounds), rarely/never was understood, and rarely understood others. R30's current Physician Order Report dated 4/5/24, identified R30 had an order for albuterol sulfate solution (used to treat wheezing and shortness of breath caused by breathing problems such as asthma) for nebulization 2.5 milligrams (mg) per 3 milliliters (ml) for inhalation for moderate persistent asthma three times daily started on 11/16/23. R30's care plan dated 11/29/21, did not address nebulizer treatments. R30 did not have an assessment for self administration of medications. During an observation on 4/3/24 at 10:05 a.m., trained medication aide (TMA)-A brought R30 to her room and prepared R30's nebulizer with albuterol sulfate. TMA-A placed the nebulizer mask onto R30's face and gave her the call light and said she would be back to check on her and exited the room. TMA-A did not stay with R30 while the nebulizer treatment was in progress. During an observation on 4/3/23 at 10:16 a.m., TMA-A returned to R30's room, removed the nebulizer mask, took it apart, rinsed it in the bathroom sink, and placed the nebulizer set up on a paper towel and left R30 seated in her wheelchair in her room. During an interview on 4/3/24 at 10:18 a.m., TMA-A stated she had been taught that it was okay to leave a resident alone during a nebulizer treatament as long as they had their call light within reach. TMA-A stated she was not sure if R30 had ever been assessed for self administration of medications. During an interview on 4/5/24 at 10:03 a.m., corporate registered nurse (CRN) stated R30 had not been assessed for self administration of medications. R39: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's admission Minimum Data Set (MDS) dated [DATE], identified end-stage renal (kidney) failure with hemodialysis (a treatment where a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do it adequately). R39's physician orders dated 3/8/24, included calcium acetate (a mineral used to prevent high blood phosphate levels in people who are on dialysis due to severe kidney disease) 667 milligrams, three times daily with meals. During an observation on 4/2/24 at 7:04 p.m., trained medication aid (TMA)-B provided R39 with her medication, including calcium acetate, which was to be given with meals, at a time when R39 had not recently had a meal. During an interview on 4/2/24 at 7:12 p.m., TMA-B stated she knew the calcium acetate was supposed to be given with meals, but she was not able to get it to R39 at that time. TMA-B stated she had mentioned this to a nurse manager (unidentified) because R39 often receives this medication late or not at all due to her dialysis times conflicting with medication administration times. During an interview on 4/5/24 at 10:47 a.m., registered nurse (RN)-A stated the calcium acetate for R39 should be given with meals as directed, so the medication works as it was supposed to. During an interview on 4/5/24 at 10:57 a.m., the assistant director of nursing (ADON) would expect the medication to be given as directed, following the six rights of giving medications. A document, general policies in administering medications dated 12/2023, identified the purpose was to ensure all RNs, licensed practical nurses (LPN)s, TMAs at Havenwood Care Center would be trained to do medication pass according to industry standards using the six rights of medication pass: right medication, dose, resident, time, method, documentation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview and record review, the facility failed to ensure medications with a shortened expiration period were labeled with an opened-on date and failed to ensure expired medications were disposed for one of two medication carts in the facility. This practice had the potential to affect all residents with medications stored in the facility. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and a diagnosis of multiple sclerosis. R2's provider orders dated 5/6/22, identified an order for Flonase Allergy Relief, one spray to each nostril two times per day related allergic rhinitis. R13's quarterly MDS dated [DATE], identified moderately intact cognition and a diagnosis of chronic obstructive pulmonary disease (COPD). R13's provider orders dated 5/3/23, identified an order for albuterol sulfate inhaler 90 micrograms (mcg) per actuation. Gve one to two puffs every four to six hours as needed for shortness of breath. During an observation on 4/5/24 at 9:58 a.m., the North medication cart contained a bottle of Flonase for R2, without an opened-on date and with a manufacturer expiration date of 2/2024. The North cart also contained an albuterol sulfate inhaler for R13 dispensed on 3/19/24, with no opened-on date and whose dose-meter read 202. During an interview on 4/5/24 at 9:58 a.m., trained medication aid (TMA)-C stated she would normally go through her cart every couple of weeks for expired medications, or whenever she had time. TMA-C stated it was important to date medications when opened and to remove expired medications from use so the medications work like they should. During an interview on 4/5/24 at 10:05 a.m., the assistant director of nursing (ADON) stated pharmacy consultant did a medication cart audit every three months. It was her expectation not to have expired medications in the medication cart, and to put an opened-on date for medications like inhalers. This was important so the medications were effective. A document, Thrifty [NAME] Pharmacy - Pharmacy Services, storage of medications dated October 2022, identified medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. Medication storage conditions are monitored daily by nursing staff and corrective action taken if problems are identified.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview and document review, the facility failed to ensure nutrient and/or calorie substantive snacks were offered and readily available for 3 of 6 residents (R6, R50, R308) who voiced concern at a resident council meeting. This had the potential to affect all residents residing at the facility. In addition, the facility failed to prevent a greater than 14-hour lapse between dinner and breakfast meals and without offering a snack in the evening. Findings include: During a resident council meeting on 4/3/24 at 2:00 p.m., the following residents stated concerns with recent changes to the snack cart: R6, whose quarterly Minimum Data Set (MDS) dated [DATE] identified intact cognition, stated the facility hardly ever comes around with snacks. They used to, but the cart went away. R308, whose admission MDS dated [DATE] identified moderately impaired cognition, added they didn't come around at all with the snack cart. R50, whose quarterly MDS dated [DATE] identified moderately impaired cognition, stated the facility said it was due to temperatures (safety) and infection control. During an interview on 4/4/24 a 8:56 a.m., NA-G stated she didn't think there was a snack cart anymore and she wasn't sure why not. During an interview on 4/4/24 at 8:59 a.m., NA-D stated there was a snack cart in the kitchenette between meals, the residents would have to ask for a snack to be able to get one. They passed water at 2 p.m. and 10 p.m., but there was no offering of snacks at that time. During an interview on 4/4/24 at 9:01 a.m. nursing assistant (NA)-F stated they used to have a snack cart that was out all the time, but too many people took too much stuff off it and now they didn't have it anymore. During an interview on 4/4/24 at 1:44 p.m., the certified dietary manager (CDM) confirmed dinner was served at 5 p.m. and breakfast at 8 a.m. and that was a total of 15 hours. The CDM also confirmed the resident snack cart was not available in the evenings or anytime there were not dietary staff in the unit kitchenettes. Once meal service was over, the dietary staff put the snack carts back in the locked kitchenettes, including after dinner. The CDM explained residents pouring their own coffee was a safety hazard, and family/guests pouring juice was an infection control hazard. So, the residents had to ask if they wanted a cup of coffee or juice, and staff would go get it for them. The CDM stated offering snacks was important because the residents could be hungry. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/5/24 at 8:42 a.m., the administrator stated she recognized the hours between meals were too many and that their snack offering didn't meet the requirements for needing a substantial snack. The administrator further stated this was important to help residents keep consistent weights and not lose weight. A document, Havenwood Resident Council Meeting Minutes dated 3/27/24, identified an announcement The snack carts, drink carts and coffee carts will be going away. The mock survey to prepare dietary for our next state survey revealed this is an infection control issue as well as a safety issue. Moving forward, a staff member will have to pour and serve you your drinks. A snack/drink cart will be passed mid-afternoon around the 3:00 p.m. mark. A document, Mealtimes and Frequency dated 10/2019 identified the mealtimes for breakfast at 8 a.m., lunch at 12 p.m., and dinner at 5 p.m. Taking into consideration there may not be more than 14 hours between meal services unless a substantial bedtime snack is offered, all residents will have available to them, a bedtime snack. Adequacy of the snack would be determined by individuals in the group and evaluation of the overall nutritional status of those in the facility.