STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025

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 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40948

Based on observation, interview and document review, the facility failed to ensure flooring was maintained in a safe manner for 1 of 1 resident (R49) reviewed for environment.

Findings include:

R49's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and had non-Alzheimer's dementia.

During observation on 2/11/25 at 8:42 a.m., the floor in R49's room had a black substance built up on the seams between the flooring tiles in the room which covered approximately 50 percent of the floor. When walking on the black substance between the seams would stick to your shoes.

During an interview on 2/12/25 at 11:44 a.m., housekeepers (HSK)-A and HSK-B stated R49's room was cleaned about three days a week and included sweeping and mopping the floor. They stated the stuff coming up between the tiles was sticky and not sure if it was cleanable. HSK-A and HSK-B stated sometimes they can get a little bit of it to come off, but within a couple of days more sticky stuff would come up through the seams.

During an interview on 2/12/25 at 11:58 a.m., the maintenance director (M)-A stated he was aware of the substance coming between the seams in R49's room and sated it was probably the glue from the tiles. M-A stated the resident resident's floor was replaced in the past year, and after the resident moved into the room is when the glue started to come out. About mid-summer R49 was moved out of his room and the floor was scraped and rewaxed. Within a week more of the glue was coming out from between the seams. M-A stated the floor needed to be replaced in the room, but the resident would need to be moved out of the room before they could do it; however, there was not a current plan in place to replace the flooring.

During an interview on 2/12/25 at 12:40 p.m., licensed practical nurse (LPN)-A, the infection preventionist, stated she was aware of the substance on R49's floor and stated it was sticky and tacky to touch and the floor could not be cleaned thoroughly because of the substance being sticky. Further, the floor in R49's room would need to be replaced.

During an interview on 2/12/25 at 1:20 p.m., the administrator stated it was unacceptable for R49 to be in the room with a floor in that condition and it needed to be replaced.

(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

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	02/12/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy for maintenance of flooring was requested, but not received.

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

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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 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** 40943 Based on interview and document review, the facility failed to accurately code a significant weight loss on the Minimum Data Set (MDS) for 1 of 3 residents (R30) reviewed for nutrition Findings include: R30's quarterly MDS dated [DATE], identified R30 had a severe cognitive impairment and diagnoses t included diabetes, hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body), chronic kidney disease, dysphasia (difficulty swallowing food or liquids) and aphasia (a comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain). R30's weight was 153 pounds (lbs.) and R30 had no loss of 5% or more in the last month or loss of 10% or more in last 6 months. R30's medical records identified the following weights: - 7/14/24 172.5 lbs. - 1/3/25 153.3 lbs. Which is a 11.13 percent decrease in weight in 180 days. R30's Mini Nutrition assessment dated [DATE], identified the registered dietician would continue R30's current plan of care and monitor weights monthly. Intake would be assessed regularly to ensure that nutrient needs were being met. Laboratory values would be reviewed for trends, and interventions would be adjusted as necessary. R30 would not trigger for any significant weight changes as evidenced by a 5% change in 30 days or 10% change in 180 days. The RD would continue to monitor weights monthly and reassess quarterly or as needed if significant changes in weight, intake, or health status occurred. During an interview with the RD-A and dietary manager (DM)-A on 2/11/25 at 1:10 p.m., the RD stated she just did the quarterly assessment on R30 and R30 was not a significant weight loss. Upon review of R30's weights, the RD stated her initial report did not identify R30's 180-day weight for some reason it did not pull that. R30 should have been triggered on the MDS as a significant weight loss. During an interview on 2/12/25 at 9:33 a.m., registered nurse (RN)-D stated her role was the facility's MDS coordinator. The RD completed the nutrition assessment, and that information was pulled into section K of the MDS. RN-D stated R30's quarterly MDS dated [DATE] was coded incorrectly. Coding of the MDS was important because it affected reimbursement, quality reports, and R30 could have had further weight loss because the appropriate interventions were not put into place. During an interview on 2/12/25 at 12:21 p.m., the director of nursing (DON) stated R30 should have been recognized as a significant weight loss in 6 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 1:05 p.m., the administrator stated assessments were expected to be completed accurately to ensure accurate care planning and interventions were implemented to either stabilize weight and/or to prevent further weight loss. The facility policy Resident Assessment Minimum Data Set (MDS revised 1/2025, identified assessments will be completed by staff qualified and knowledgeable to assess a specific care area. Assessments would be coded accurately to correctly assess medical, functional, and psychosocial problems and strengths to develop person-centered care plans and interventions to maintain and improve status.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 41575 Based on observation, interview and document review, the facility failed to develop a baseline care plan to ensure immediate resident needs were identified and addressed for 1 of 4 residents (R211) whom were newly admitted . Findings include: R211's Discharge Summary dated 1/24/25, identified R211 was hospitalized for acute blood loss anemia and acute knee pain due to gout. R211's bleeding resolved and was restarted on anticoagulant medications as well as gout medications to treat his left knee pain. R211's progress note dated 1/24/25, identified R21 arrived at the facility to be admitted . R21 had a foley catheter in place, which would remain until his urology appointment in March. R21 had experienced a lot of falls at home prior to admission and would need assist of one and walker with ambulation. On 2/11/25, at 8:14 a.m. R211 was observed sitting in a recliner watching television in his room. The door to the room was open and R211's foley catheter bag was visible attached to the side of his recliner. R211's medical record lacked evidence a baseline care plan had been developed to ensure staff were knowledgeable in R211's care needs despite R211 having an indwelling foley catheter, need for enhanced barrier precautions, and need for assistance with activities of daily living (ADLs) and mobility. When interviewed on 2/12/25, at 12:43 p.m. the director of nursing (DON) stated they were unable to locate a baseline care plan for R211. It was the facility's practice to have a baseline care plan completed for all residents within 48 hours of their admission. A baseline care plan was important as it identified a resident's care needs and how to care for each resident. The facility's undated Baseline Care Plan policy, identified the facility would develop a baseline care plan within 48 hours of admission. The care plan would include at minimum initial goals, physician orders, dietary orders, therapy services, social services, PASARR recommendations, instructions to provide effective and person centered care, address resident health and safety concerns to prevent decline or injury and identify needs for supervision, behavioral interventions and assistance with ADL's.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on observation, interview and document review, the facility failed identify enhanced barrier precautions (EBP) interventions for 1 of 1 resident (R18) reviewed with a surgical wound. Findings include: R18's admission minimum data set (MDS) dated [DATE], identified R18 was admitted on [DATE], was cognitively intact and was receiving surgical wound care. R18's orders report dated 1/24/25, identified staff were to monitor R18's dressing placement and for signs and symptoms of infection such as increased redness, warmth, swelling, drainage, or generalized fever over 101. Staff were to notify the charge nurse so they could notify the provider. R18's care plan revised 2/12/25, identified R18 recently had a hip replacement and required staff to complete dressing changes and monitor and report any signs or symptoms of infection. The plan further identified R18 required assist of one staff for transfers, toileting and dressing. However, the plan failed to address R18's need for EBP. During observation on 2/10/25 at 7:06 p.m., there was no personal protection equipment (PPE) cart near or inside R18's room. Further, there was no sign directing staff to wear PPE during dressing changes or cares. On 2/12/25 at 7:33 a.m., RN-C was observed in R18's room and changing R18's dressing. Observation of the dressing identified a dark red spot, approximately 1-inch in diameter in the middle area of the outside of the dressing. While wearing gloves, RN-C removed R18's dressing and stated there was an area on the distal end of the incision that appeared to be a fluid filled bubble/blister. RN-C stated the skin around the distal end appeared to be darker red although was not warm to touch. RN-C cleansed and reapplied a dressing to the wound. RN-C stated the wound looked worse than the other day and thought it may be starting to get infected. RN-C did not apply or wear a gown during the dressing change. On 2/12/25 at 12:32 p.m., RN-C stated upon R18's admission she was told by the infection preventionist, staff did not need to wear PPE while providing wound care. RN-C stated she worked with multiple residents during the day and had the potential to carry bacteria on her clothing. RN-C stated wearing PPE would help prevent the spread of bacteria to/from herself and the resident. RN-C stated she had not worn PPE including a gown when she cared for the wound or changed R18's dressing. The Care Plan policy reviewed 4/2015, identified a care plan started on the day of admission, was reviewed every 90 days and would be updated as needed. The care plan included what kind of services were needed, who provided the services and how the care plan would help the resident reach their goals of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on interview and document review, the facility failed to revise and update a comprehensive care plan for 1 of 3 residents (R10) reviewed for weight loss. Findings include: R10's quarterly minimum data set (MDS) dated [DATE], identified R10 was cognitively intact and required set-up assistance for eating, and had a weight loss that was not a physician-prescribed weight-loss regimen. R10's progress notes, identified the following: - 10/16/24, registered dietician (RD)-A identified R10 weighed 115 lbs. and had been drinking a nutritional supplement daily. RD-A's recommendations included staff to offer and provide high calorie, high protein shakes. - 11/5/24 RD-A identified R10's weight had been stable for one week and recommendations included high caloric foods per patient request and continue to follow up and monitor weights. - 11/12/24 RD-A identified staff were to provide alternate meals upon request, offer high calorie/high protein shakes, food items to help promote weight gain, and to monitor intake and weights weekly. R10's care plan dated 4/3/24, identified R10 had a potential for alteration in nutrition. Interventions included staff to offer a regular diet, thin liquids and assist with meal set up. Further interventions included weights as ordered, offer food alternatives as needed, and offer snacks two times per day. The plan failed to identify individualized interventions for weekly weights, weekly intake documentation and options for high calorie, high protein foods to help promote weight gain as recommended by the RD. On 2/11/25 at 12:42 p.m., RD-A stated in R10 weighed 125 lbs. on August 9, 2024 and had lost by November 18, 2024 10 weighed 110 lbs., a weight loss of 15 lbs. in 3 months. RD-A stated a significant change assessment was completed on 10/16/24. RD-A had talked with R10 about a plan to increase her weight and recommendations included higher calorie/higher protein shakes and continue with the nutritional supplement. RD-A stated in December 2024, documentation of weekly meal intakes and weights were recommended. R10's care plan failed to identify the recommendations. During an interview on 2/12/25 at 1:05 p.m., the administrator stated staff were expected to complete accurate assessments to aid in care planning and implementing interventions to either stabilize weight or to prevent loss. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan policy reviewed 4/2015, identified a care plan started on the day of admission, was reviewed every 90 days and would be updated as needed. The care plan included what kind of services were needed, who provided the services and how the care plan would help the resident reach their goals of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure a bed was kept in the low position to prevent falls for 1 of 2 residents (R40) reviewed for falls. Findings include: R40's Falls Risk assessment dated [DATE], identified R40 was at high risk for falls. R40's quarterly Minimum Data Set (MDS) dated [DATE], identified R40 had moderate cognitive impairment and a diagnosis of unspecified convulsions. R40 required substantial/maximal assistance to roll left and right. R40's care plan revised 12/19/24, identified R40 had decreased physical mobility with potential for falls related to lower extremity weakness, impaired mobility related to general muscle weakness and poor coordination manifested by inability to transfer, wheel self, turn and reposition self, sit up, lie down or get feet and legs into bed independently. R40 was unable to ambulate. The care plan directed to follow fall interventions as listed in nursing orders. R40's nursing order dated 2/6/25, identified R40's fall interventions included a contour mattress with cutout, low bed, mats at bedside and anti-tip bars to wheelchair. During an observation on 2/11/25 a 9:04 a.m., registered nurse (RN)-B and nursing assistant (NA)-A transferred R40 into bed using a full body mechanical lift. The bed was approximately 3.5 feet (ft) high. NA-A pulled R40's privacy closed and began assisting R40's roommate on the other side. RN-B pulled the full body mechanical lift from the room. However, R40's bed was left in an elevated position and was not in the view of staff. - At 9:14 a.m., NA-B stepped into the room and asked NA-A if she needed help. NA-B stated NA-A could provide incontinence care to R40. NA-B looked into R40's dresser drawer for supplies and stated she needed to leave the room to find more. However, R40's bed remained in an elevated position and was not in view of staff. - At 9:19 a.m., NA-B returned to the room and provided incontinence care to R40. R40's bed was lowered to the floor and R40 was given her call light. During an interview on 2/11/25 at 9:29 a.m., NA-B stated R40 was kind of high risk for falls. R40 rolled out of bed and staff thought it was because R40 had a seizure. NA-B stated she had never seen R40 roll ever but R40 should not have been left unattended in an elevated bed because she could have another seizure. During an interview on 2/12/25 at 8:44 a.m., RN-C stated R40 was a fall risk due to a history of seizures. R40 was care planned for a low bed and floor mats to prevent falls and/or injury. R40 should not have been left unattended in an elevated bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 12:17 p.m., the director of nursing (DON) stated R40 should not have been left unattended in an elevated bed for safety to prevent falls. During an interview on 2/12/25 at 1:01 p.m., the administrator stated staff were expected to follow care planned intervention for safety. The facility policy Fall Prevention revised 3/2022, identified the facility would identify residents who were at high risk for falls and develop individual fall precautions for those residents to prevent falls and fall related injury.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to prevent weight loss for 1 of 3 residents (R30); and failed to implement assessess nutrition interventions to prevent further weight loss for 1 of 3 residents (R10) reviewed for nutrition. Findings include: R30: R30's quarterly MDS dated [DATE], identified R30 had severe cognitive impairment and diagnoses included diabetes, hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body), chronic kidney disease, dysphasia (difficulty swallowing food or liquids) and aphasia (a comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain). R30's weight was 153 pounds (lbs) and R30 had no loss of 5% or more in the last month or loss of 10% or more in last 6 months. R30's Mini Nutrition assessment dated [DATE], identified the registered dietician would continue R30's current plan of care and monitor weights monthly. Intake would be assessed regularly to ensure that nutrient needs were being met. Laboratory values would be reviewed for trends, and interventions would be adjusted as necessary. R30 would not trigger for any significant weight changes as evidenced by a 5% change in 30 days or 10% change in 180 days. The RD would continue to monitor weights monthly and reassess quarterly or as needed if significant changes in weight, intake, or health status occurred. R30's care plan revised 2/7/25, identified R30 had a potential for alteration in nutrition related to diabetes, hemiplegia of right side, heart disease and depression. The care plan directed to provide a regular diet, set up tray, open and pour liquids, butter bread, cut meat and arrange food then R40 was independent in eating. Weigh as ordered. Offer alternates as needed. Offer snacks two times a day. R30's weights identified the following: - 7/14/24 172.5 lbs - 7/21/24 157.6 lbs - 7/28/24 154.7 lbs - 7/30/24170.6 lbs - 8/9/24 171 lbs - 8/16/24 171 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/23/24 167.2 lbs - 8/30/24 164 lbs - 8/30/24 207 lbs - 9/6/24 164.4 lbs - 9/13/24 162.8 lbs - 9/20/24 162 lbs - 9/27/24 165 lbs - 10/11/24 164 lbs - 10/18/24 165 lbs - 10/25/24 164.6 lbs - 11/1/24 164 lbs - 11/15/24 162.2 lbs - 11/22/24 160 lbs - 12/6/24 158 lbs - 12/13/24 156.7 lbs - 12/20/24 156 lbs - 1/3/25 153.3 lbs - 2/7/25 146.8 lbs This identified R30's weight loss was 25.7 lbs or 14.89 percent (%) in 6 months. R30's Nutrition assessment dated [DATE], failed to identify weight Loss of 5% or more in the last month or loss of 10% or more in last 6 months. R30's meal intakes identified the following: - 7/14/24 dinner 76-100% - 7/15/24 breakfast 26-50% and dinner 26-50% - 7/16/24 breakfast 51-75% and 26-50%; dinner 1-25% (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/17/24 breakfast 1-25%, dinner 1-25% - 7/20/24 breakfast 1-25%, dinner 1-25% - 7/21/24 breakfast none, dinner 1-25% - 7/23/24 breakfast 26-50% - 7/24/24 breakfast 26-50%, dinner 76-100% - 7/25/24 breakfast 26-50%, dinner 1-25% - 7/26/24 breakfast 51-75%, dinner 1-25% -7/27/24 breakfast 51-75% - 7/29/24 breakfast 51-75%, dinner 1-25% - 7/30/24 breakfast 51-75%, dinner 1-25% - 8/2/24 breakfast 51-75%, lunch 1-25%, dinner 76-100% - 8/8/24 dinner 76-100% - 8/9/24 breakfast 1-25%, lunch 51-75% and dinner 1-25% - 8/13/24 lunch 1-25%, dinner 26-50% - 8/14/24 breakfast 51-75%, lunch 1-25%, dinner 1-25% - 8/19/24 dinner none - 8/20/24 dinner 51-75% - 8/21/24 breakfast 1-25% - 8/22/24 lunch none - 8/23/24 breakfast 26-50%, lunch 1-25% - 8/24/24 breakfast 26-50%, lunch 1-25% - 8/28/24 breakfast 26-50% - 8/31/24 dinner 1-25%- - 9/1/24 breakfast 1-25%, lunch 26-50% (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/3/24 dinner 1-25% - 9/3/24 dinner 1-25% - 9/5/24 breakfast 76-100% - 9/8/24 breakfast 1-25% - 9/13/24 breakfast 1-25%, lunch 76-100% - 9/18/24 dinner 26-50% - 9/23/24 dinner 51-75% - 9/26/24 dinner 76-100% - 9/27/24 breakfast 1-25% - 9/29/24 dinner 51-75% - 10/1/24 dinner 76-100% - 10/6/24 breakfast 51-75% - 10/10/24 breakfast 51-75% - 10/17/24 lunch 51-75% -10/18/24 dinner 26-50% - 10/20/24 dinner 26-50% - 10/25/24 dinner 26-50% - 10/30/24 breakfast 26-50%, lunch 76-100% -11/2/24 breakfast 1-25% - 11/9/24 breakfast 26-50%, lunch 26-50% - 11/10/24 breakfast 76-100% - 11/18/24 breakfast 1-25%, lunch 51-75% - 11/19/24 lunch 26-50% - 11/21/24 dinner 51-75% (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/22/24 dinner 26-50% - 11/26/24 breakfast 51-75%, lunch 76-100% - 11/27/24 breakfast 76-100% - 11/29/24 breakfast 1-25% - 11/30/24 breakfast 26-50% - 12/1/24 breakfast 51-75%, lunch 51-75% - 12/4/24 lunch 76-100% - 12/9/24 breakfast 76-100%, lunch 76-100% - 12/10/24 breakfast 26-50% - 12/11/24 breakfast 1-25%, dinner 1-25% - 12/12/24 breakfast 76-100%, lunch 1-25%, dinner 51-75% - 12/13/24 breakfast 51-75%, lunch 76-100% - 12/14/24 breakfast 76-100%, lunch 26-50% - 12/15/24 breakfast 51-75%, lunch 1-25% - 12/16/24 breakfast 26-50%, lunch 26-50%, dinner 51-75% - 12/17/24 breakfast 51-75%, lunch 51-75% - 12/18/24 breakfast 51-75%, lunch 51-75% - 12/19/24 lunch 51-75% - 12/20/24 breakfast 1-25%, lunch 1-25% - 12/23/24 breakfast 51-75%, lunch 26-50% - 12/24/24 breakfast 51-75% - 12/25/24 breakfast 51-75%, lunch 26-50% - 12/26/24 dinner 76-100% - 12/27/24 breakfast 51-75%, lunch 26-50% (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/28/24 lunch 1-25%, dinner 26-50% - 12/29/24 breakfast 76-100%, lunch 51-75% - 12/30/24 breakfast 26-50%, lunch 1-25% - 12/31/24 breakfast 51-75% - 1/2/25 breakfast 51-75%, lunch 26-50% - 1/3/25 breakfast 51-75%lunch 26-50% - 1/4/25 dinner 1-25% - 1/5/25 lunch 51-75% - 1/6/25 breakfast 1-25% - 1/10/25 lunch 76-100% - 1/11/25 breakfast 26-50% - 1/14/25 dinner 76-100% - 1/15/25 breakfast 1-25% - 1/17/25 breakfast 1-25%, lunch 26-50% - 1/18/25 breakfast 51-75%, lunch 26-50% - 1/21/25 breakfast 51-75%, lunch 76-100% - 1/24/25 breakfast 51-75%, lunch 51-75% - 1/26/25 breakfast not taken - 1/27/25 breakfast 1-25% - 1/29/25 breakfast none, dinner 51-75% - 1/30/25 breakfast 26+-50%, - 1/31/25 breakfast none, lunch 1-25% - 2/1/25 breakfast 1-25% - 2/2/25 breakfast 1-25% (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/725 breakfast none, lunch 26-50% - 2/10/25 breakfast 51-75%, lunch 1-25%, dinner 51-75% - 2/11/25 breakfast 76-100%, lunch 26-50% - 2/12/25 breakfast 1-25% During an observation on 2/10/25 at 11:59 a.m., R30 was assisted in her wheelchair to the dining room to wait for her lunch meal. R30 was given a cup of tea, a glass of milk and a glass of water. - At 12:41 p.m., R30 was served her lunch meal of chicken ala king over a buttered biscuit, parsley carrots and fruit salad. R30 had tea, water and milk to drink. - At 12:47 p.m., trained medication aide (TMA)-A asked R30 if she was going to eat. R30 shook her head no and TMA-A stated ok and walked away. - At 12:49 pm., nursing assistant (NA)-C asked R30 if she would at least eat her dessert. R30 nodded her head yes and NA-C brought R30 a cup of fruit salad. R30 ate the fruit salad but no other part of her meal. During an observation on 2/10/25 at 6:10 p.m., R30 was sitting in her wheelchair at the dining room table but R30 was asleep. R30 dinner meal of fried potatoes, hamburger steak and peas with carrots was in front of R30. R30 had eaten the peas with carrots but other part of her meal. NA-D approached R30 and asked if she was done eating. R30 nodded yes and NA-D assisted R30 from the dining room. NA-D did not encourage R30 to eat more or offered to assist R30. During an observation on 2/11/25 at 12:22 p.m., R30 was sitting in her wheelchair at the dining room table. R30 had her lunch meal of shepherd's pie, peas and pudding in front of R30. R30 had eaten a few bites of her meal. No staff offered to assist R30 or encouraged R30 to eat more. (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview with the registered dietician (RD)-A and dietary manager (DM)-A on 2/11/25 at 1:10 p.m., RD-A stated she was unable to speak with R30 for R30's quarterly assessment so RD-A spoke with staff about R30. R30 had difficulty with self-feeding and the nursing assistants explained they didn't always help R30, but they were always watching R30 from a distance. If R30 had difficulty with a meal, the nursing assistant would approach R30 and offer assistance. Limited self-feeding happened so staff needed to be there proactively. RD-A stated when she pulled the report for R30's weights, it did not show R30 had a significant weight loss. RD-A stated weight entries were not documented consistently, and this played a factor as well. Inconsistency was also identified with meal intakes. For example, if a resident did not want breakfast but requested a banana, staff should not document the resident ate 100% of their meal. RD-A stated the weekly weights and meal intakes were so important because the assessment would not be accurate due to either a lack of information or inaccurate information. RD-A stated she has explained this to nursing through email and during R30's care conference. If I see something I let them know, but if they do it or not is out of my control. RD-A stated she relied on nursing staff to also identify weight loss or gain when entering weight into the medical record and to obtain a re-weigh. RD-A stated finger foods were also recommended for R30, and shepherd's pie would be harder for R30 to eat independently. Staff wanted to encourage the nursing assistants to monitor meals and make sure every resident received foods that would allow the most independence. Residents could not or would not always verbalize the need for help. RD-A stated she did bring R30 to the quality assurance and performance improvement (QAPI) meeting because R30's weights were constantly fluctuating, however, RD-A stated she did not recognize R30 had had a significant weight loss.

During an interview on 2/12/25 at 8:47 a.m., RN-C stated the facility changed the process of weights from weekly to monthly at the beginning of the year. Some residents were weekly depending on need, and some were daily. Nursing and dietary monitored residents' weights to ensure no resident had either lost or gained too much weight in a period. The nursing assistants collected the meal percentages. They wrote the percentages on a sheet and then the nurse entered it into the computer. RN-C stated she knew R30 lost about 30 lbs since her admission and staff did try to assist R30 but R30 was just a picky eater and would only eat what R30 wanted to eat. RN-C stated the percentage of the meal eaten reflected what was gone from the resident's plate. For example, if the resident only wanted a banana that was 100% of the meal.

During an interview on 2/12/25 at 9:33 a.m., RN-D stated R30 did have a significant weight loss that should have been recognized, and interventions care planned to either stabilized R30's weight or to prevent further weight loss.

During an interview with the director of nursing (DON) and RN-A on 2/12/25 at 12:21 p.m., the DON stated, staff should have recognized R30's significant weight loss and implemented interventions to either promote the stabilization of R30's weight or to prevent further loss.

42075

R10:

R10's quarterly MDS dated [DATE], identified R10 was cognitively intact, required set-up assistance for eating, and had a weight loss that was not a physician-prescribed weight-loss regimen.

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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	02/12/2025

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's mini nutritional assessment dated [DATE], identified a nutritional risk score of 6.0 and identified R10 as malnourished. Risk factors included weight loss of 3.2 and 6.6 lbs. during the last 3 months, no change in food intake, was bed or chair bound, had suffered psychological stress or acute distress in the past months, and had a BMI less than 19. R10's weights identified the following: - 1/6/25 108 lbs. - 12/30/24 107 lbs. - 12/23/24 107 lbs. - 12/2/24 110 lbs. - 11/25/24 110 lbs. - 11/18/24 110 lbs. - 11/11/24 112 lbs. - 11/4/24 112 lbs. - 10/21/24 109 lbs. - 10/14/25 115 lbs. - 10/12/24 115 lbs. - 10/11/24 114 lbs. - 10/10/24 115 lbs. - 9/30/24 114 lbs. - 9/23/24 112 lbs. - 9/20/24 111 lbs. - 9/19/24 114 lbs. - 9/2/24 114 lbs. - 8/30/24 116 lbs. - 8/29/24 117 lbs. - 8/28/24 118 lbs. (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- 8/27/24 119 lbs.

- 8/26/24 117 lbs.

- 8/25/24 118 lbs.

- 8/23/24 118 lbs.

- 8/21/24 119 lbs.

- 8/20/24 120 lbs.

- 8/19/24 121 lbs.

- 8/16/24 122 lbs.

- 8/15/24 123 lbs.

- 8/9/24 125 lbs.

- 8/8/24 126 lbs.

- 8/4/24 123 lbs.

R10's Nutrition MDS assessment dated [DATE], identified R10 weighed 107 lbs. and had a weight loss of 5% or more in the past month, or a loss of 10% or more in the last 6 months and was not a physician-prescribed weight-loss regimen.

R10's progress notes, identified the following:

- On 10/16/24, registered dietician (RD)-A identified R10 weighed 115 lbs. and had been drinking a nutritional supplement daily. RD-A's recommendations included staff to offer and provide high calorie, high protein shakes.

- On 11/5/24 RD-A identified R10's weight had been stable for one week and recommendations included high caloric foods per patient request and continue to follow up and monitor weights.

- On 11/12/24 RD-A identified staff were to provide alternate meals upon request, offer high calorie/high protein shakes, food items to help promote weight gain, and to monitor intake and weights weekly.

R10's care plan dated 4/3/24, identified R10 had a potential for alteration in nutrition. Interventions included staff to offer a regular diet, thin liquids and assist with meal set up. Further interventions included weighs as ordered, offer food alternatives as needed, and offer snacks two times per day. The plan failed to identify individualized interventions for weekly weights, weekly intake documentation and options for high calorie, high protein foods to help promote weight gain as recommended by the RD.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 9:29 a.m., R10 was seated at a dining room table and had the morning meal in front of her that included two slices of toast and a glass of juice. At 10:01 a.m., R10 was observed leaving the dining room. R10 had eaten 3/4th of the toast and drank the juice. On 2/12/25 9:25 a.m., licensed practical nurse (LPN)-C stated she would document morning meal intake for the residents that ate in the dining room. LPN-C stated she knew what the residents normally ate for their morning meal and would mark the intakes accordingly. LPN-C stated R10 usually had two slices of dry toast and juice every morning and would mark 100% intake when R10 ate all her meal. On 2/11/25 at 12:42 p.m., RD-A stated in R10 weighed 125 lbs. on August 9, 2024 and had lost by November 18, 2024 10 weighed 110 lbs., a weight loss of 15 lbs. in 3 months. RD-A stated a significant change assessment was completed on 10/16/24. RD-A had talked with R10 about a plan to increase her weight and recommendations included higher calorie/higher protein shakes and continue with the nutritional supplement. RD-A stated in December 2024, documentation of weekly meal intakes and weights were recommended. R10's care plan failed to identify the recommendations. On 2/12/25 at 9:58 a.m., nursing assistant (NA)-I stated the nurses would let NAs know when a resident needed to be weighed. The NA's told the nurses the weight and the nurses would document in the chart. On 2/12/25 at 11:50 a.m., LPN-B stated weights used to be done on bath days but that had recently changed and was uncertain why. LPN-B stated when a resident needed to be weighed, she would let the NAs know, they would weigh the resident and report the weight back to the nurse. If there was a 5 lb. weight difference from the previous weight LPN-B stated she would re-weigh the resident herself and would contact the provider if needed. On 2/12/25 at 12:05 p.m., LPN-A residents used to be weighed on bath days but that had recently changed. LPN-A stated she was uncertain why it had changed. LPN-A stated the nurse that received the weight would document in the resident's chart and follow up as needed. LPN-A stated the RD would follow the resident's weight whenever there was a weight loss. The RD would recommend interventions including nutritional supplement, high protein/high calorie shakes and/or supplements ans sometimes snacks between meals. The RD would communicate the recommendations to the unit manager. The unit manager would add the recommendations to the care plan and notify staff. LPN-A was uncertain if any of these interventions were recommended for R10. Further, LPN-A stated R10's weight should have been monitored weekly. During an interview with the DON and RN-A on 2/12/25 at 12:21 p.m., the DON stated staff were expected to collect weights per facility policy, and to document meal intakes accurately. During an interview on 2/12/25 at 1:05 p.m., the administrator stated staff were expected to collect weights according to facility policy, accurately document meal intakes and to complete accurate assessments to aid in care planning and implementing interventions to either stabilize weight or to prevent loss. The Interventions for Unintended Weight Loss policy dated 2019, identified unintended weight loss or gradual weight loss would be identified and monitored so that appropriate and individualized interventions could be implemented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Weighing a Resident revised 1/20/25, identified all residents would be weighed on admission and at least monthly while they are in the nursing home. Monthly weights will be done the first seven days of each month. A. Tell the resident what you are going to do. B. Take the resident to the scale or bring Medi-lift to resident's room. C. Check to be sure the scale is balanced. (Allow the scale time to balance - wait until the scale reads 0) If using the Media-lift scale, balance the scale to zero with sling prior to getting resident into sling. D. Ask the resident to step on the scale. Read the weight indicated on the screen of the scale. If you use Medi-lift scale, press the weight button after resident is in sling. E. Record the weight in the designated spot. NOTE: 1. If it is necessary to weigh a resident with braces, an artificial limb, or clothing, a note should be made on the record that the brace or clothing is included in the weight. 2. A resident may be weighed in a WC or on a platform balance scale. In this case, weigh the chair first and write down the weight. Then weigh the resident in the chair. Write this down. Take the weight of the resident and the chair and subtract the weight of the chair to get the weight of the resident. 3. When weighing a resident in a WC it is important that the WC is wheeled forward enough so that the platform is off the floor. 4. If the resident has oxygen or anti-rollback on their W/C it should be noted as well. 5. If a resident's weight needs to be monitored more closely, they will be set up as indicated. Such as weekly weights for weight loss or daily weights for fluid status monitoring. The facility policy Interventions for Unintended Weight Loss dated 2019, identified uintended weight loss or gradual weight loss will be identified and monitored so that appropriate and individualized intervention can be implemented. Patients/residents will be weighed upon admission or readmission, weekly for the first 4 weeks after admission, and at least monthly thereafter to help identify and document weight trends. Weekly weights may be ordered due to a significant change in condition, if food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance. Factors that may impact weight and the significance of apparent weight changes include: a. Usual weight through adult life b. Current medical condition (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

c. Therapeutic diet

d. Calorie restricted diet or calorie-enhanced diet

e. Recent changes in food or fluid intake

f. Edema

g. Dehydration

Staff will follow a consistent approach to weighing and use an appropriately calibrated and functioning scale (e.g., wheelchair scale or bed scale). Since weight varies throughout the day, a consistent process and technique (e.g., weighing the patient/resident wearing a similar type of clothing, at approximately the same time of the day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, and verifying scale accuracy) can help make weight comparisons more reliable.

The facility policy Method To Determine Percent of Meal Eaten reviewed 4/2015, identified the following:

1. Count the number of nutritious items served at the meal. Do not count: desserts (unless fruits), coffee, tea, Jello, Jello salad, broth, donut, sweet roll, cake, and pie.

2. Figure the amount of food consumed of each item that counts from above:

None eaten = 0 points

1/4 eaten = .25 points

1/2 eaten = .5 points

3/4 eaten = .75 points

All eaten = 1 point

3. Total the number of points eaten.

4. Divide the number of points eaten by the number of points served and multiple by 100 to obtain the percentage of the meal eaten.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure a complete medical record was maintained to include the physician reviewed orders, treatments and care plans during routine visits for 1 of 2 residents (R7) reviewed during medication administration. Findings include: R7's undated Resident Face Sheet identified admitted [DATE]. Diagnoses included epilepsy, diabetes, pain, autistic disorder, fibromyalgia and chronic kidney disease. R7's Physician Order Report dated 10/7/24 to 1/7/25, lacked complete orders. The signed physician order report identified 12 ordered medications on page one and two of the documents. Of the 12 orders, only nine were legible as the document had faded and incomplete printed areas over the pages. R7's activities of daily living (ADL) order with start date 8/15/20, appeared to order a non-pharmaceutical intervention for pain, however, was illegible as the scanning was faded and incomplete in areas. Pages three and four of the order report were not available. When interviewed on 2/12/25, at 11:52 a.m. the medical records staff member (MR)-F stated she was unable to locate the full four-page Physician Order Report dated 10/7/24 through 1/7/25. MR-F usually checked the documents after she scanned them into the resident's medical records to ensure the document was legible. MR-F stated she must have missed checking R7's physician report and she was unsure why only two pages of the four-page document was scanned. It should have been the full four pages as there were more orders on the missing pages. During interview on 2/12/25, at 12:00 p.m. the director of nursing (DON) confirmed they were unable to locate the complete four-page Physician Order Report for R7's medical record. The facility policy Doctors Review and Renewal Policy revised 4/2015, identified the physician's progress notes would be stamped each visit, and the physician would sign that the plan of care was reviewed, including resident care plan, medications, treatments and all other orders.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41575

Based on interview and document review, the facility failed to ensure long term residents received routine physician visits every 60 days as required for 2 of 2 residents (R7, R39) reviewed during medication administration.

Findings include:

R7:

R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 had intact cognition. Diagnoses included epilepsy, diabetes, pain, autistic disorder, polyneuropathy, fibromyalgia, conduct disorder, and chronic kidney disease.

R7's medical record identified R7 had physician visits for his primary care on 7/26/24 and 1/8/25. R7's medical record lacked documentation of routine 60 day visits for 165 days, from 7/26/24 to 1/8/25.

During interview on 2/12/25, at 11:52 a.m. the medical record staff (MR)-F stated she was only able to find documentation of physician visits July 25, 2024 and January 8, 2024. It appeared a visit had been scheduled in September and November 2024, however the visits were not completed or billed. MR-F thought they must have been canceled for some reason.

A joint interview was conducted with consultant registered nurse (RN)-A and the director of nursing (DON), 2/12/25, at 12:00 p.m. RN-A stated R7's primary physician stopped rounding at the facility and had also canceled R7's medical appointments the facility had scheduled. R7 had agreed to change to a different primary physician and then was seen by that physician in January, so the facility hoped to continue regularly scheduled visits from that point on. RN-A stated R7 had not been seen for recertification visits every 60 days and it was the facility's usual practice to have established residents seen every 60 days to be re-certified as required.

40943

R39:

R39's quarterly MDS dated [DATE], identified R39 had a severe cognitive impairment and included a diagnosis of dementia. R39 exhibited no hallucinations, delusions or behaviors during the assessment period.

R39's medical record identified R39 was evaluated by a medical provider on 6/25/24, 8/21/24, 11/5/24 and 1/15/25.

(continued on next page)

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	02/12/2025

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

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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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 12:00 p.m., MR-F stated she was responsible for the facility's medical records. MR-F stated she was responsible to figure out when a resident was last seen then schedule a follow up visit every 60 days with the resident's provider. There was a 10-day grace period as well, but the resident must be seen by day 70. R39 was seen on 8/21/24 but not again until 11/5/24 which was 76 days. MR-F stated she did not start her role until January 2025 and could not say why R39 was not seen timely. After 11/5/24, R39 was seen again on 1/15/25 which was 71 days. MR-F stated R39 was scheduled on 1/8/25 but for some reason that was cancelled. MR-F stated she was new to her role at that time and must have mistakenly counted days when the appointment was rescheduled for 1/15/25. It just slipped through my fingers. During an interview on 2/12/25 at 12:31 p.m., the DON stated the facility needed to ensure timely physician visits occurred to ensure appropriate resident care was provided. During an interview on 2/12/25 at 1:14 p.m., the administrator stated staff were expected to ensure timely physician visits occurred. The facility policy Doctors Review and Renewal Policy revised 4/2015, identified the following: A. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The physician's progress notes should be stamped each visit and the physician sign that he has reviewed the plan of care including resident care plan, meds, treatments, and all other orders. B. A physician visit will be considered timely if it occurs not later than 10 days after the date the visit was required. C. If any resident is receiving physical therapy, they must be seen by their physician every 30 days and orders reviewed. D. If a resident is on Medicare they must be seen by their physician every 30 days and orders reviewed. E. Medications, orders and plan of care must be RENEWED by the physician at least every 90 days. The computer sheet will be generated at these times and the physician will review, sign, and date to renew the orders. F. On new admits and hospital returns all MD orders are to be computer generated the first time the MD rounds.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to comprehensively assess and implement interventions for identified behaviors for 1 of 3 residents (R17) reviewed for dementia care. Findings include: R39's quarterly Minimum Data Set (MDS) dated [DATE], identified R39 had a severe cognitive impairment, R39 used antipsychotic medication daily and exhibited no hallucinations, delusions or behaviors during the assessment period and had a diagnosis of dementia. R39's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 8/21/24, identfiied R38 was unable to complete BIMS interview. R39 was at risk for alteration in thought process with potential for anxiety, falls, and decreased mobility related to cognitive decline secondary to unspecified dementia.Would proceed to anticpate R39 needs and intervene when making poor decisions. R39's care plan revised 11/26/24, identified R39 had alteration in thought process with potential for anxiety related dementia and nursing home placement manifested by impaired cognition. Staff were directed to reorient and validate as needed. Staff would anticipate and meet needs, provide cues and supervision when making poor decisions, and intervene as needed. R39 was not to leave facility unattended. Explain all procedures before doing them. Approach in an unhurried calm manner. Offer information regarding schedules, routines, locations, and services as R39 and family need. Encourage family and or friends to visit or maintain usual contact. R39's nursing progress notes identified the following: - 1/21/25 at 3:06 a.m., R39 had been yelling out all night. When asked if R39 needed anything R39 stated get out of my room you b**ch. R39 continued to yell you b**ch over and over for about half an hour after this nurse left the room. When the aide went in to try calm R39, R39 yelled at her to get out as well. R39 was unable to be consoled and continued to yell in her room despite every effort to give her what she could need. - 1/21/25 at 11:39 a.m., R39 slapped a staff member across the face with cares. R39 had been yelling at staff constantly - 1/22/25 at 2:23 a.m., R39 was awake most of the night yelling out. When staff entered the room, R39 told her to get out of my room! R39 had had her as needed (PRN) Zyprexa (an antipsychotic medication) earlier in the day and was not available to give again. This behavior continued throughout the night until around 3:00 a.m. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/22/25 at 1:51 p.m., R39 got up for breakfast without complaint. R39 then stayed up in her wheelchair and wheeled herself around with some talking to herself. Between 11:00 a.m. to 12:00 p.m., R39 was yelling to herself in her room I want to lay down but no one to help me. Help. R39 was not using the call light at this time. The nursing assistant (NA) asked to bring R39 to lunch and R39 said no. Writer asked R39 again about 15 minutes later and R39 still did not want to come to lunch. R39 was assisted to lie down, and staff saved her lunch meal for when R39 was hungry. - 1/23/25 at 2:25 a.m., R39 was awake yelling out again tonight. Attempted to talk with R39 and asked if R39 was hungry, R39 stated that she was and that she would like some toast. This nurse made R39 some toast and gave R39 some apple juice. R39 continued to yell, appearing to be talking to people in the room trying to get them to try the toast as it was the best thing R39 had tasted in years. R39 was upset that they wouldn't try the toast. (There was no one in the room with her) After R39 finished her toast and juice R39 continued to yell out. PRN Zyprexa was given. Will continue to monitor. - 1/23/25 at 4:54 a.m., R39 finally settled and fell asleep around 4:00 a.m. - 1/28/25 at 2:59 a.m., R39 slept fairly well. R39 did holler out a few times during the night and was talking loudly. R39 had a shower last night on the evening shift and was very upset. - 1/30/25 at 2:43 p.m., R39 did not need her PRN Zyprexa this shift. R39 got up for both meals. R39 was yelling for help in room between breakfast and lunch, writer helped R39 change sweaters, that was what R39 was asking for help with. R39 then went to music at activities for a short time. R39 yelled out loud to herself minimally this shift. - 2/2/25 at 2:31 a.m., R39 refused her bedtime medication. PRN Zyprexa given. R39 too half the medication and refused to finish. R39 kicked and pinched staff. - 2/4/25 at 2:39 a.m., R39 was very agitated and hollering out. Talking about going to school and R39 would be late if she did not get to the bus. Unable to redirect R39. PRN Zyprexa given for agitation. - 2/4/25 at 5:08 a.m., R39 sleeping. Was no longer hollering out or agitated about 30 minutes after PRN Zyprexa was given. - 2/6/25 at 4:54 a.m., R39 slept well all night. Continued to holler at staff when they come in to give medication or reposition/change her, but as soon as staff left, R39 was calm and quiet again. - 2/8/25 at 3:10 a.m., R39 was yelling out all shift. PRN Zyprexa was attempted to be administered but R39 refused to take. - 2/11/25 at 5:29 a.m., R39 slept well throughout the night. R39 started hollering nonstop at around 5:00 a.m. this morning. Unable to redirect. R39 was given PRN Zyprexa. R39's medical record lacked any assessment into R39's distress and behaviors and implementation of specific interventions. R39's Physician orders identified the following: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/18/24, identified Zyprexa (olanzapine) (an antipsychotic medication) 5 milligram (mg) tablet. Give 1 tablet by mouth once a day in the morning. - 1/21/25, Zyprexa 2.5 mg tablets. Give 2.5 mg by mouth once a day as needed. Used for behaviors. Add note when given. Okay to stand until next face to face visit. - 1/21/25, Zyprexa 2.5 mg tablets. Give 2.5 mg by mouth once a day as needed. Used for behaviors. Add note when given. Okay to stand until next face to face visit. Saff were to monitor behavior and document every shift. R39 needed her PRN Zyprexa put a note In for the doctor. If R39 was lethargic, notify the charge nurse. - 1/28/25, Zyprexa 5 mg tablet. Give 1.5 tablet by mouth once a day in the evening. R39's electronic medication administration record (EMAR) dated January 2025, identified R39 received Zyprexa 2. 5mg PRN on the following days; - On 1/23/25 at 2:36 a.m. for other - On 1/25/25 at 4:13 p.m. for behavior issues yelling at table R39's EMAR dated February 2025, identified R39 received Zyprexa 2.5 mg PRN on the following days: - On 2/1/25 at 11:37 p.m. for behavior issue refused all bedtime (HS) meds - On 2/4/25 at 2:38 a.m. for other agitation - On 2/11/25 at 5:40 a.m. for other agitation at 5 am. There was no evidence of non pharmological interventions attempted prior to the administration of Zyprexa and what the result was of the medication. During a continuous observation on 2/10/25 at 6:15 p.m., R39 was sitting in her room in her wheelchair next to her bed with an overbed table against the wall in front of her. R39 had her hairbrush in her hands and was pulling on the bristles. R39 repeatedly stated I don't care. breakfast, whatever. R39 was wearing a dark blue cardigan sweater over a gown, black slippers and a blanket across her lap. - At 6:19 p.m., R39 loudly sang I don't know what that is and oh my bra they took it off because I don't need one. R39 could be clearly heard five rooms away. - At 6:40 p.m., R39 turned her wheelchair to face her bed. R39 repeatedly stated I want my bed, I don't know, are you helpless?, yes, yes, I am, I don't want the chair over there I want it over here where I can sit on it, I don't know who put it over there, I don't know what's going on. I have nothing on my feet besides my shoes. I have socks but I don't know how to put them on and you should, yes, you should. - At 6:42 p.m., well I just don't I have socks right here and I just don't know how to put them on, didn't you ever dress yourself?, I don't know, do you know nothing? (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 6:44 p.m., help me get my socks on, are you helpless?, yes, I am. R39 began weeping. Oh, I don't like it either. I don't like being helpless. - At 6:50 p.m., R39 continued hollering. Trained medication aide (TMA)-B pushed the medication cart up against the wall outside R39's door but did not redirect R39. R39 loudly sang ooohhhhhhh, I don't know what to dooooooo. Cooome and help meeeeeeeeeee. Take my shoes off. TMA-B was directly outside R39's room and did not respond. Oh, are you that helpless!?! Yes, I am. Didn't you ever dress yourself? No, my mother dressed me. - At 6:52 p.m., TMA-B administered R39 her bedtime medication. However, TMA-B did not offer R39 toileting, repositioning or to lie down. TMA-B exited the room and R39 began hollering again. - At 6:56 p.m., What do I got to do now? Go to bed in your clothes. What do you know? Nothing! - At 6:56 p.m., R39 was crying. I don't know how to do things. Who put you to bed last night? Nobody. I didn't go to bed. Are you helpless? Yes, I am. My mother never showed me how. You poor child. - At 7:04 p.m., the social worker (SS)-A approached R39 and stated Hi, did you have any chocolate today? SS-A continued to reminisce with R39 about family. SS-A offered R39 a drink of water and R39 took a drink. SS-A asked R39 if she wanted to lie down and R39 stated yes. SS-A turned on R39's call light, reassured R39 someone would assist her to bed and left the room. - At 7:09 p.m., R39 began hollering. How did I get so helpless? Have you always been so helpless? I guess so. My mother did everything. - At 7:11 p.m., just climb into bed. I'll fall on my face in between. No, you won't. How do you know that? You're not that bad. - At 7:14 p.m., NA-E entered R39's room and asked R39 if she needed something because R39's call light was on. I don't know. NA-E turned off R39's call light and told R39 if she remembered what she needed to press her call light. NA-E left the room. R39 immediately started hollering. Oh, my legs hurt. I just want to go to bed. - At 7:23 p.m., NA-F entered R39's and assisted R39 to bed. R39 was quiet after lying down. During an interview on 2/10/25 at 7:33 p.m., NA-F stated R39 hollered a lot. R39 was impatient and would holler out when R39 wanted something. NA-F stated she was too busy, and this was the first chance she had to assist R39 to bed. R39 did not get along with a lot of people and NA-F was responsible to put her to bed that shift. R39 would swat you. R39 didn't mean it but would hit. NA-F stated once R39 laid down R39 would be quiet the rest of the night. During an interview on 2/10/25 at 7:38 p.m., TMA-B stated R39 hollered like that every day. R39 hallucinated all day long and R39 believed she was sitting with people and talking to them. R39 sang I don't know all day long. Staff tried to talk to her and bring her to activities or to watch tv but R39 didn't like that stuff. R39 liked to stay in bed but staff had to get her up for meals. TMA-B During an interview on 2/11/25 at 10:16 a.m., NA-G stated R39 yelled a lot. Staff could ask R39 what she wanted and sometimes R39 would say and other times R39 wouldn't. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 4:14 p.m., TMA-B stated R39 did have a PRN dose of Zyprexa that could be used once a day for R39's behaviors. Before giving, TMA-B had to talk to the charge nurse who assessed R39. The charge nurse could give the PRN dose of Zyprexa but most of the time the charge nurse told the TMA to do it. TMA-B stated there were no non-pharmacological interventions to try first. Staff just needed to tell the charge nurse what was going on so the charge nurse could assess the behavior. During an interview on 2/11/25 at 4:16 p.m., RN-E stated, for behaviors, she would assess the situation and try to diffuse the R39's agitation. If that didn't work, RN-E would check to see the last time the PRN Zyprexa was used and would administer the medication. RN-E redirect like conversation, find something common, calm, reminiscing, RN-E did not know R39 well and would have to ask the staff who would know R39 better what interventions worked best. RN-E stated R39's care plan really didn't direct specific interventions about R39's behaviors. As an employee, RN-E stated she expected the care plan be more resident centered and have triggers and interventions identified to either prevent behaviors or to calm R39 so R39 would not need that PRN medication. During an interview on 2/12/25 at 7:13 a.m., NA-H stated R39's behaviors had no rhyme or reason that NA-H could think of. If R39's son came to visit, R39 would be calm but then got worked up again when he left. You can try every intervention you can think of and then if you try too long, R39 would become combative. R39 had a stuffed puppy that she liked and would help R39 stay calm. Also, if a man came into the dining room, R39 would scream at him to leave. During an observation in the dining room on 2/12/25 at 7:27 a.m., R39 was reading aloud from the conversational starter on her table. A male resident from another unit came into the dining room to talk to another female resident and R39 yelled you get out of here! The male resident did not respond but left the dining room shortly after. During an interview on 2/12/25 at 8:55 a.m., RN-C stated there was no rhyme or reason to R39's behaviors. RN-C stated there were no unique resident-centered interventions care planned R39's behaviors and staff should attempt non-pharmacological interventions before giving an antipsychotic medication. Staff were also expected to document all behaviors and attempts at redirection for monitoring. During an interview on 2/12/25 at 12:31 p.m., the director of nursing (DON) stated staff were expected to find something for R39 to do, go on walks, out of her room, get her up or lie her down. The behaviors often occurred in the dining room prior to meals and R39 was in the dining room way before the meal started. Staff should offer a snack, a drink. The DON stated R39's care plan should have interventions that are individualized to R39's behaviors so staff could identify triggers and have resources to try to prevent R39's behaviors or to calm R39. During an interview on 2/12/25 at 1:14 p.m., the administrator stated the care plan should show specific resident centered care plan to promote non-pharmacological interventions to prevent behaviors. Staff were expected to follow the care plans. A facility policy regarding dementia care was requested but not received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure as needed medication from facility standing orders were transcribed and administered appropriately to reduce the risk of complications for 1 of 1 resident (R56) reviewed for loose stools. Findings include: R56's admission Minimum Data Set (MDS) dated [DATE], identified R56 had mild cognitive impairment and was continent of both bowel and bladder with no constipation present. A diagnosis of diarrhea was included. R56's Medication Administration Record (MAR) dated 2/1/25 to 2/10/25, identified loperamide (an antidiarrheal) OTC (over the counter) medication was added on 2/5/25. Instructions were for loperamide 2 milligrams (mg) to be administered four times per day for diarrhea. Special instructions instructed to give 2 mg of the medication after each loose stool, not to exceed 8 mg in a 24-hour period. The medication was scheduled to be given every day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Staff initialed the medication administration as administered as follows: - 2/5/24 at 12:00 p.m. the 4:00 p.m. and 8:00 p.m. scheduled doses were documented as resident refused. - 2/6/25, the medication was administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. - 2/7/25, the medication was administered at 8:00 a.m. The 12:00 p.m., 4:00 p.m., and 8:00 p.m. scheduled doses were documented as resident refused. - 2/8/25, the medication was administered at 9:00 p.m. The 8:00 a.m., 12:00 p.m., and 4:00 p.m., scheduled doses were documented as resident refused. - 2/9/25, the medication was administered at 8:00 a.m., and 12:00 p.m. with the 4:00 p.m. and 8:00 p.m. scheduled doses refused. A notation was made in the MAR, R56 had stated she should not be taking loperamide four times per day and did not want it. - 2/10/25, the medication was refused at 8:00 a.m., 12:00 p.m., and 4:00 p.m. The medication was discontinued after 4:00 p.m. R56's bowel monitoring record identified R56 had four bowel movements on 2/5/25, a medium bowel movement on 2/6/25, and two medium bowel movements on 2/9/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/10/25, at 5:57 p.m. R56 stated she had loose stools on 2/5/25, then her stools were fairly normal. R56 stated she only took the loperamide two times after the first loose stool on 2/5/25 and that did the trick. The nurses mentioned something about taking it four times per day and R56 told the nurse there was no way she was taking it that often. R56 told the nurses she should not be taking loperamide like that and should only take it when it was needed after a loose stool. R56 indicated she never took any more of the loperamide after the two initial doses on 2/5/25 and refused it after that. During interview on 2/11/25, at 4:47 p.m. licensed practical nurse (LPN)-B stated the loperamide order was transcribed from the facility standing orders and should not have scheduled times for administration. The medication was to be given for a loose stool and so should have been transcribed on to the MAR as a one-time order from standing orders. Then if needed to be given again, would need to be re-entered onto the MAR again and each time it was needed. R56 did not have a physician order for as needed (PRN) loperamide and so when taking it from the facility's standing orders would be a one-time only medication administration. When interviewed on 2/11/25, at 5:05 p.m., the director of nursing (DON) stated she had spoken with R56 who denied having loose stools and so the DON questioned why R56 was still receiving scheduled loperamide. The DON contacted R56's primary provider and had the medication discontinued. The DON stated if the loperamide order was transcribed from the facility's standing orders, the medication should not have been scheduled with administration times. The medication should have been identified as PRN on the resident's MAR. The medication was transcribed to the MAR incorrectly and therefore, lead to medication errors as well. Medication errors occurred each time the medication had been given on the scheduled times. If R56 had been experiencing loose stools for that amount of time, the provider should have been notified. It was the facility's policy to notify the provider if a resident was having four or more loose stools in a 24-hour period. When interviewed on 2/12/25, at 9:30 p.m., LPN-D stated on 2/5/25, she had entered the loperamide order on R56's MAR from the facility's standing orders in order to administer R56 the medication for complaints of loose stools. LPN-D indicated the medication should have been identified as PRN and not scheduled four times per day. LPN-D thought she must not have pressed the PRN button and so the medication had not been recorded on R56's MAR correctly. The facility's policy Medication Discrepancies revised 4/2015, identified a goal to ensure safe administration of all medications to residents. Medication discrepancies included medications given at the wrong time, a PRN medication given sooner than the physician's stated order, or an order transcribed incorrectly,

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 1 of 5 residents (R51) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE], identified R5 had intact cognition. Diagnoses included paroxysmal atrial fibrillation, heart disease, and secondary hypertension. R5's Physician Order Report signed 10/9/24, identified R5's current medication regimen with their corresponding start dates and included the following: Eliquis (an anticoagulant) 2.5 milligrams (mg) two times per day, aspirin (reduces the formation of blood clots) 81 mg every day, and Diltiazem (to prevent chest pain) 120 mg every day. R5's Consultant Pharmacist's Medication Review dated August 2024, identified R5's medication regimen had been reviewed by the consulting pharmacist (CP) and listed an irregularity regarding the medication Diltiazem. The CP comment included concomitant use of Diltiazem with oral anticoagulants such as Eliquis was associated with higher bleeding risk. A suggested course of action was listed to consider reassessing risks vs. benefits of using Diltiazem. There was no recorded response from the physician on either accepting the recommendation or rejecting it despite the follow up implementation time frame for the physician to address ASAP (as soon as possible) but no later than 30 days. R5's Consultant Pharmacist's Medication Review dated October 2024, identified R5's medication regimen had been reviewed by the consulting pharmacist (CP) and listed an irregularity regarding the medication Diltiazem. The CP comment included concomitant use of Diltiazem with oral anticoagulants such as Eliquis was associated with higher bleeding risk. An additional comment was added the CP had not found a response to his August recommendation and so was renewing the recommendation again. A suggested course of action was listed to consider reassessing risks vs. benefits of using Diltiazem. There was no recorded response from the physician on either accepting the recommendation or rejecting it despite the follow up implementation time frame for the physician to address ASAP (as soon as possible) but no later than 30 days. R5's medical record lacked evidence the consulting pharmacist's recommendation on R5's Diltiazem dose irregularity had been forwarded, reviewed and/or acted upon by the physician despite the recommendation being made both in August and October and R5 continued to receive the medication which had been identified as a potential for increased risk of bleeding, with need for close monitoring for signs of bleeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/12/25, at 12:00 p.m. the director of nursing (DON) stated she was unable to find the provider's response to the CP's recommendations. The DON was responsible to ensure the physician reviewed the recommendations. When pharmacy recommendations were received, she sorted them into physician rounding and fax for non-rounding physicians. Sometimes the physician would take the CP recommendation forms back to the clinic for further review and did not always return them. The DON was working on a new process to ensure recommendations were being followed up on. The expectation was to have the physician address all pharmacy recommendations within 14 days. The facility policy Pharmacy Service Medication Regimen Review dated 10/2022, identified the consultant pharmacist would review the medication regimen of each resident at least monthly to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The pharmacist would provide a written report to the DIN within 3 business days of completing the monthly review. Copies of the report would be provided to the DON, the patient's attending physician and the facility's medical director. Recommendations would be acted upon and documented by the facility staff and/or the prescriber. The physician would accept and act upon suggestions or reject and provide an explanation for disagreeing.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to provide a face-to-face provider evaluation for continued use of a as needed (PRN) psychotropic medication for 1 of 2 residents (R39) reviewed for mood/behavior. Findings include: R39's quarterly Minimum Data Set (MDS) dated [DATE], identified R39 had severe cognitive impairment. R39 used antipsychotic medication daily and exhibited no hallucinations, delusions or behaviors during the assessment period. R39 had a diagnosis of dementia. R39's Physician order dated 1/21/25, identified Zyprexa (olanzapine) (an antipsychotic medication) 2.5 milligram (mg) tablets. Give 2.5 mg by mouth once a day as needed. Used for behaviors. Add note when given. Okay to stand until next face to face visit. R39's electronic medication administration record (EMAR) dated January 2025, identified R39 received Zyprexa 2. 5mg PRN on the following days; - On 1/23/25 at 2:36 a.m. for other - On 1/25/25 at 4:13 p.m. for behavior issues yelling at table R39's EMAR dated February 2025, identified R39 received Zyprexa 2.5 mg PRN on the following days: - On 2/1/25 at 11:37 p.m. for behavior issue refused all bedtime (HS) meds - On 2/4/25 at 2:38 a.m. for other agitation - On 2/11/25 at 5:40 a.m. for other agitation at 5 am. R39's medical record 1/22/25 through 2/12/25, failed to identify R39's physician failed to document the rationale and duration of need for PRN antipsychotic medication. During an interview on 2/11/25 at 5:05 p.m., the director of nursing (DON) stated PRN antipsychotic medications should be re-evaluated by the physician every 14 days with a documented rationale and duration for use. During an interview on 2/12/25 at 1:14 p.m., the administrator stated staff were expected to ensure PRN antipsychotic medication rationale and duration for use was clearly documented to ensure appropriate use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Psychotropic Medication Monitoring Policy and Procedure reviewed 6/2023, identified orders for PRN psychotropic medications would be given only for specific, clearly documented circumstances. PRN psychotropic medications require a face-to-face assessment by the prescribing provider 14 days after initiating of the new medication. Specific target behaviors and interventions will be listed for PRN psychotropic medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 1 resident (R211) reviewed for catheter care; and 1 of 1 resident (R18) reviewed with a surgical wound. Findings include: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R211: R211's admission Minimum Data Set (MDS) dated [DATE], identified R211 was cognitively intact. R211 required maximum assistance with dressing and transfers and moderate assistance with toileting. R211 had an indwelling foley catheter with a diagnosis of retention of urine. R211's care plan with revision date 2/12/25, identified enhanced barrier precautions were needed due to the indwelling foley catheter. On 2/10/25 at 6:15 p.m., R18's room was observed and there was no personal protective equipment (PPE) cart in or near R18's room. Further, there was no sign posted outside R18's room identifying R18 was on EBP. On 2/10/25, at 6:45 p.m. R211 was observed seated in a recliner in reclined position in his room. Nursing assistant (NA)-J entered the room and assisted R211 to stand and ambulate to the side of his bed. NA-J with gloved hands transferred, removed clothing, assisted to wash up and position R211's catheter leg bag on to the bed. At no time did NA-J wear a gown. On 2/10/25, at 7:37 p.m. registered nurse (RN)-F entered R211's room. RN-F stated the facility did not allow residents to sleep at night with leg bags as the urine would not drain properly. RN-F changed R211's beg bag to a leg bag maintaining proper hand hygiene ; however, RN-F failed to wear a gown for EBP requirements. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/10/25, at 7:45 p.m. RN-F stated it was not the facility's practice to initiate EBP with standard catheter care. EBP would only be initiated if the resident had some type of infection. The facility initiated EBP with all residents with wounds or supra pubic catheter care, but not for standard catheter care, or colostomies. If staff were required to do EBP with resident care, there would be signage on the resident's door to indicate that and R211 did not have any signage in his room. On 2/11/25, at 2:55 p.m. NA-J assisted R211 with toileting cares. Although NA-J used proper hand hygiene with glove use, NA-J failed to wear a gown when assisting R211 with toileting cares. When interviewed on 2/11/25, at 3:00 p.m. NA-J stated she had not worn EBP when she had assisted R211 to the bathroom. Staff only had to wear EBP when working with R211's catheter or when providing peri care. NA-J assisted R211 to the bathroom but had not grabbed a washcloth and washed him up, so had not really provided peri care. NA-J had wiped R211's peri area with toilet paper to clean after his bowel movement when she assisted him off the toilet. That may have constituted peri care, and she should have been wearing a gown while assisting him with toileting. During interview on 2/12/25, at 8:56 a.m. infection preventionist licensed practical nurse (LPN)-A stated EBP was required for all residents with wounds, gastrostomy tubes, and foley catheters. The residents did not have signage on their doors to identify if EBP was required. Staff knew which residents required EBP as it was identified on the resident's care sheet and was also passed along during shift report. Staff were required to wear gown and gloves for EBP whenever working with a resident's foley catheter and should have been wearing EBP when changing a foley catheter leg bag to a collection bed bag. During interview on 2/12/25, at 12:00 p.m. the director of nursing (DON) stated it was the facility's expectation for staff to use EBP for foley catheter care as well as peri care with all residents with wounds or invasive medical devices. Staff were trained on EBP during their orientation on hire and at all staff meetings. Residents who required EBP during care were identified on staff care sheets and a gown was required for all close contact personal care. 42075 R18: R18's admission MDS dated [DATE], identified R18 was admitted on [DATE], was cognitively intact and was receiving surgical wound care. R18's care plan revised 2/12/25, identified R18 recently had a hip replacement and required staff to complete dressing changes and monitor and report any signs or symptoms of infection. The plan further identified R18 required assist of 1 staff for transfers, toileting and dressing. However, the plan failed to address R18's need for contact and/or EBP. R18's orders report dated 1/24/25, identified the following: - Right hip: monitor dressing placement and monitor for any signs and symptoms of infection such as increased redness, warmth, swelling, drainage, or generalized fever over 101. Notify charge nurse if noted so that provider can be notified. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 2/10/25 at 7:06 p.m., there was no PPE cart near or inside R18's room. Further, there was no sign directing staff to wear PPE during dressing changes or cares R18's orders report dated 1/24/25, identified staff were to monitor R18's dressing placement and for signs and symptoms of infection such as increased redness, warmth, swelling, drainage, or generalized fever over 101. Staff were to notify the charge nurse so they could notify the provider. R18's care plan revised 2/12/25, identified R18 recently had a hip replacement and required staff to complete dressing changes and monitor and report any signs or symptoms of infection. The plan further identified R18 required assist of one staff for transfers, toileting and dressing. However, the plan failed to address R18's need for EBP. During observation on 2/10/25 at 7:06 p.m., there was no personal protection equipment (PPE) cart near or inside R18's room. Further, there was no sign directing staff to wear PPE during dressing changes or cares. On 2/11/25 at 10:10 a.m., registered nurse (RN)-C was in R18's room and assisted R18 to lay down in bed. Wearing gloves, RN-C assessed the area around R18's surgical dressing by touching and stated the dressing was intact with no drainage outside of the dressing. The skin around the dressing was a little warm to touch. RN-C failed to wear a gown while assessing R18's surgical wound. On 2/12/25 at 7:33 a.m., RN-C was observed in R18's room and changing R18's dressing. Observation of the dressing identified a dark red spot, approximately 1-inch in diameter in the middle area of the outside of the dressing. While wearing gloves, RN-C removed R18's dressing and stated there was an area on the distal end of the incision that appeared to be a fluid filled bubble/blister. RN-C stated the skin around the distal end appeared to be darker red although was not warm to touch. RN-C cleansed and reapplied a dressing to the wound. RN-C stated the wound looked worse than the other day and thought it may be starting to get infected. RN-C did not apply or wear a gown during the dressing change. On 2/12/25 at 12:15 p.m., licensed practical nurse (LPN)-A stated staff were to wear PPE during direct patient care for residents that had catheters, tubes and open wounds that required a dressing change, including surgical wounds. LPN-A stated R18 should have been placed in EBP because the wound was open and draining. Further, LPN-A stated all staff should wear a gown and gloves when providing direct patient care or working with or changing a wound dressing. On 2/12/25 at 12:32 p.m., RN-C stated upon R18's admission she was told by the infection preventionist, staff did not need to wear PPE while providing wound care. RN-C stated she worked with multiple residents during the day and had the potential to carry bacteria on her clothing. RN-C stated wearing PPE would help prevent the spread of bacteria to/from herself and the resident. RN-C stated she had not worn PPE including a gown when she cared for the wound or changed R18's dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Enhanced Barrier Precautions policy dated 11/2024, identified EBP expanded the use of PPE and referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfer of multidrug-resistant organisms (MDRO)'s to staff hands and clothing. MDRO's may be indirectly transferred from resident to resident during high contact care activities. Residents with wounds and indwelling medical devices are at an especially high risk of both acquisition of and colonization with MDRO's. The policy further identified EBP would be implemented for residents with wounds and/or indwelling medical devices during high-contact resident care activities regardless of MDRO infection or colonization. High risk care activities included device care or use, and wound care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, and interview, the facility failed to have a system in place to ensure water temperatures were maintained a comfortable temperature for 2 of 13 residents (R22 ,R45) who resided on Maple Lane unit reviewed for complaints of cold-water temperatures. This had the potential to affect all 13 residents residing who resided on Maple Lane unit. Findings include: R22's annual Minimum Data Set (MDS) dated [DATE], identified R22 had severe cognitive impairment and was dependent on staff for bathing, dressing and grooming. R45's quarterly MDS dated [DATE], identified R45 had moderate cognitive impairment and was independent with dressing and grooming and required supervision with bathing. During interview on 2/10/25, at 1:45 p.m. family member (FM)-H stated R22 did not have hot water in his room. Staff had to take R22 to another wing in the facility for his showers as there wasn't any hot water on the wing R22 resided. FM-H felt it was terrible the residents had to wash up in cold water and were carted down two halls half naked for their showers. During interview on 2/10/25, at 6:23 p.m. R45 stated the water never got hot in their sink. It was always lukewarm at best. They washed up the best they could and had to take their showers on the other wing. On 2/11/25, at 8:14 a.m. licensed practical nurse (LPN)-B was observed running water at the end of the resident hallway in the facility's sunshine conference room. LPN-B stated running the water in the sink helped to get hot water going to the resident rooms in the wing. At 9:15 a.m. the continuously running water in the sink remained a cool tepid temperature to the touch. During interview on 2/11/25, at 3:48 p.m. maintenance director (M)-A stated the facility installed a new hot water heater in November 2024 alongside the exiting water heaters, and he thought that had corrected the problem until now. M-A had only just learned of the lack of hot water on the Maple Lane unit the day prior and had called a local heating and plumbing to come out, however, they would not be able to come until the following week. M-A had done a few water temperatures that day and had ranged 93 to 98 degrees, so the temperatures were a little under what they should be. M-A stated hot water temperatures should be at maximum temperature of 115 degrees. M-A did not have a consistent process for monitoring the water temperatures. On 2/11/25, at 5:09 p.m. LPN-B stated she reported the cold-water issues to maintenance a few times over the past couple of months. Staff filled out their requests to maintenance in the maintenance logbook on each wing. The maintenance staff would pick up the forms and she did not know what happened to them after that. There were no copies made of the requests. The current maintenance book for the wing was reviewed and had several blank maintenance requests forms, however, no current requests were documented. The maintenance book failed to identify staff requests for hot water on Maple Lane. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/25, at 8:32 a.m. M-A was observed testing the water temperature at the end of resident's hall Maple Lane. The hot water had been running five minutes prior to test. The temperature of the running hot water at the sink registered 89.7 degrees. M-A stated he only did hot water tests when he had complaints about the hot water, and he had only gotten complaints two days prior. M-A stated he thought the aides had been bringing residents from Maple Lane to another resident wing to take their showers as the showers on Maple Lane did not work. Hot water issues had been coming up from time to time. MD-A thought the old plumbing was causing the issues and so the facility kept getting sporadic cold water that showed up for a day or so. During interview on 2/12/25, at 12:00 p.m. the director of nursing (DON) stated the facility had ongoing hot water issues on the south wing and were doing their best to correct the problem. DON thought it was something to do with the piping and would possibly requiring tearing into some walls to fix the plumbing. A joint interview was conducted with administrator, owner and registered nurse (RN)-A on 2/12/25 at 1:56 p.m., the administrator stated there were ongoing concerns with the water temperature that were discussed during the quality assurance and performance improvement (QAPI) meeting. A new water heater had been installed but that had not resolved the issue. They called in the previous facility director who had also given them some direction on what to try to resolve the issue. Also, the administrator had started a new process for maintenance requests because it had become apparent staff were making verbal requests that could not be verified. A binder was placed on each unit for maintenance requests. That way, the administrator was able to audit those requests and ensure they were followed up on. A policy on water temperature management was not received.