DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 1, 2026

Administrator
Havenwood Care Center
1633 DELTON AVENUE NW
BEMIDJI, MN 56601

RE: CCN: 245397
Cycle Start Date: April 29, 2026

Dear Administrator:

On April 29, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 4/27/26 through 4/29/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		06/12/2026
F0000	INITIAL COMMENTS On 4/17/26 through 4/29/26, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H53971679C (2698495), H53971680C (2664268), H53971678C (2990355) H53977660C (2792289) The complaint H53971681C (2562021) was reviewed with citations issued at F677 ad F725 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		06/12/2026
F0688 SS = E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F0688	Failing to provide consistent programming to maintain functional mobility and preventing mobility losses is essential to quality of life and promoting independence at a resident’s highest practicable level.	06/12/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0688 SS = E	Continued from page 1 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: R20 R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, weakness and history of hand and hip fractures. R20's care plan reviewed 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP). R20's undated Physician Orders identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also	F0688	Continued from page 1 R20, R53, R40, R14, R66 and R32 have all had their current FMP's reviewed. R20 is no longer appropriate for participation in FMP d/t declining condition and admission to hospice. R53 has refused participation in FMP despite education and explanation of benefits. R40 has been assessed as being able to complete active exercise in a group setting and will be encouraged to participate in group exercise. R14 is no longer appropriate for current FMP d/t cognition and will have AAROM completed by nursing staff 1-2 times per week as he allows. R66 is no longer appropriate for current FMP d/t declining condition and admission to hospice. R32's FMP is no longer safe, resident is unable to ambulate and requires use of a patient assist lift for transfers. R32 will have care plan updated to include AAROM 1-2 times per week d/t cognition and vision limitations. Care plans for all 6 residents listed above will be updated by 6/5/26. The medical records of all residents were reviewed by a team of facility staff. This review identified 37 residents who had been evaluated by therapy with FMP's being written in the past. A further review of 62 residents identified 27 residents who need AA/PROM that require the exercises to be completed by staff. These 27 residents will be reviewed by 6/5/26 by the interdisciplinary team to evaluate the appropriateness of ongoing programing to include acceptance from resident, personal preference, tolerance, etc. The residents identified as having an ongoing need will have AAROM/PROM completed by nursing staff at least 1-2 times per week. 40 residents have the capacity to actively participate in the exercise program that will be offered by activities 4-5 times per week beginning on 6/8/26. 8 residents were assessed as being appropriate for both exercise programing and AAROM/PROM. Residents can have the choice to participate in the exercise video and/or staff lead exercise group. Content for the exercise program will be overseen by activity director and/or assistant administrator. The facility policy for Quality of Care notes the facility will ensure that a resident who enters the facility without limited range of motion or mobility difficulties does not experience reduction in range of motion or mobility unless the resident's clinical condition demonstrates that a reduction in range of	06/12/2026

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F0688 SS = E	Continued from page 2 listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. On 4/29/26, at 3:23 p.m. physical therapist (PT)-A and therapy director (TD) assisted R20 to complete the full OT and PT FMP program exercises in the therapy room. R20 became visibly weak, shaky toward the end of the exercises. PT-A and TD both stated R20 had no decline since P20 was last seen by therapy. R53 R53's quarterly MDS dated 3/20/26, identified R53 had intact cognition and was dependent on staff for most ADLs, mobility and transfers. R53 had impaired range of motion (ROM) to both lower extremities and	F0688	Continued from page 2 motion or mobility is unavoidable. A resident with limited range of motion or mobility will receive appropriate treatment and services to increase range of motion and mobility and/or to prevent further decrease in range of motion or mobility. The policy was updated to include that this may be accomplished via services provided by therapy staff, nursing staff or both and may include formal therapy programs, AAROM/PROM, and scheduled exercise groups Education will be provided to all nursing, activity and therapy staff on the facility policy for Quality of Care and expectations for completion of AAROM/ROM and exercise classes by 6/8/26. Education will be provided to all nursing staff on completion of PROM and AAROM. Education will include an explanation of benefits of PROM/AAROM and competency of performing PROM/AAROM for dependent residents by 6/5/26. Additionally, education will include importance of facilitating attendance and encouraging all residents who are able to attend and participate in group exercise classes offered at the facility. Participation at exercise group will be tracked on the activity acceptance checklist for each resident participating. Participation will be reported monthly in QAPI for the next 3 months. Audits for AAROM/PROM program and exercise group participation/documentation will be completed by Director of Nursing or designee at a rate of 3x/wk for 2 weeks, 2x/wk for 2 weeks and 1x/wk for 2 weeks and as needed afterwards and will begin on 6/10/26. Audits will be completed via chart review to ensure completed and/or offered per care plan along with appropriate documentation. Results of audits will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

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F0688 SS = E	Continued from page 3 was unable to ambulate. Diagnoses included paraplegia (paralysis lower half of body), spondylosis (degenerative spinal condition) and chronic pain. R53's care plan revised 3/16/26, identified R53 had decreased physical mobility with potentials for falls due to low back pain with bilateral sciatica, spinal stenosis, weakness and limited functional ROM. Staff were directed to assist R53 with mobility, transfers and repositioning. R53 was to participate in FMP per her plan of care. R53's undated Physician Orders report identified an order for FMP dated 9/4/25, with an open-ended end date. R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. On 4/29/26, at 4:02 p.m. R53 was seated in her room watching television. TD entered the room and received permission to assist R53 with her exercises. TD completed all exercises from the PT and OT FMP program. R53 was smiling and cooperative throughout the exercises. After completion of the exercises, TD stated she did not find a decline in R53's function since she was last seen by therapy. R53 stated she was unsure how often staff assisted	F0688		06/12/2026

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F0688 SS = E	Continued from page 4 her with her exercises or when they were last done. R53 stated she wished it were more often. R40 R40's quarterly MDS dated 2/4/26, identified R40 had moderately impaired cognition and was independent with ADLs. R40 had full ROM of extremities and was able to ambulate independently. Diagnoses included dementia, traumatic subdural hemorrhage, repeated falls, dizziness and giddiness, disorder of the autonomic nervous system, and osteoarthritis of the knees. R40's undated Physician Orders report identified an order for PT and OT FMP one time per day with start date 12/5/25 and open-ended end date. R40's care plan revised 3/16/26, identified decreased physical mobility with potential for falls due to dementia, poor coordination and balance, history of falls, and poor sequencings skills. Staff were directed to provide limited assistance with transfer and ambulation and OT and PT FMP per plan of care. R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights.	F0688		06/12/2026

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F0688 SS = E	Continued from page 5 The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was non-ambulatory. A diagnosis of dementia was included. R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's care plan revised 3/16/26, identified falls and alteration in skin related to poor coordination/balance, pain, dementia with cognitive losses and poor sequencing skills manifested by inability to transfer, always wheel self, always turn and reposition self, sit up, lie down or get feet and legs into bed independently. Unable to ambulate. Occupational therapy (OT) and physical therapy (PT) functional maintenance program as ordered. R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R14 frequently refused to do restorative exercises, however, the documentation did not reflect R14 had refused or had been offered. R66 R66's MDS dated 3/3/26, identified R66 was cognitively intact and required substantial/maximal assistance with upper body dressing and personal hygiene, partial/moderate assistance with eating,	F0688		06/12/2026

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F0688 SS = E	Continued from page 6 and was dependent on staff for all other care areas. Diagnoses included dementia, anxiety and diabetes. R66's care plan revised 3/16/26, identified decreased physical mobility with potential for falls and alterations in skin r/t Diabetes, Dementia, Alzheimer's disease, Heart failure, poor balance at times and poor sequencing skills manifested by need for staff assist with mobility needs at times. R66 was to participate in a functional maintenance program as ordered by therapy. R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R66 frequently refused to do restorative exercises, however, the documentation did not reflect R66 had refused or had been offered. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assist with bed mobility and transfers and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's medical record contained the following information on the restorative program: R32's provider orders dated 11/19/25, identified Functional Maintenance Plan (FMP) was ordered with special instruction for walking program as part of FMP. R32's progress noted dated 11/19/25, identified R32 was discharged from PT services on 11/7/25. PT	F0688		06/12/2026

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F0688 SS = E	Continued from page 7 FMP in place with walking program apart of her FMP. Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H stated they were only able to provide FMP services to R32 twice and that did not include ambulation services. The nursing assistants on the floor would be responsible for ambulation. During an interview on 4/29/26 at 9:49 a.m., TD stated the restorative aide would provide the exercise services and nursing and NAs provided ambulation services on the floor. R32's program for the exercises #1-6 (above) would be completed by the restorative aide and #7 would be completed by NAs on the floor. During an interview on 4/29/26 at 10:39 a.m., a trained medication aide (TMA)-C stated there was a list of residents who required ambulation and would be updated regularly by the nurse manager. If there were concerns on ability of the resident to continue walking, then we would let the nurse manager know	F0688		06/12/2026

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F0688 SS = E	Continued from page 8 and she would have ordered a screening from therapy to see if changes needed to be made with the program. I think there was a screening done for R32 that stated she was not to ambulate. During a follow up interview on 4/29/26 at 10:47 a.m., the TD stated when a request came in it would be charted and documented in their system. R36 had never received a request to rescreen her regarding ambulation. This was also verified by the physical therapist (PT)-A. During interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:07 p.m., the director of nursing (DON) stated when residents were started on an FMP the restorative aide would work on the range of motion aspect of the plan and the NA's on the unit would do the ambulation portion of the plan. R36 should have received the ordered FMP to maintain their level of function related to activities of daily living. During interview on 4/29/26, at 4:30 p.m. TD stated therapy completed the functional maintenance program form to initiate restorative nursing exercises when they discharged a resident from therapy. Therapy did not oversee the program. If a resident was not being seen or refusing restorative services, they would report to the charge nurse, and the charge nurse would notify therapy, if they needed to be re-evaluated. TD thought nursing oversaw the restorative program. When interviewed on 4/29/26, at 5:36 p.m. the interim DON stated she did not know if the previous restorative aide had documented her work correctly, but the facility did pull the restorative aide from time to time to work on the floor assisting with resident care. The facility had two restorative aides who each worked two days per week, and one worked every	F0688		06/12/2026

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F0688 SS = E	Continued from page 9 other weekend and the other, one weekend a month, for resident restorative program. The facility policy Quality of Care reviewed 10/2023, identified the facility would ensure a resident with limited range of motion or mobility would receive appropriate treatment and services to increase range of motion and mobility and/or prevent further decrease in range of motion or mobility. The facility policy Restorative Care dated 7/19/21, identified it was the intent of the restorative program to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The resident would be assessed by physical therapy and recommendations for restorative care therapy were submitted on the restorative therapy form. A nursing assistant trained to perform restorative care therapy would complete 15 minutes daily with the resident. Time would be documented by the therapy aide. The restorative care lead nurse would maintain documentation of residents who received restorative care and would make progress notes on therapy, minutes of therapy provided and plan review.	F0688		06/12/2026
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F0725	Failure to have sufficient staffing to carry out care planned interventions has the potential to affect all residents residing at the facility. R20, R53, R40, R14, R66 and R32 will have had their maintenance therapy programs reviewed, and revised if indicated by 6/5/26. An internal review of facility needs was completed by key leadership staff on 5/22/26 and included a review of staffing levels. The facility staffing structure was changed to no longer include specific daily rehab aid services. ROM programs will be conducted by staff CNA's under the direction of charge nurses and included as part of daily cares for residents who are assessed as having a need. This service will be conducted 1-2/week and on either day or evening shift as scheduled by the overseeing RN. The facility policy for Quality of Care notes the facility will ensure that a resident who enters the facility without limited range of motion or mobility difficulties does not experience reduction in range of motion or mobility unless the resident's clinical condition demonstrates that a reduction in range of motion or mobility is unavoidable. A resident with limited range of motion or mobility will receive appropriate treatment and services to increase range of motion and mobility and/or to	06/12/2026

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F0725 SS = E	Continued from page 10 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and document review, the facility failed to provide sufficient staffing to provide exercise services for the restorative nursing program for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: See also F688: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. R20: R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle	F0725	Continued from page 10 prevent further decrease in range of motion or mobility. The policy was updated to include that this may be accomplished via services provided by therapy staff, nursing staff or both and may include formal therapy programs, AAROM/PROM, and scheduled exercise groups Education will be provided to all nursing, activity and therapy staff on the facility policy for Quality of Care and expectations for completion of AAROM/ROM and exercise classes by 6/5/26. Education will be provided to all nursing staff on completion of PROM and AAROM. Education will include an explanation of benefits of PROM/AAROM and competency of performing PROM/AAROM for dependent residents. Additionally, education will include importance of facilitating attendance and encouraging all residents who are able to attend and participate in group exercise classes offered at the facility. Audits for AAROM/PROM program and exercise group participation/documentation will be completed by Director of Nursing or designee at a rate of 3x/wk for 2 weeks, 2x/wk for 2 weeks and 1x/wk for 2 weeks and as needed afterwards and will begin on 6/10/26. Audits will be completed via chart review to ensure completed and/or offered per care plan along with appropriate documentation. Results of audits will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

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F0725 SS = E	Continued from page 11 weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. R53: R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. R40 R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions	F0725		06/12/2026

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F0725 SS = E	Continued from page 12 using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. R66 R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with	F0725		06/12/2026

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F0725 SS = E	Continued from page 13 movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed. R32: R32's Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed. The restorative program documentation was reviewed and identified the following: 1/19/26-1/25/16, 6 of 39 residents received services. 1/26/26-2/1/26, 0 of 38 residents received services. 2/2/26-2/8/26, 25 of 39 residents received services. 2/9/26-2/15/26, 9 of 40 residents received services. 2/16/26-2/22/26, 28 of 38 residents received services. 2/23/26-3/1/26, 6 of 39 residents received services.	F0725		06/12/2026

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F0725 SS = E	Continued from page 14 3/2/26-3/8/26, 2 of 38 residents received services. 3/9/36-3/15/26, 0 of 38 residents received services. 3/16/26-3/22/26, 0 of 37 residents received services. 3/23/26-3/29/26, 1 of 37 residents received services. 3/30/26-4/5/26, 3 of 40 residents received services. 4/6/26-4/12/26, 0 of 40 residents received services. 4/13/26-4/19/26, 27 of 40 residents received services. 4/20/26-4/26/26, 26 of 41 residents received services. 4/27/26-5/3/26, 30 of 38 residents received services. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H, who was a restorative aide, stated initially she was going to be just doing functional maintenance programs for the residents today (4/28/26) but was only able to work until about noon. She was then instructed to stop working on the FMP's and was pulled to the floor to work as a NA. NA-H stated being pulled to the floor happened a lot. There was another NA who would help with FMPs, but they also called to work as an NA on the floor. When NA-H is working as the restorative aide she reviewed the lists of residents and decide which ones could be done on that day. NA-H can't get through the list and there are residents who do not get the FMP services. Most of the residents on an FMP had not received services on a regular basis or not even at all. Most of the residents were not receiving their ordered FMP due to having to be pulled to the floor all the time and only working a couple of days a week. During a follow up interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had	F0725		06/12/2026

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F0725 SS = E	Continued from page 15 been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:04 p.m. the director of nursing (DON) stated there are two aides who worked the restorative nursing program and they are both part time. For about 6 months the facility only had one part-time restorative aide. The restorative aides would start with the FMPs right away when they get to the facility, but they are frequently called out to floor to work as a NA. This is because of call-ins or short staffing on the floor. She stated it was not acceptable to be pulling the restorative aides to the floor all the time, because they have close to fifty residents to assist and are unable to get to all of them in a week and the residents go without their FMP. A staffing policy was not obtained.	F0725		06/12/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure staff served meals	F0812	Failure to serve food on Walnut Grove in a manner that maintains sanitary and safe consumption has the potential to affect all residents residing on that unit. On 4/28/26, DA-A placed a hairnet when it was identified that it was missing immediately rectifying the noncompliance. A review of resident complaints indicate no concerns with food being served in a sanitary manner. The facility policy for Employee Sanitary Practices was reviewed on 5/19/26 and is up to date with current expectations and best practices. Education will be provided to all dietary staff by 6/1/26 with a review of the policy and expectations for compliance with hairnet use when serving food and/or in areas where food is prepared. Education will be completed verbally and/or in writing with signature indicating receipt of education and understanding. Audits for hairnet use will begin on 6/1/26 and will include direct observation of food service and/or prep to ensure proper hairnet use. Audits will be conducted by the Dietary Manager or designee across both day and PM shift at a rate of 20/week for 2 weeks, 10/week for 2 weeks and 5/week for 2 weeks. Results of audits will be brought to QAPI for review and determination of ongoing auditing needs.	06/12/2026

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F0812 SS = E	Continued from page 16 while securing their hair with a hair covering on1 of 2 units Walnut Unit) . This had the potential to affect all 23 residents who ate meals on the Walnut Unit. Findings include: According to section 2-402.11 of the Food and Drug Administration (FDA) Food code dated 2017: “A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair." This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps. During an observation on 4/28/26 at 12:06 p.m., dietary aide (DA)-A was serving meals from the Walnut Grove kitchenette. DA-A leaned over the steam table food containers while setting up the individual resident plates for the noon meal. DA-A was not wearing a hairnet. At 12:15 p.m., DA-A left the kitchenette to deliver food to a resident and then began to clean off tables where residents had finished. During an interview on 4/28/26 at 12:20 p.m., DA-A stated hairnets were required whenever in the kitchen and/or while serving food. DA-A touched her head and stated “I don’t have one on? Oh no, I thought I had one on.” DA-A left the Walnut Grove kitchenette and went into the main kitchen. When DA-A returned a moment later, DA-A was wearing a hair net. During an interview on 4/29/26 at 3:17 p.m., the dietary manager (DM)-A stated staff should always wear a hairnet, especially while serving food to ensure hair does not get into the food to prevent illness and for palatability. The facility policy Employee Sanitary Practices dated 2019, identified all food and nutrition services employees will practice good personal hygiene and safe food handling procedures. All employees will: wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food	F0812		06/12/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F0585	Failure to follow the facility procedure for missing items has the potential to affect all residents residing at the facility. On 4/19/26 R14’s missing item was located and returned to the resident. To identify other missing items for which the facility	06/12/2026

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F0585 SS = D	Continued from page 17 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal	F0585	Continued from page 17 policy was not followed, an interview of all current residents and/or representatives will be conducted by the social worker or designee between the dates of 5/25/26 and 5/29/26. Reports of missing items in the last 3 months not having a corresponding missing item report will have proper documentation and follow up completed. The facility Missing Items Report was reviewed and was not revised. Education for all staff will occur by 6/5/26 with an explanation of expectations for follow up on reports of missing items. This includes completion of a missing item form, determination of potential theft and actions to take if theft is suspected or reported, and notification to the social worker for additional follow up. Audits for compliance will be completed by the social worker or designee starting 6/10/26. Audits will be conducted via chart review for notes on missing items and random interviews with staff and residents to assess for proper procedure being followed including filling out a form. Missing item forms identified in audits will be completed by social worker or designee and follow up per facility policy will begin immediately. Ongoing education will be completed if/when it is noted the facility policy was not followed. Progress note review and random interviews with residents and staff will be completed at a rate of 5x/week for a period of 2 weeks, 3x/week for a period of 2 weeks, and weekly for a period of 2 weeks. Results of audits will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

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F0585 SS = D	Continued from page 18 agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a report of missing personal property was followed up on for 1 of 3 residents (R14) reviewed for resident rights. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment. Diagnoses included dementia, edema, restlessness and agitation. R14 required set up/clean up assistance with eating, maximal/substantial assistance with dressing, bathing and personal hygiene and was dependent on staff with toileting and putting on and taking off	F0585		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

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F0585 SS = D	Continued from page 19 footwear. During an interview on 4/28/26 at 6:09 p.m., family member (FM)-A stated R14's wedding ring went missing a "few months" ago. FM-A reported the missing wedding ring to the nursing assistants, the cart nurses, registered nurse (RN)-A who was the unit manager and the previous director of nursing (DON) who was no longer at the facility. FM-A stated she was simply told no staff had seen the ring. After the wedding ring was missing for a week, FM-A reported the missing ring to the police. FM-A had received no further information about the missing ring. FM-A stated she was concerned a staff member had taken the ring and the facility was not investigating the concern. During an interview on 4/29/26 at 3:22 p.m., trained medication aide (TMA)-B stated she had heard "something" about R14 was missing a wedding ring a "few months" prior but really didn't recall anything else about it. During an interview on 4/29/26 at 3:22 p.m., RN-A stated she didn't recall anyone reporting R14 had a missing wedding ring. During an interview on 4/29/26 at 3:25 p.m., RN-C stated she was unaware of R14's missing wedding ring. Any missing item should be documented in a progress note, and it should be documented on the report sheet in the binder at the desk. The report sheet was kept in the binder for two weeks and then the report sheets were filed away by the director of nursing (DON). Then, an investigation would be done to try to find the missing item: laundry, housekeeping and nursing staff would be told to look for the item and be aware that it was missing. R14's medical record failed to identify R14 was missing a wedding ring. R14's Missing Item form was requested but not received. During an interview on 4/29/26 at 3:27 p.m., the social services (SS)-A stated she was unaware R14 was missing a wedding ring and there was no missing item report completed. During an interview on 4/29/26 at 3:28 p.m., licensed practical nurse (LPN)-A stated she didn't know anything about R14 missing a wedding ring. When a resident was admitted, staff really encouraged family to swap out any expensive or meaningful jewelry like a wedding for another ring,	F0585		06/12/2026

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F0585 SS = D	Continued from page 20 so the resident was still able to wear a ring but the likelihood of getting lost was not there. Staff report to social services and then an investigation was done to look in the room etc. During an interview on 4/29/26 at 3:31 p.m., the DON stated she was unaware R14 was missing a wedding ring. Staff were expected to complete a missing item report and, if possible, the resident was interviewed to determine when the item was last seen. Laundry, housekeeping, activities and nursing staff were informed to look for the item, and, on certain items, a police report may be filed. The DON stated she honestly did not know if a report had been filed for R14's missing ring because she was unaware it was missing. At 5:25 p.m., the DON stated R14's wedding ring had been found. It was found in laundry back in December 2025 and kept in the safe until 4/29/26 when the SA began asking about it. Staff did not complete a missing item report. The DON stated she expected staff to follow the procedure for a missing item and to report the concern to ensure all were aware of the missing item. If staff had been aware of R14's missing wedding ring, they would have known who the found wedding ring belonged to and R14 would have gotten it back sooner. The facility. The facility Missing Items Report revised 11/18/18, included information for staff to collect and identified the following: the resident's name, date, description of item(s) missing, date/time last seen, date/time noticed missing, thinks misplaced details, thinks taken and, if so, by whom, who it was reported to and who reported the missing item(s). Staff were instructed to complete the form immediately and give the report to the unit manager. The unit manager would search probably places immediately and list the employee(s) assigned to search. If the item was not found, family would be contacted. If the family was unaware of the item(s) location, the item was to be treated as a misappropriated item and reported to law enforcement and the state agency (SA).	F0585		06/12/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	Failure to timely update care plans with relevant goals and interventions has the potential to affect all residents residing at the facility. All care plans for those receiving EBP and ROM or exercise services, including R20 and R32 will be reviewed, and, if needed, updated to include resident specific interventions and goals by 6/5/26. On 5/19/26 a policy was developed specific to care plan revision to include updates to the care plan	06/12/2026

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F0657 SS = D	Continued from page 21 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include ordered functional maintenance program (FMP) with goals and interventions for 2 of 6 residents (R20, R32) who received exercises, in addition, the facility include enhanced barrier precautions (EBP) including measurable goals and interventions for 1 of 6 residents (R66) whose care plans were reviewed for EBP. Findings include: R20: R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, anxiety, weakness and history of hand and hip fractures. R20's undated Physician Orders report identified an order for physical therapy FMP with a start date	F0657	Continued from page 21 with changes in services being provided and safety needs. Education on the new policy will be provided to all nursing staff by 6/5/26 and will include policy review and include an emphasis on expectations for care plan updates with changes in services and/or EBP. Director of Nursing or designee will audit for timely care plan updates for changes services being provided and EBP needs 5x/week for a period of 6 weeks beginning on 6/10/26. Failure to update care plans with relevant changes will result in re-education to nurse responsible. Following initial 6 weeks of audits, results will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

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F0657 SS = D	Continued from page 22 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. R20's care plan dated 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP), with goals and staff interventions. During interview on 4/29/26, at 5:36 p.m. the director of nursing (DON) stated if a resident was being seen by the restorative aide for the FMP, that should be addressed in their plan of care. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assistance with bed mobility and transfers	F0657		06/12/2026

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F0657 SS = D	Continued from page 23 and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's undated Physicians Orders report identified an order for a FMP with walking as part of the FMP with a start dated of 11/19/25, with no end date identified. R32's Restorative Care Program dated 11/7/25, identified R32 was discharged from PT and was to start a FMP to maintain lower extremity strength and range of motion to decrease the burden of care with transfers and ambulation. The FMP identified the resident was to do each exercise 15 times. The exercises included: Seated chair march Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out) Hip adduction with a ball. (squeezing your knees together with a ball between them) Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it) Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart) Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's care plan with the last review date of 3/13/26, identified R32 had decreased physical mobility with potential for falls due to recent left knee replacement. Staff were directed to assist R32 to turn and reposition, pivot transfer and to assist with	F0657		06/12/2026

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F0657 SS = D	Continued from page 24 sit up and lay down in bed and get leg and feet in and out of bed. R32's care plan lacked any documentation related to a FMP with goals and interventions. During an interview on 4/29/26, registered nurse (RN)-B stated when a resident was started on an FMP the care plan for the resident should be updated. R32's care plan lacked any documentation of an FMP. During an interview on 4/29/26 at 4:07 p.m., the DON stated the FMP for a resident was ordered by PT and should be placed on the resident's care plan. R32's FMP lacked any documentation related to an FMP or ambulation. R66: R66's quarterly MDS dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastrostomy tube (g-Tube), tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should wear with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C stated R66 was at risk for infection because of her g-tube and staff wore PPE including a gown and gloves during direct patient cares. During interview on 4/29/26 at 5:26 p.m., DON stated staff were instructed to wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility policy Quality of Care dated 10/2023, identified the facility would strive to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. A policy for resident care plan was not received.	F0657		06/12/2026

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F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely cares to dependent residents for 2 of 7 residents (R14, R18) who's activities of daily living cares were observed. Findings include: R14: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was dependent on staff for toileting. R14 diagnoses included dementia, edema, restlessness and agitation. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 8/21/25, identified the CAA was triggered due to R14's needing extensive assistance with toileting and frequent incontinence of urine. Staff offer to assist R14 to the restroom or to use his urinal every 2-3 hours and as needed. R14 was at risk for alterations in skin, offensive body odor, falls and bladder infections. Complicated by history of falls, dementia, R14's care plan revised 4/29/26, identified R14 had an alteration in elimination related to dementia with cognitive losses, receiving diuretic, poor sequencing skills, history of retention of urine and constipation manifested by need for staff assistance with toileting, R14 was incontinent of bladder and bowel. Staff will check brief for incontinence q 2-3 hours and as needed, change brief as needed with incontinence. Provide total assistance of 1 staff to change brief. May require 2 staff to change brief at times. Provide total assistance of 1-2 staff to pull up/down pants and provide peri rectal care after elimination. A continuous observation of R14 was completed on 4/29/26 starting at 8:04 a.m., through 11:10 a.m. At 8:04 a.m. R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was	F0677	Failure to provide ADLs for residents who are unable to do so themselves places all residents with impaired ADL abilities at risk for unmet needs. R14 was provided incontinence cares on 4/29/26 at around 1100. R18 was assisted with shaving on 4/29/26. An audit was completed to identify all residents with assistance with toileting and shaving tasks identifying 45 residents requiring toileting assistance and 20 residents requiring shaving assistance. Care plans of those residents identified as having ADL assistance needs will be reviewed by 6/5/26 to ensure inclusion of those needs. The policy for Quality of Care was reviewed on 5/20/26 and is up to date with no changes being made. Procedural changes for direct care staff include expectations to document last toileting on rounding sheets kept at nurses station. Education for nursing staff will be completed by 6/5/26 and include explanation for expectations of toileting and ADL assistance, benefits to the resident and importance of adhering to care planned interventions. Audits for compliance with toileting schedules and shaving will be conducted by the Director of Nursing or designee at a rate of 21/week for 2 weeks, 14/week for 2 weeks and 7/week for 2 weeks beginning on 6/10/26. Noncompliance with toileting schedules or shaving will be corrected in the moment by competing the task and re-education by auditor. Results of audits will be brought to QAPI for review and determination of ongoing auditing needs.	06/12/2026

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F0677 SS = D	Continued from page 26 dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. [It was unknown what time R14 was placed in the wheelchair] At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat. At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered toileting. At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on.	F0677		06/12/2026

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F0677 SS = D	Continued from page 27 At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually toileted R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while. R14 was not offered nor placed on the commode to attempt to void. At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously toileted that morning and would have to ask the nursing assistants. RN-C stated R14 was due to a bowel movement that morning and had received a laxative. When the laxative "kicked in", staff would place R14 on the commode. However, when R14 was already incontinent staff laid him down and provided incontinence care. R14 was not placed on the commode every time he was toileted because staff did not want to cause R14 agitation. At 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last toileted. TMA-B stated she was told R14 had been assisted with morning cares by the night shift staff and had toileted before	F0677		06/12/2026

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F0677 SS = D	Continued from page 28 day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's toileting so staff really had "no idea". R14 should have been toileted at 9:00 a.m. at the latest because R14 was care planned to be toileted every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of toileting times differently. TMA-B used her care sheet and wrote down the times and whether the resident was incontinent or had voided. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last toileting time and staff just kept a mental note when they resident was due again. Yea, some staff did write it down on the care sheet but "to each his own I guess". NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated toileting times were given during shift report. For R14, staff should offer toileting every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been toileted that morning. R14 had been incontinent around midnight the night before and R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done, she did it as observed. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be toileted between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be toileted every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation on how staff tracked toileting times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged toileting times which could lead to prolonged exposure to moisture and skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been toileted before 9:00 a.m. or earlier. During an interview on 4/29/26 at 3:31 p.m., the	F0677		06/12/2026

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F0677 SS = D	Continued from page 29 director of nursing (DON) stated R14 should have been toileted immediately after breakfast or within his care planned timeframe to prevent incontinence/skin breakdown and to lessen R14's behaviors/agitation. Additionally, staff should always offer R14 to sit on the commode even when R14 was incontinent as care planned. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. R18: R18's five-day MDS dated 3/3/26, identified R18 had severe cognitive impairment and required maximum to total assistance with activities of daily living (ADLs). Diagnoses included dementia, kidney disease, cerebral infarction (stroke), anxiety and diabetes. R18's care plan dated 3/31/26, identified R18 had a self-care deficit with a goal to remain clean and free of odor daily. Staff were directed to comb R18's hair, brush his teeth and shave him. R18's Resident Care Sheet dated 4/22/26, directed staff in bold and capitalized text to shave daily, family request. During observation on 4/27/26, at 11:17 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 had 1/4-inch grey whiskers scattered over his chin, cheeks, neck and below his nose. R18 was unable to recall if he had shaven that day. During observation on 4/28/26, at 10:38 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 continued to have grey whiskers scattered over his face and neck and remained unshaven. During observation on 4/29/26, at 8:59 a.m. R18 was seated in his wheelchair in the hallway. R18's was clean shaven.	F0677		06/12/2026

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F0677 SS = D	Continued from page 30 When interviewed on 4/29/26, at 9:00 a.m. LPN-B stated she was not sure why the aides would not have shaved R18 on 4/27/26, or 4/28/26, but he was shaved today. There were different nursing assistants on then there were the other two days. R18 was supposed to be shaved every day. When interviewed on 4/29/26, at 9:53 a.m. RN-B stated R18 should be shaven daily. RN-B was not sure why R18 was not shaved the other two days. RN-B was aware R18's shaver battery was very low when he was shaved that morning, so perhaps that was the reason, but the goal was to shave him every day. R18 could have refused, however the point of care documentation did not indicate R18 refused care. During interview on 4/29/26, at 9:54 a.m. NA-B stated she was not sure why R18 was not shaved the previous two days, but he was shaven now. R18 was supposed to be shaven every day. Some of the younger NA's just did not notice or didn't know better. R18 never refused assistance with cares and always allowed them to assist hiem to shave daily without any problems. During interview on 4/29/26, at 4:36 p.m. the DON stated she would have expected staff to shave R18 as care planned or document why it could not be completed. The facility Quality of Care Policy reviewed 10/2023, identified based on the comprehensive assessment of a resident the facility strove to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with State and Federal Regulations.	F0677		06/12/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F0686	Failure to provide services that would prevent the development of pressure ulcers and skin breakdown places all residents who are dependent on staff for repositioning at risk. On 4/29/29 at around 1100, R14 was assisted with repositioning. An audit was completed between the dates of 5/21/26 and 5/22/26 to identify all residents who	06/12/2026

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F0686 SS = D	Continued from page 31 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents received timely repositioning for 1 of 3 residents (R14) reviewed for pressure ulcers. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment was dependent on staff for repositioning. Diagnoses included dementia, edema, restlessness and agitation. R14's Braden Scale (prediction for pressure ulcer scale) dated 2/13/26, identified R14 was a moderate risk for pressure injury/ulcer. R14's care plan revised 4/29/26, included an intervention to provide assist of one staff to turn and reposition every 2-3 hours. A continuous observation was conducted on 4/29/26 at starting at 8:04 a.m., R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. It was unknown when R14 was seated in his wheelchair. At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat. At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered repositioning.	F0686	Continued from page 31 are dependent on staff for proper offloading and repositioning to prevent the development of facility acquired pressure ulcers and skin breakdown. This audit identified 45 residents who require assistance with completing this task. Care plans for those residents identified in the audit will be reviewed by 6/5/26 to ensure inclusion of those needs and interventions to be carried out to meet goals of minimizing risk for pressure ulcer/skin breakdown development. The policy for Skin Care Management was reviewed on 5/20/26 and is up to date with no changes being made. Procedural changes for direct care staff include expectations to document last turn/repo on rounding sheets at the nurses station. Education for nursing staff will be completed by 6/5/26 and include explanation for expectations of adherence to turning/repositioning schedules and benefits to the resident. Audits for compliance with turning/repositioning will be conducted by the Director of Nursing or designee at a rate of 21/week for 2 weeks, 14/week for 2 weeks and 7/week for 2 weeks beginning on 6/10/26. Noncompliance with turning/repositioning will be corrected in the moment by completing the task and re-education by auditor. Results of audits will be brought to QAPI for review and determination of ongoing auditing needs.	06/12/2026

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F0686 SS = D	Continued from page 32 At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. Staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. RN-C did not offer to reposition R14. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on. At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually repositioned R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while.	F0686		06/12/2026

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F0686 SS = D	Continued from page 33 At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. R14's skin was pink, dry and intact. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously repositioned that morning and would have to ask the nursing assistants. During an interview on 4/29/26 at 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last repositioned. TMA-B was told R14 was assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's repositioning so staff really had "no idea". R14 should have been repositioned at 9:00 a.m. at the latest because R14 was care planned to be repositioned every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of repositioning times differently. TMA-B used her care sheet and wrote down the times. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last repositioning time and staff just kept a mental note when they resident was due again. Some staff wrote it down, but not everyone. NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated repositioning times were given during shift report. For R14, staff should offer repositioning every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been repositioned that morning. R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be repositioned between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A	F0686		06/12/2026

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F0686 SS = D	Continued from page 34 stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be repositioned every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation of how staff tracked times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged repositioning times which could lead to skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been repositioned before 9:00 a.m. or earlier. That is a large time span and, because it wasn't kept track of, staff don't know. During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been repositioned immediately after breakfast or within his care planned timeframe to prevent skin breakdown and to lessen R14's behaviors/agitation. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. The facility policy Skin Care reviewed 6/2023, identified staff would ensure proper identification of residents at risk for skin breakdown, prevention of development of pressure ulcers, and determining appropriate treatment of pressure ulcers and/or impaired skin for residents. Care plans will be individualized to address resident specific needs.	F0686		06/12/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F0755	Failure to clarify medication orders has the potential to affect residents receiving orders with unclear instructions. On 4/28/26, the stop date for R12's enoxaparin was clarified by facility RN with PCP via phone and verified entered stop date was correct. An audit of all enoxaparin orders going back 45 days was completed between the dates of 5/22/26 to ensure all orders had correctly entered stop dates with no other similar instances being identified. The policy for Pharmacy Services was reviewed on 5/20/26 with no changes being made. All licensed nurses will be re-educated on expectations for clarification on orders with unclear directions or stop dates. Education will be completed by 6/5/26. Audits will be conducted beginning 6/10/26 at a rate of 5x/week by the Director of Nursing or designee for 6 weeks and will be completed via	06/12/2026

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F0755 SS = D	Continued from page 35 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a stop date for medication was confirmed by the primary care provider for temporary medications that required an end date for 1 of 6 residents (R12) reviewed for medication management. Findings include:R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition. R12 received injectable medication for all seven days of the observation period and received anticoagulant medication. A complete drug regimen review was completed, and no potentially clinically significant medication issues were noted. Diagnoses included diabetes, fracture of the right femur, altered mental status, calculus of the kidney, hydronephrosis and metabolic encephalopathy. R12's Interagency Transfer Orders dated 4/15/26, identified an order for enoxaparin (a blood thinner) 40 milligram (mg) syringe, inject 0.4 millimeters (ml) under the skin every night to prevent deep vein thrombosis for diagnosis of total right hip arthroplasty. The quantity listed 13.6 ml with no refills. R12's Medication Administration Record (MAR) for April 2026, identified enoxaparin syringe 40 mg/0.4 ml: subcutaneous (SQ) at bedtime for fracture of right femur. Start/End date 4/15/26 to 5/18/26. Special Instructions were listed as RX for 13.6 ml/ 0.4 ml per dose=34 doses total. The medication was recorded as administered as ordered starting 4/15/26. When interviewed on 4/28/26, at 4:13 p.m. licensed practical nurse (LPN)-C stated the pharmacy had	F0755	Continued from page 35 chart review for new enoxaparin orders to ensure stop dates were obtained on the original order and/or communication to clarify occurred. Any missed opportunity for clarification will be noted by DON and re-education will occur verbally. Results of audits will be reviewed in QAPI to determine ongoing auditing needs.	06/12/2026

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F0755 SS = D	Continued from page 36 filled the enoxaparin in 40 mg / 0.4 ml prefilled single use syringes. Nursing staff administered the one prefilled syringe every evening. LPN-A was unsure what the special instructions on P12's MAR meant. During interview on 4/28/26, at 4:36 p.m. registered nurse (RN)-B stated the special instructions were to demonstrate how the end date of the medication was determined. The medication was filled for 13.6 ml quantity with no refills, so she did the math, versus contacting the medical provider, to determine 34 doses were ordered and figured out the end date from there. RN-B stated she had not contacted R12's primary care provider to verify the stop date of the medication and no verbal order had been obtained to stop the medication. During telephone interview on 4/29/26, at 9:06 a.m. the consulting pharmacist (CP)-D stated if a medication required an end date, either the pharmacist would call the provider to obtain it or nursing would do it. The quantity of medication with no refills could mean that the med should be stopped when ran out of medication, but not always. CP-D thought she would probably just check with the provider to make sure. It was better to double check with the provider rather than just assume. When interviewed on 4/29/26, at 4:27 p.m. the director of nursing (DON) stated usually medication orders such as enoxaparin had a stop date, especially when discharging from the hospital. She would expect staff to reach out to the provider to notify of the need for an end date to the enoxaparin and verification the dose was completed when the medication was gone. No refills on a medication did not always mean to discontinue the medication and needed to be verified by the primary care provider. The facility policy Pharmacy Services dated 10/2022, identified prescription medications were dispensed only upon receipt of clear, complete, and signed orders of a person lawfully authorized to prescribe. Any dose or order that appeared inappropriate, considering the resident's age, allergies, diagnosis or current medication regimen would be verified with the prescriber.	F0755		06/12/2026
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides-	F0805	Failure to provide food in forms that meet the residents needs places residents who reside at the facility at risk for poor nutritional intake and/or other complications in relation to food consumption. On 5/8/26 R12 was assessed by ST and diet was changed to regular textures/consistency with thin liquids. Order was updated in medical record to	06/12/2026

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F0805 SS = D	Continued from page 37 §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was prepared and served to meet resident needs for 1 of 2 residents (R12) reviewed for nutrition. Findings include: R12's Speech Therapy Daily Note dated 3/16/25, recommended general precautions to include resident seated at 90 degrees for all oral intake, one to one assist to follow safe swallow strategies of small bites/sips, slow rate, alternate bites/sips and only feed resident when she is alert. R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition and required set up assistance with eating. R12's care plan dated 4/27/26, identified a potential for alteration in nutrition with a goal to maintain independence with eating after set up. Staff were directed to assist to setup meals as needed. R12 should be sitting upright as close to 90 degrees as possible when eating in bed. Staff were to encourage R12 to sit up in wheelchair with eating. R12's Physician Orders with print date 4/29/26, identified a dietary order 4/15/26, for a heart healthy/cardiac diet. Special instructions included to cut food into small bite size pieces, resident to sit at 90 degrees for all intake, slow rate of intake, small bites/sips, alternate bites/sips, assist of one and to only feed when alert. R12's Dietary Menu card,Tuesday dinner dated 4/28/26, identified a heart healthy diet and to cut P12's food into bite sized pieces. During observation on 4/28/26, at 12:19 p.m. R12 was in bed in her room, watching television and eating her lunch. R12's lunch tray was on her bedside table over her bed and R12 was in a semi upright position in bed, with the head of the bed raised to an approximately 75-degree angle. R12's lunch consisted of a half of a submarine sandwich on a white hoagie roll with lunch meat and cheese. Three large pieces of lettuce and a large slice of tomato was also on the plate. R12 had the half-consumed sandwich in her hand and was taking	F0805	Continued from page 37 reflect upgraded diet d/t improving condition. By 6/5/26 all resident diet orders will be audited to ensure accuracy. Any discrepancy found will be rectified in cooperation with PCP and ST. The policy for Diet Orders was reviewed and remains accurate. Licensed nurses and dietary staff will receive education on the policy and procedural expectations for verification of diet consistencies and textures prior to serving. This will be completed by 6/5/26 via verbal instruction. Audits will be completed by the assistant administrator or designee beginning 6/10/26 at a rate of 21/week for a period of 2 weeks, followed by 14/week for a period of 2 weeks, and then 7/week for a period of 2 weeks and an emphasis will be placed on modifications (such as cut into bite size pieces) being followed through and served appropriately in conjunction with the diet order.	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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F0805 SS = D	Continued from page 38 bites from it. No one was in the room with R12 as she ate. During interview on 4/28/26, at 12:28 p.m. trained medical assistant (TMA)-A entered R12's room and stated R12 was not positioned at a 90-degree angle as ordered and TMA-A stated she was not aware R12 had orders for her food to be cut into bite size pieces. TMA-A knew R12 had eaten a full sweet roll the day prior that had not been cut up for her. R12 should be seated at a 90-degree angle and food cut up in bite size pieces if that was what was ordered, as it would have been ordered to assist R12 to eat safely and prevent choking. TMA-A thought the order stemmed from when R12 had been more acutely ill and less alert. When interviewed on 4/28/26, at 12:33 a.m. nursing assistant (NA)-A stated the nurse aide care plan did identify R12's food was to be cut into bite size pieces but did not direct staff to ensure R12 was at a 90-degree angle to eat. NA-A stated R12's head of bed was elevated but was not fully at a 90-degree angle. NA-A stated usually the dietary staff was responsible to make sure resident food was cut up as ordered but if it wasn't, then the NA's should be doing it, kind of like a second check. During interview on 4/28/26, at 12:44 p.m. dietary aide (DA)-A stated dietary staff were supposed to cut up resident food when it was ordered, but if it wasn't, then the NA's should do it. DA-A felt sure she had cut up R12's sandwich into bite size pieces and thought maybe the NA"s had given her the wrong tray instead, but she could not be entirely sure of that. DA-A stated R12's dietary slip identified her food needed to be cut up in small bite size pieces. During interview on 4/28/26, at 12:52 p.m. registered nurse (RN)-B stated it was not an official order to keep R12's diet as small bite size pieces and to be seated at a 90-degree angle when eating. RN-A left those special instructions on her chart as an additional note and R12's family had requested that as well. RN-A felt it was important to keep the special instructions listed when R12 had returned from the hospital on 4/15/26, but now R12's diet may need to be re-evaluated as she has improved since her return. The facility policy Diet Orders dated 2/2025, identified all meals provided to residents would have a written physician order. No further information was received.	F0805		06/12/2026

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F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	Failure to properly implement proper infection prevention and control procedures has the potential to impact all residents who reside in the facility. R25 and R66 both continue to have indwelling devise that require the use of EBP during all high contact activities with caregivers. The current facility policy for EBP was reviewed on 5/20/26 and includes when EBP is indicated and was not revised Education for all staff covering expectations of compliance with EBP for residents with indwelling devices including wearing gowns and gloves when high contact direct care is being provided will be completed by 6/5/26. Beginning on 6/10/26 the Director of Nursing or designee will audit high contact activities with staff 21/week for a period of 2 weeks, followed by 14/week for a period of 2 weeks, and then 7/week for a period of 2 weeks with an emphasis on those residents with indwelling medical devices. If at such time staff observation results in inadequate EBP practice, DON or designee will provide real time feedback and education to specific staff member. Results of all EBP audits will be reported to the QAPI for determination of ongoing auditing needs.	06/12/2026

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F0880 SS = D	Continued from page 40 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) according to CDC guidelines during direct cares for 2 of 4 residents (R25, R66) reviewed who were on enhanced barrier precautions. Findings include: R25 R25's annual Minimum Data Set (MDS) dated 2/11/26, identified R25 had an indwelling Foley catheter and was dependent on staff for activities of daily living (ADL's) including catheter care. R25's had a diagnosis of renal insufficiency. R25's care plan dated 3/6/25, identified R25 was at risk for infection due to his indwelling catheter and staff were to wear PPE, including gown and gloves, when caring for R25. On 4/27/26 at 1:45 p.m., nursing assistant (NA)-C exited R25's bathroom wearing gloves and was holding a urine collection graduate. NA-C bent down next to R25 and drained urine from the catheter drainage bag into the graduate. NA-C stood, walked into the bathroom and emptied the urine into the toilet. NA-C failed to wear a gown during catheter	F0880		06/12/2026

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F0880 SS = D	Continued from page 41 cares. During interview, NA-C stated when he emptied a resident's catheter, he always wore gloves and if there was a risk of infection then he would also wear a gown. NA-C stated he had worn gloves but not a gown when he emptied R25's catheter. NA-C stated there was a risk of splashing urine onto his clothes and potentially spreading bacteria to another resident. NA-C stated he should have worn a gown with R25's catheter cares. R66 R66's quarterly Minimum Data Set (MDS) dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastric tube, tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should where with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C was at R66's bedside and administering medication through the resident's gastrostomy tube (G-tube). Nursing assistant (NA)-D entered the room, put on a pair of gloves and walked to the resident's bedside. RN-C and NA-D were on either side of the bed. RN-C was wearing a gown and gloves. NA-D was wearing gloves, however, was not wearing a gown. R66's bed was thigh-height, and the resident was lying in bed with a lift sheet behind her hips and back, and her legs were resting on pillows behind her calves. RN-C and NA-D leaned over the bed and used the lift sheet to scoot the resident up towards the top of the bed. RN-C and NA-D walked to the foot of the bed and lifted and repositioned the pillows behind R66's lower legs. NA-D walked into the bathroom, removed her gloves, washed her hands and then exited the room. RN-C stated R66 was at risk for infection because of her g-tube and NA-D should have worn a gown and gloves while assisting with direct care. During interview on 4/29/26 at 10:35 a.m., NA-D stated she usually wears a gown when caring for residents with any type of tubes including g-tubes, although forgot to put on a gown when she repositioned R66. NA-D stated wearing a gown was important to prevent bringing in and spreading bacteria to R66, as well as to help prevent spreading bacteria to/from other residents. During interview on 4/29/26 at 5:26 p.m., director of	F0880		06/12/2026

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F0880 SS = D	Continued from page 42 nursing (DON) stated staff should wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility Enhanced Barrier Precautions policy dated 3/26, 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 organism (MDRO)’s to staff hands and clothing. MDRO’s may indirectly be transferred from resident to resident during high contact care activities. Resident 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.	F0880		06/12/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/27/26 through 4/29/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed H53971679C (2698495), H53971680C (2664268), H53971678C	20000		06/12/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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20000	Continued from page 1 (2990355) H53971681C (2562021) and H53977660C (2792289) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		06/12/2026
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven	20570	Corrected	06/12/2026

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20570	Continued from page 2 days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include ordered functional maintenance program (FMP) with goals and interventions for 2 of 6 residents (R20, R32) who received exercises, in addition, the facility include enhanced barrier precautions (EBP) including measurable goals and interventions for 1 of 6 residents (R66) whose care plans were reviewed for EBP. Findings include: R20: R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, anxiety, weakness and history of hand and hip fractures. R20's undated Physician Orders report identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated.	20570		06/12/2026

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20570	Continued from page 3 R20's care plan dated 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP), with goals and staff interventions. During interview on 4/29/26, at 5:36 p.m. the director of nursing (DON) stated if a resident was being seen by the restorative aide for the FMP, that should be addressed in their plan of care. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assistance with bed mobility and transfers and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's undated Physicians Orders report identified an order for a FMP with walking as part of the FMP with a start dated of 11/19/25, with no end date identified. R32's Restorative Care Program dated 11/7/25, identified R32 was discharged from PT and was to start a FMP to maintain lower extremity strength and range of motion to decrease the burden of care with transfers and ambulation. The FMP identified the resident was to do each exercise 15 times. The exercises included: Seated chair march Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out) Hip adduction with a ball. (squeezing your knees together with a ball between them) Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it) Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart) Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait	20570		06/12/2026

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20570	Continued from page 4 belt (a belt to place around a resident to assist with standing and balance). R32's care plan with the last review date of 3/13/26, identified R32 had decreased physical mobility with potential for falls due to recent left knee replacement. Staff were directed to assist R32 to turn and reposition, pivot transfer and to assist with sit up and lay down in bed and get leg and feet in and out of bed. R32's care plan lacked any documentation related to a FMP with goals and interventions. During an interview on 4/29/26, registered nurse (RN)-B stated when a resident was started on an FMP the care plan for the resident should be updated. R32's care plan lacked any documentation of an FMP. During an interview on 4/29/26 at 4:07 p.m., the DON stated the FMP for a resident was ordered by PT and should be placed on the resident's care plan. R32's FMP lacked any documentation related to an FMP or ambulation. R66: R66's quarterly MDS dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastrostomy tube (g-Tube), tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should wear with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C stated R66 was at risk for infection because of her g-tube and staff wore PPE including a gown and gloves during direct patient cares. During interview on 4/29/26 at 5:26 p.m., DON stated staff were instructed to wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility policy Quality of Care dated 10/2023, identified the facility would strive to ensure residents received treatment and care in accordance with professional standards of practice, their	20570		06/12/2026

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Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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20570	Continued from page 5 comprehensive care plan and their personal preferences. A policy for resident care plan was not received. SUGGESTED METHOD OF CORRECTION: The DON could review policies on the care plan process and assessments and ensure it aligns with requirements, make changes where needed, educate staff on the process, audit charts and ensure resident care plans are updated to reflect care and services received and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		06/12/2026
20800	Nursing Personnel; Staffing requirements CFR(s): MN Rule 4658.0510 Subp. 1 Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and document review, the facility failed to provide sufficient staffing to provide exercise services for the restorative nursing program for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: See also 20890: Rehab - Range of Motion: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. R20: R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in	20800	Corrected	06/12/2026

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20800	Continued from page 6 self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. R53: R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had	20800		06/12/2026

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20800	Continued from page 7 received restorative exercises five times and refused one time during the 15-week time period. R40 R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's Restorative Program log dated 1/19/26	20800		06/12/2026

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20800	Continued from page 8 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. R66 R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed. R32: R32's Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed.	20800		06/12/2026

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20800	Continued from page 9 The restorative program documentation was reviewed and identified the following: 1/19/26-1/25/16, 6 of 39 residents received services. 1/26/26-2/1/26, 0 of 38 residents received services. 2/2/26-2/8/26, 25 of 39 residents received services. 2/9/26-2/15/26, 9 of 40 residents received services. 2/16/26-2/22/26, 28 of 38 residents received services. 2/23/26-3/1/26, 6 of 39 residents received services. 3/2/26-3/8/26, 2 of 38 residents received services. 3/9/36-3/15/26, 0 of 38 residents received services. 3/16/26-3/22/26, 0 of 37 residents received services. 3/23/26-3/29/26, 1 of 37 residents received services. 3/30/26-4/5/26, 3 of 40 residents received services. 4/6/26-4/12/26, 0 of 40 residents received services. 4/13/26-4/19/26, 27 of 40 residents received services. 4/20/26-4/26/26, 26 of 41 residents received services. 4/27/26-5/3/26, 30 of 38 residents received services. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H, who was a restorative aide, stated initially she was going to be just doing functional maintenance programs for the residents today (4/28/26) but was only able to work until about noon. She was then instructed to stop working on the FMP's and was pulled to the floor to work as a NA. NA-H stated being pulled to the floor happened a lot. There was another NA who would help with FMPs, but they also called to work as an NA on the floor. When NA-H is working as the restorative aide she reviewed the lists of residents and decide which ones could be done on that day. NA-H can't get through the list and there are residents who do not get the FMP services. Most of the residents on an FMP had not received services	20800		06/12/2026

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20800	Continued from page 10 on a regular basis or not even at all. Most of the residents were not receiving their ordered FMP due to having to be pulled to the floor all the time and only working a couple of days a week. During a follow up interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:04 p.m. the director of nursing (DON) stated there are two aides who worked the restorative nursing program and they are both part time. For about 6 months the facility only had one part-time restorative aide. The restorative aides would start with the FMPs right away when they get to the facility, but they are frequently called out to floor to work as a NA. This is because of call-ins or short staffing on the floor. She stated it was not acceptable to be pulling the restorative aides to the floor all the time, because they have close to fifty residents to assist and are unable to get to all of them in a week and the residents go without their FMP. A staffing policy was not obtained.	20800		06/12/2026
20850	Adequate and Proper Nursing Care; Shaving CFR(s): MN Rule 4658.0520 Subp. 2 D Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely cares to	20850	Corrected	06/12/2026

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20850	Continued from page 11 dependent residents for 2 of 7 residents (R14, R18) who's activities of daily living cares were observed. Findings include: R14: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was dependent on staff for toileting. R14 diagnoses included dementia, edema, restlessness and agitation. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 8/21/25, identified the CAA was triggered due to R14's needing extensive assistance with toileting and frequent incontinence of urine. Staff offer to assist R14 to the restroom or to use his urinal every 2-3 hours and as needed. R14 was at risk for alterations in skin, offensive body odor, falls and bladder infections. Complicated by history of falls, dementia, R14's care plan revised 4/29/26, identified R14 had an alteration in elimination related to dementia with cognitive losses, receiving diuretic, poor sequencing skills, history of retention of urine and constipation manifested by need for staff assistance with toileting, R14 was incontinent of bladder and bowel. Staff will check brief for incontinence q 2-3 hours and as needed, change brief as needed with incontinence. Provide total assistance of 1 staff to change brief. May require 2 staff to change brief at times. Provide total assistance of 1-2 staff to pull up/down pants and provide peri rectal care after elimination. A continuous observation of R14 was completed on 4/29/26 starting at 8:04 a.m., through 11:10 a.m. At 8:04 a.m. R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. [It was unknown what time R14 was placed in the wheelchair] At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat.	20850		06/12/2026

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20850	Continued from page 12 At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered toileting. At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on. At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually toileted R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the	20850		06/12/2026

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20850	Continued from page 13 full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while. R14 was not offered nor placed on the commode to attempt to void. At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously toileted that morning and would have to ask the nursing assistants. RN-C stated R14 was due to a bowel movement that morning and had received a laxative. When the laxative "kicked in", staff would place R14 on the commode. However, when R14 was already incontinent staff laid him down and provided incontinence care. R14 was not placed on the commode every time he was toileted because staff did not want to cause R14 agitation. At 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last toileted. TMA-B stated she was told R14 had been assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's toileting so staff really had "no idea". R14 should have been toileted at 9:00 a.m. at the latest because R14 was care planned to be toileted every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of toileting times differently. TMA-B used her care sheet and wrote down the times and whether the resident was incontinent or had voided. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last toileting time and staff just kept a mental note when they resident was due again. Yea, some staff did write it down on the care sheet but "to each his own I guess". NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated toileting times were given during shift report. For R14, staff should offer toileting every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C	20850		06/12/2026

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20850	Continued from page 14 stated she did speak with the nursing assistants to determine when R14 had been toileted that morning. R14 had been incontinent around midnight the night before and R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done, she did it as observed. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be toileted between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be toileted every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation on how staff tracked toileting times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged toileting times which could lead to prolonged exposure to moisture and skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been toileted before 9:00 a.m. or earlier. During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been toileted immediately after breakfast or within his care planned timeframe to prevent incontinence/skin breakdown and to lessen R14's behaviors/agitation. Additionally, staff should always offer R14 to sit on the commode even when R14 was incontinent as care planned. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. R18: R18's five-day MDS dated 3/3/26, identified R18 had severe cognitive impairment and required maximum to total assistance with activities of daily living (ADLs). Diagnoses included dementia, kidney disease, cerebral infarction (stroke), anxiety and diabetes. R18's care plan dated 3/31/26, identified R18 had a self-care deficit with a goal to remain clean and free of odor daily. Staff were directed to comb R18's hair, brush his teeth and shave him. R18's Resident Care Sheet dated 4/22/26, directed staff in bold and capitalized text to shave daily, family request. During observation on 4/27/26, at 11:17 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 had 1/4-inch grey whiskers scattered over his chin,	20850		06/12/2026

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20850	Continued from page 15 cheeks, neck and below his nose. R18 was unable to recall if he had shaven that day. During observation on 4/28/26, at 10:38 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 continued to have grey whiskers scattered over his face and neck and remained unshaven. During observation on 4/29/26, at 8:59 a.m. R18 was seated in his wheelchair in the hallway. R18's was clean shaven. When interviewed on 4/29/26, at 9:00 a.m. LPN-B stated she was not sure why the aides would not have shaved R18 on 4/27/26, or 4/28/26, but he was shaved today. There were different nursing assistants on then there were the other two days. R18 was supposed to be shaved every day. When interviewed on 4/29/26, at 9:53 a.m. RN-B stated R18 should be shaven daily. RN-B was not sure why R18 was not shaved the other two days. RN-B was aware R18's shaver battery was very low when he was shaved that morning, so perhaps that was the reason, but the goal was to shave him every day. R18 could have refused, however the point of care documentation did not indicate R18 refused care. During interview on 4/29/26, at 9:54 a.m. NA-B stated she was not sure why R18 was not shaved the previous two days, but he was shaven now. R18 was supposed to be shaven every day. Some of the younger NA's just did not notice or didn't know better. R18 never refused assistance with cares and always allowed them to assist hiem to shave daily without any problems. During interview on 4/29/26, at 4:36 p.m. the DON stated she would have expected staff to shave R18 as care planned or document why it could not be completed. The facility Quality of Care Policy reviewed 10/2023, identified based on the comprehensive assessment of a resident the facility strove to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with State and Federal Regulations. SUGGESTED METHOD OF CORRECTION: The DON could review policies on resident dependent care and toileting and ensure it aligns with requirements, make changes where needed. Educate staff on the process, ensure staff are providing care to residents as care planned, audit charts and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20850		06/12/2026

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20890	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2 A Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: R20 R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, weakness and history of hand and hip fractures. R20's care plan reviewed 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP). R20's undated Physician Orders identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The	20890	Corrected	06/12/2026

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20890	Continued from page 17 restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. On 4/29/26, at 3:23 p.m. physical therapist (PT)-A and therapy director (TD) assisted R20 to complete the full OT and PT FMP program exercises in the therapy room. R20 became visibly weak, shaky toward the end of the exercises. PT-A and TD both stated R20 had no decline since P20 was last seen by therapy. R53 R53's quarterly MDS dated 3/20/26, identified R53 had intact cognition and was dependent on staff for most ADLs, mobility and transfers. R53 had impaired range of motion (ROM) to both lower extremities and was unable to ambulate. Diagnoses included paraplegia (paralysis lower half of body), spondylosis (degenerative spinal condition) and chronic pain. R53's care plan revised 3/16/26, identified R53 had decreased physical mobility with potentials for falls due to low back pain with bilateral sciatica, spinal stenosis, weakness and limited functional ROM. Staff were directed to assist R53 with mobility, transfers and repositioning. R53 was to participate in FMP per her plan of care. R53's undated Physician Orders report identified an order for FMP dated 9/4/25, with an open-ended end date.	20890		06/12/2026

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20890	Continued from page 18 R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. On 4/29/26, at 4:02 p.m. R53 was seated in her room watching television. TD entered the room and received permission to assist R53 with her exercises. TD completed all exercises from the PT and OT FMP program. R53 was smiling and cooperative throughout the exercises. After completion of the exercises, TD stated she did not find a decline in R53's function since she was last seen by therapy. R53 stated she was unsure how often staff assisted her with her exercises or when they were last done. R53 stated she wished it were more often. R40 R40's quarterly MDS dated 2/4/26, identified R40 had moderately impaired cognition and was independent with ADLs. R40 had full ROM of extremities and was able to ambulate independently. Diagnoses included dementia, traumatic subdural hemorrhage, repeated falls, dizziness and giddiness, disorder of the autonomic nervous system, and osteoarthritis of the knees. R40's undated Physician Orders report identified an order for PT and OT FMP one time per day with start date 12/5/25 and open-ended end date.	20890		06/12/2026

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20890	Continued from page 19 R40's care plan revised 3/16/26, identified decreased physical mobility with potential for falls due to dementia, poor coordination and balance, history of falls, and poor sequencings skills. Staff were directed to provide limited assistance with transfer and ambulation and OT and PT FMP per plan of care. R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was non-ambulatory. A diagnosis of dementia was included. R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes	20890		06/12/2026

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20890	Continued from page 20 Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's care plan revised 3/16/26, identified falls and alteration in skin related to poor coordination/balance, pain, dementia with cognitive losses and poor sequencing skills manifested by inability to transfer, always wheel self, always turn and reposition self, sit up, lie down or get feet and legs into bed independently. Unable to ambulate. Occupational therapy (OT) and physical therapy (PT) functional maintenance program as ordered. R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R14 frequently refused to do restorative exercises, however, the documentation did not reflect R14 had refused or had been offered. R66 R66's MDS dated 3/3/26, identified R66 was cognitively intact and required substantial/maximal assistance with upper body dressing and personal hygiene, partial/moderate assistance with eating, and was dependent on staff for all other care areas. Diagnoses included dementia, anxiety and diabetes. R66's care plan revised 3/16/26, identified decreased physical mobility with potential for falls and alterations in skin r/t Diabetes, Dementia, Alzheimer's disease, Heart failure, poor balance at times and poor sequencing skills manifested by need for staff assist with mobility needs at times. R66 was to participate in a functional maintenance program as ordered by therapy. R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15	20890		06/12/2026

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20890	Continued from page 21 repetitions, and Encourage R66 to assist with movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R66 frequently refused to do restorative exercises, however, the documentation did not reflect R66 had refused or had been offered. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assist with bed mobility and transfers and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's medical record contained the following information on the restorative program: R32's provider orders dated 11/19/25, identified Functional Maintenance Plan (FMP) was ordered with special instruction for walking program as part of FMP. R32's progress noted dated 11/19/25, identified R32 was discharged from PT services on 11/7/25. PT FMP in place with walking program apart of her FMP. Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand,	20890		06/12/2026

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20890	Continued from page 22 and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H stated they were only able to provide FMP services to R32 twice and that did not include ambulation services. The nursing assistants on the floor would be responsible for ambulation. During an interview on 4/29/26 at 9:49 a.m., TD stated the restorative aide would provide the exercise services and nursing and NAs provided ambulation services on the floor. R32's program for the exercises #1-6 (above) would be completed by the restorative aide and #7 would be completed by NAs on the floor. During an interview on 4/29/26 at 10:39 a.m., a trained medication aide (TMA)-C stated there was a list of residents who required ambulation and would be updated regularly by the nurse manager. If there were concerns on ability of the resident to continue walking, then we would let the nurse manager know and she would have ordered a screening from therapy to see if changes needed to be made with the program. I think there was a screening done for R32 that stated she was not to ambulate. During a follow up interview on 4/29/26 at 10:47 a.m., the TD stated when a request came in it would be charted and documented in their system. R36 had never received a request to rescreen her regarding ambulation. This was also verified by the physical therapist (PT)-A. During interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return.	20890		06/12/2026

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20890	Continued from page 23 NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:07 p.m., the director of nursing (DON) stated when residents were started on an FMP the restorative aide would work on the range of motion aspect of the plan and the NA's on the unit would do the ambulation portion of the plan. R36 should have received the ordered FMP to maintain their level of function related to activities of daily living. During interview on 4/29/26, at 4:30 p.m. TD stated therapy completed the functional maintenance program form to initiate restorative nursing exercises when they discharged a resident from therapy. Therapy did not oversee the program. If a resident was not being seen or refusing restorative services, they would report to the charge nurse, and the charge nurse would notify therapy, if they needed to be re-evaluated. TD thought nursing oversaw the restorative program. When interviewed on 4/29/26, at 5:36 p.m. the DON stated she did not know if the previous restorative aide had documented her work correctly, but the facility did pull the restorative aide from time to time to work on the floor assisting with resident care. The facility had two restorative aides who each worked two days per week, and one worked every other weekend and the other, one weekend a month, for resident restorative program. The facility policy Quality of Care reviewed 10/2023, identified the facility would ensure a resident with limited range of motion or mobility would receive appropriate treatment and services to increase range of motion and mobility and/or prevent further decrease in range of motion or mobility. The facility policy Restorative Care dated 7/19/21, identified it was the intent of the restorative program to promote the residents ability to adapt and adjust to living as independently and safely as possible. The resident would be assessed by physical therapy and recommendations for restorative care therapy were submitted on the restorative therapy form. A nursing assistant trained to perform restorative care therapy would complete 15 minutes daily with the resident. Time would be documented by the therapy aide. The restorative care lead nurse would maintain documentation of residents who received restorative care and would make progress notes on therapy, minutes of therapy provided and plan review.	20890		06/12/2026

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20890	Continued from page 24 SUGGESTED METHOD OF CORRECTION: The DON)could review policies on restorative nursing and the functional maintenance program and ensure it aligns with requirements, make changes where needed. Educate staff on the process, ensure a restorative aide is assigned daily to assist residents with their ordered exercises, assign a staff member to supervise and manage the program, have therapy review each resident's program for appropriateness, audit charts and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20890		06/12/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents received timely repositioning for 1 of 3 residents (R14) reviewed for pressure ulcers. Findings include: R14’s quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment was dependent on staff for repositioning. Diagnoses included dementia, edema, restlessness and agitation. R14’s Braden Scale (prediction for pressure ulcer scale) dated 2/13/26, identified R14 was a moderate risk for pressure injury/ulcer. R14’s care plan revised 4/29/26, included an intervention to provide assist of one staff to turn	20900	Corrected	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20900	Continued from page 25 and reposition every 2-3 hours. A continuous observation was conducted on 4/29/26 at starting at 8:04 a.m., R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. It was unknown when R14 was seated in his wheelchair. At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat. At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered repositioning. At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. Staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. RN-C did not offer to reposition R14. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on.	20900		06/12/2026

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20900	Continued from page 26 At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually repositioned R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while. At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. R14's skin was pink, dry and intact. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously repositioned that morning and would have to ask the nursing assistants. During an interview on 4/29/26 at 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last repositioned. TMA-B was told R14 was assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's repositioning so staff really had "no idea". R14 should have been repositioned at 9:00 a.m. at the latest because R14 was care planned to be repositioned every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of repositioning times differently. TMA-B used her care sheet and wrote down the times. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last	20900		06/12/2026

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20900	Continued from page 27 repositioning time and staff just kept a mental note when they resident was due again. Some staff wrote it down, but not everyone. NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated repositioning times were given during shift report. For R14, staff should offer repositioning every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been repositioned that morning. R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be repositioned between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be repositioned every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation of how staff tracked times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged repositioning times which could lead to skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been repositioned before 9:00 a.m. or earlier. That is a large time span and, because it wasn't kept track of, staff don't know. During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been repositioned immediately after breakfast or within his care planned timeframe to prevent skin breakdown and to lessen R14's behaviors/agitation. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. The facility policy Skin Care reviewed 6/2023, identified staff would ensure proper identification of residents at risk for skin breakdown, prevention of development of pressure ulcers, and determining appropriate treatment of pressure ulcers and/or impaired skin for residents. Care plans will be individualized to address resident specific needs.	20900		06/12/2026

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20900	Continued from page 28 SUGGESTED METHOD OF CORRECTION: The DON or designeed could audit to ensure residents who are at risk/or have current pressure ulcers are implementing the interventions in place. The DON or designee could review and revise policies and educate staff on the requirements and then audit for compliance. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) days.	20900		06/12/2026
20945	Assistance with Eating - Nursing Personnel CFR(s): MN Rule 4658.0530 Subp. 1 Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was prepared and served to meet resident needs for 1 of 2 residents (R12) reviewed for nutrition. Findings include: R12's Speech Therapy Daily Note dated 3/16/25, recommended general precautions to include resident seated at 90 degrees for all oral intake, one to one assist to follow safe swallow strategies of small bites/sips, slow rate, alternate bites/sips and only feed resident when she is alert. R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition and required set up assistance with eating. R12's care plan dated 4/27/26, identified a potential for alteration in nutrition with a goal to maintain independence with eating after set up. Staff were directed to assist to setup meals as needed. R12	20945	Corrected	06/12/2026

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20945	Continued from page 29 should be sitting upright as close to 90 degrees as possible when eating in bed. Staff were to encourage R12 to sit up in wheelchair with eating. R12's Physician Orders with print date 4/29/26, identified a dietary order 4/15/26, for a heart healthy/cardiac diet. Special instructions included to cut food into small bite size pieces, resident to sit at 90 degrees for all intake, slow rate of intake, small bites/sips, alternate bites/sips, assist of one and to only feed when alert. R12's Dietary Menu card,Tuesday dinner dated 4/28/26, identified a heart healthy diet and to cut P12's food into bite sized pieces. During observation on 4/28/26, at 12:19 p.m. R12 was in bed in her room, watching television and eating her lunch. R12's lunch tray was on her bedside table over her bed and R12 was in a semi upright position in bed, with the head of the bed raised to an approximately 75-degree angle. R12's lunch consisted of a half of a submarine sandwich on a white hoagie roll with lunch meat and cheese. Three large pieces of lettuce and a large slice of tomato was also on the plate. R12 had the half-consumed sandwich in her hand and was taking bites from it. No one was in the room with R12 as she ate. During interview on 4/28/26, at 12:28 p.m. trained medical assistant (TMA)-A entered R12's room and stated R12 was not positioned at a 90-degree angle as ordered and TMA-A stated she was not aware R12 had orders for her food to be cut into bite size pieces. TMA-A knew R12 had eaten a full sweet roll the day prior that had not been cut up for her. R12 should be seated at a 90-degree angle and food cut up in bite size pieces if that was what was ordered, as it would have been ordered to assist R12 to eat safely and prevent choking. TMA-A thought the order stemmed from when R12 had been more acutely ill and less alert. When interviewed on 4/28/26, at 12:33 a.m. nursing assistant (NA)-A stated the nurse aide care plan did identify R12's food was to be cut into bite size pieces but did not direct staff to ensure R12 was at a 90-degree angle to eat. NA-A stated R12's head of bed was elevated but was not fully at a 90-degree angle. NA-A stated usually the dietary staff was responsible to make sure resident food was cut up as ordered but if it wasn't, then the NA's should be doing it, kind of like a second check. During interview on 4/28/26, at 12:44 p.m. dietary	20945		06/12/2026

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20945	Continued from page 30 aide (DA)-A stated dietary staff were supposed to cut up resident food when it was ordered, but if it wasn't, then the NA's should do it. DA-A felt sure she had cut up R12's sandwich into bite size pieces and thought maybe the NA"s had given her the wrong tray instead, but she could not be entirely sure of that. DA-A stated R12's dietary slip identified her food needed to be cut up in small bite size pieces. During interview on 4/28/26, at 12:52 p.m. registered nurse (RN)-B stated it was not an official order to keep R12's diet as small bite size pieces and to be seated at a 90-degree angle when eating. RN-A left those special instructions on her chart as an additional note and R12's family had requested that as well. RN-A felt it was important to keep the special instructions listed when R12 had returned from the hospital on 4/15/26, but now R12's diet may need to be re-evaluated as she has improved since her return. The facility policy Diet Orders dated 2/2025, identified all meals provided to residents would have a written physician order. No further information was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the dietician could review policies on resident diet orders and assistance provided residents to eat and ensure it aligns with requirements, make changes where needed. Educate staff on the process, ensure dietary is following diet orders for type and texture and ensure staff are assisting residents with meals as directed in each resident's plan of care, ensure residents have been assessed to meet their dietary needs and audit charts and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20945		06/12/2026
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21385	Corrected	06/12/2026

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21385	Continued from page 31 Based on observation, interview and document review the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) according to CDC guidelines during direct cares for 2 of 4 residents (R25, R66) reviewed who were on enhanced barrier precautions. Findings include: R25 R25's annual Minimum Data Set (MDS) dated 2/11/26, identified R25 had an indwelling Foley catheter and was dependent on staff for activities of daily living (ADL's) including catheter care. R25's had a diagnosis of renal insufficiency. R25's care plan dated 3/6/25, identified R25 was at risk for infection due to his indwelling catheter and staff were to wear PPE, including gown and gloves, when caring for R25. On 4/27/26 at 1:45 p.m., nursing assistant (NA)-C exited R25's bathroom wearing gloves and was holding a urine collection graduate. NA-C bent down next to R25 and drained urine from the catheter drainage bag into the graduate. NA-C stood, walked into the bathroom and emptied the urine into the toilet. NA-C failed to wear a gown during catheter cares. During interview, NA-C stated when he emptied a resident's catheter, he always wore gloves and if there was a risk of infection then he would also wear a gown. NA-C stated he had worn gloves but not a gown when he emptied R25's catheter. NA-C stated there was a risk of splashing urine onto his clothes and potentially spreading bacteria to another resident. NA-C stated he should have worn a gown with R25's catheter cares. R66 R66's quarterly Minimum Data Set (MDS) dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastric tube, tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should where with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C was at R66's bedside and administering medication	21385		06/12/2026

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21385	Continued from page 32 through the resident's gastrostomy tube (G-tube). Nursing assistant (NA)-D entered the room, put on a pair of gloves and walked to the resident's bedside. RN-C and NA-D were on either side of the bed. RN-C was wearing a gown and gloves. NA-D was wearing gloves, however, was not wearing a gown. R66's bed was thigh-height, and the resident was lying in bed with a lift sheet behind her hips and back, and her legs were resting on pillows behind her calves. RN-C and NA-D leaned over the bed and used the lift sheet to scoot the resident up towards the top of the bed. RN-C and NA-D walked to the foot of the bed and lifted and repositioned the pillows behind R66's lower legs. NA-D walked into the bathroom, removed her gloves, washed her hands and then exited the room. RN-C stated R66 was at risk for infection because of her g-tube and NA-D should have worn a gown and gloves while assisting with direct care. During interview on 4/29/26 at 10:35 a.m., NA-D stated she usually wears a gown when caring for residents with any type of tubes including g-tubes, although forgot to put on a gown when she repositioned R66. NA-D stated wearing a gown was important to prevent bringing in and spreading bacteria to R66, as well as to help prevent spreading bacteria to/from other residents. During interview on 4/29/26 at 5:26 p.m., director of nursing (DON) stated staff should wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility Enhanced Barrier Precautions policy dated 3/26, 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 organism (MDRO)'s to staff hands and clothing. MDRO's may indirectly be transferred from resident to resident during high contact care activities. Resident 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. SUGGESTED METHOD OF CORRECTION: The DON, ICP, or designee could review facility	21385		06/12/2026

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21385	Continued from page 33 policies/procedures regarding isolation and or/enhanced barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take that findings to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		06/12/2026
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a stop date for medication was	21535	Corrected	06/12/2026

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21535	Continued from page 34 confirmed by the primary care provider for temporary medications that required an end date for 1 of 6 residents (R12) reviewed for medication management. Findings include:R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition. R12 received injectable medication for all seven days of the observation period and received anticoagulant medication. A complete drug regimen review was completed, and no potentially clinically significant medication issues were noted. Diagnoses included diabetes, fracture of the right femur, altered mental status, calculus of the kidney, hydronephrosis and metabolic encephalopathy. R12's Interagency Transfer Orders dated 4/15/26, identified an order for enoxaparin (a blood thinner) 40 milligram (mg) syringe, inject 0.4 millimeters (ml) under the skin every night to prevent deep vein thrombosis for diagnosis of total right hip arthroplasty. The quantity listed 13.6 ml with no refills. R12's Medication Administration Record (MAR) for April 2026, identified enoxaparin syringe 40 mg/0.4 ml: subcutaneous (SQ) at bedtime for fracture of right femur. Start/End date 4/15/26 to 5/18/26. Special Instructions were listed as RX for 13.6 ml/ 0.4 ml per dose=34 doses total. The medication was recorded as administered as ordered starting 4/15/26. When interviewed on 4/28/26, at 4:13 p.m. licensed practical nurse (LPN)-C stated the pharmacy had filled the enoxaparin in 40 mg / 0.4 ml prefilled single use syringes. Nursing staff administered the one prefilled syringe every evening. LPN-A was unsure what the special instructions on P12's MAR meant. During interview on 4/28/26, at 4:36 p.m. registered nurse (RN)-B stated the special instructions were to demonstrate how the end date of the medication was determined. The medication was filled for 13.6 ml quantity with no refills, so she did the math, versus contacting the medical provider, to determine 34 doses were ordered and figured out the end date from there. RN-B stated she had not contacted R12's primary care provider to verify the stop date of the medication and no verbal order had been obtained to stop the medication. During telephone interview on 4/29/26, at 9:06 a.m. the consulting pharmacist (CP)-D stated if a medication required an end date, either the	21535		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
21535	Continued from page 35 pharmacist would call the provider to obtain it or nursing would do it. The quantity of medication with no refills could mean that the med should be stopped when ran out of medication, but not always. CP-D thought she would probably just check with the provider to make sure. It was better to double check with the provider rather than just assume. When interviewed on 4/29/26, at 4:27 p.m. the director of nursing (DON) stated usually medication orders such as enoxaparin had a stop date, especially when discharging from the hospital. She would expect staff to reach out to the provider to notify of the need for an end date to the enoxaparin and verification the dose was completed when the medication was gone. No refills on a medication did not always mean to discontinue the medication and needed to be verified by the primary care provider. The facility policy Pharmacy Services dated 10/2022, identified prescription medications were dispensed only upon receipt of clear, complete, and signed orders of a person lawfully authorized to prescribe. Any dose or order that appeared inappropriate, considering the resident's age, allergies, diagnosis or current medication regimen would be verified with the prescriber. SUGGESTED METHOD OF CORRECTION: The DON in conjunction with the pharmacist or designee could review policies on medication orders and ensure it aligns with requirements, make changes where needed. Educate staff on the process, audit charts and ensure orders are verified and have end dates when needed and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		06/12/2026
21880	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 20 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman	21880	Corrected	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

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21880	Continued from page 36 pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a report of missing personal property was followed up on for 1 of 3 residents (R14) reviewed for resident rights. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment. Diagnoses included dementia, edema, restlessness and agitation. R14 required set up/clean up assistance with eating, maximal/substantial assistance with dressing, bathing and personal hygiene and was dependent on staff with toileting and putting on and taking off footwear. During an interview on 4/28/26 at 6:09 p.m., family member (FM)-A stated R14's wedding ring went missing a "few months" ago. FM-A reported the missing wedding ring to the nursing assistants, the cart nurses, registered nurse (RN)-A who was the unit manager and the previous director of nursing (DON) who was no longer at the facility. FM-A stated she was simply told no staff had seen the ring. After the wedding ring was missing for a week, FM-A reported the missing ring to the police. FM-A had received no further information about the missing	21880		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

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21880	Continued from page 37 ring. FM-A stated she was concerned a staff member had taken the ring and the facility was not investigating the concern. During an interview on 4/29/26 at 3:22 p.m., trained medication aide (TMA)-B stated she had heard “something” about R14 was missing a wedding ring a “few months” prior but really didn’t recall anything else about it. During an interview on 4/29/26 at 3:22 p.m., RN-A stated she didn’t recall anyone reporting R14 had a missing wedding ring. During an interview on 4/29/26 at 3:25 p.m., RN-C stated she was unaware of R14’s missing wedding ring. Any missing item should be documented in a progress note, and it should be documented on the report sheet in the binder at the desk. The report sheet was kept in the binder for two weeks and then the report sheets were filed away by the director of nursing (DON). Then, an investigation would be done to try to find the missing item: laundry, housekeeping and nursing staff would be told to look for the item and be aware that it was missing. R14’s medical record failed to identify R14 was missing a wedding ring. R14’s Missing Item form was requested but not received. During an interview on 4/29/26 at 3:27 p.m., the social services (SS)-A stated she was unaware R14 was missing a wedding ring and there was no missing item report completed. During an interview on 4/29/26 at 3:28 p.m., licensed practical nurse (LPN)-A stated she didn't know anything about R14 missing a wedding ring. When a resident was admitted, staff really encouraged family to swap out any expensive or meaningful jewelry like a wedding for another ring, so the resident was still able to wear a ring but the likelihood of getting lost was not there. Staff report to social services and then an investigation was done to look in the room etc. During an interview on 4/29/26 at 3:31 p.m., the DON stated she was unaware R14 was missing a wedding ring. Staff were expected to complete a missing item report and, if possible, the resident was interviewed to determine when the item was last seen. Laundry, housekeeping, activities and nursing staff were informed to look for the item, and, on certain items, a police report may be filed. The DON	21880		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

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21880	Continued from page 38 stated she honestly did not know if a report had been filed for R14's missing ring because she was unaware it was missing. At 5:25 p.m., the DON stated R14's wedding ring had been found. It was found in laundry back in December 2025 and kept in the safe until 4/29/26 when the SA began asking about it. Staff did not complete a missing item report. The DON stated she expected staff to follow the procedure for a missing item and to report the concern to ensure all were aware of the missing item. If staff had been aware of R14's missing wedding ring, they would have known who the found wedding ring belonged to and R14 would have gotten it back sooner. The facility. The facility Missing Items Report revised 11/18/18, included information for staff to collect and identified the following: the resident's name, date, description of item(s) missing, date/time last seen, date/time noticed missing, thinks misplaced details, thinks taken and, if so, by whom, who it was reported to and who reported the missing item(s). Staff were instructed to complete the form immediately and give the report to the unit manager. The unit manager would search probably places immediately and list the employee(s) assigned to search. If the item was not found, family would be contacted. If the family was unaware of the item(s) location, the item was to be treated as a misappropriated item and reported to law enforcement and the state agency (SA). SUGGESTED METHOD OF CORRECTION: The director of social services or administrator could review policies and procedures on missing items, educate all appropriate staff members on the process of reporting missing personal items. The director of social services or administrator could develop monitoring systems to ensure ongoing compliance and follow up ion missing items is being done and bring the results to QAPI TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21880		06/12/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 13, 2026

Administrator
Havenwood Care Center
1633 DELTON AVENUE NW
BEMIDJI, MN 56601

RE: CCN:245397
Cycle Start Date: April 29, 2026

Dear Administrator:

On April 29, 2026, a survey was completed at your facility by the Minnesota Department(s of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 29, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 29, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 13, 2026

Administrator
Havenwood Care Center
1633 DELTON AVENUE NW
BEMIDJI, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: 1E3E0A-H1

Dear Administrator:

The above facility survey was completed on April 29, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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E0000	Initial Comments On 4/27/26 through 4/29/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		06/12/2026
F0000	INITIAL COMMENTS On 4/17/26 through 4/29/26, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H53971679C (2698495), H53971680C (2664268), H53971678C (2990355) H53977660C (2792289) The complaint H53971681C (2562021) was reviewed with citations issued at F677 ad F725 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		06/12/2026
F0688 SS = E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F0688	Failing to provide consistent programming to maintain functional mobility and preventing mobility losses is essential to quality of life and promoting independence at a resident’s highest practicable level.	06/12/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

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Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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F0688 SS = E	Continued from page 1 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: R20 R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, weakness and history of hand and hip fractures. R20's care plan reviewed 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP). R20's undated Physician Orders identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also	F0688	Continued from page 1 R20, R53, R40, R14, R66 and R32 have all had their current FMP's reviewed. R20 is no longer appropriate for participation in FMP d/t declining condition and admission to hospice. R53 has refused participation in FMP despite education and explanation of benefits. R40 has been assessed as being able to complete active exercise in a group setting and will be encouraged to participate in group exercise. R14 is no longer appropriate for current FMP d/t cognition and will have AAROM completed by nursing staff 1-2 times per week as he allows. R66 is no longer appropriate for current FMP d/t declining condition and admission to hospice. R32's FMP is no longer safe, resident is unable to ambulate and requires use of a patient assist lift for transfers. R32 will have care plan updated to include AAROM 1-2 times per week d/t cognition and vision limitations. Care plans for all 6 residents listed above will be updated by 6/5/26. The medical records of all residents were reviewed by a team of facility staff. This review identified 37 residents who had been evaluated by therapy with FMP's being written in the past. A further review of 62 residents identified 27 residents who need AA/PROM that require the exercises to be completed by staff. These 27 residents will be reviewed by 6/5/26 by the interdisciplinary team to evaluate the appropriateness of ongoing programing to include acceptance from resident, personal preference, tolerance, etc. The residents identified as having an ongoing need will have AAROM/PROM completed by nursing staff at least 1-2 times per week. 40 residents have the capacity to actively participate in the exercise program that will be offered by activities 4-5 times per week beginning on 6/8/26. 8 residents were assessed as being appropriate for both exercise programing and AAROM/PROM. Residents can have the choice to participate in the exercise video and/or staff lead exercise group. Content for the exercise program will be overseen by activity director and/or assistant administrator. The facility policy for Quality of Care notes the facility will ensure that a resident who enters the facility without limited range of motion or mobility difficulties does not experience reduction in range of motion or mobility unless the resident's clinical condition demonstrates that a reduction in range of	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0688 SS = E	Continued from page 2 listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. On 4/29/26, at 3:23 p.m. physical therapist (PT)-A and therapy director (TD) assisted R20 to complete the full OT and PT FMP program exercises in the therapy room. R20 became visibly weak, shaky toward the end of the exercises. PT-A and TD both stated R20 had no decline since P20 was last seen by therapy. R53 R53's quarterly MDS dated 3/20/26, identified R53 had intact cognition and was dependent on staff for most ADLs, mobility and transfers. R53 had impaired range of motion (ROM) to both lower extremities and	F0688	Continued from page 2 motion or mobility is unavoidable. A resident with limited range of motion or mobility will receive appropriate treatment and services to increase range of motion and mobility and/or to prevent further decrease in range of motion or mobility. The policy was updated to include that this may be accomplished via services provided by therapy staff, nursing staff or both and may include formal therapy programs, AAROM/PROM, and scheduled exercise groups Education will be provided to all nursing, activity and therapy staff on the facility policy for Quality of Care and expectations for completion of AAROM/ROM and exercise classes by 6/8/26. Education will be provided to all nursing staff on completion of PROM and AAROM. Education will include an explanation of benefits of PROM/AAROM and competency of performing PROM/AAROM for dependent residents by 6/5/26. Additionally, education will include importance of facilitating attendance and encouraging all residents who are able to attend and participate in group exercise classes offered at the facility. Participation at exercise group will be tracked on the activity acceptance checklist for each resident participating. Participation will be reported monthly in QAPI for the next 3 months. Audits for AAROM/PROM program and exercise group participation/documentation will be completed by Director of Nursing or designee at a rate of 3x/wk for 2 weeks, 2x/wk for 2 weeks and 1x/wk for 2 weeks and as needed afterwards and will begin on 6/10/26. Audits will be completed via chart review to ensure completed and/or offered per care plan along with appropriate documentation. Results of audits will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

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F0688 SS = E	Continued from page 3 was unable to ambulate. Diagnoses included paraplegia (paralysis lower half of body), spondylosis (degenerative spinal condition) and chronic pain. R53's care plan revised 3/16/26, identified R53 had decreased physical mobility with potentials for falls due to low back pain with bilateral sciatica, spinal stenosis, weakness and limited functional ROM. Staff were directed to assist R53 with mobility, transfers and repositioning. R53 was to participate in FMP per her plan of care. R53's undated Physician Orders report identified an order for FMP dated 9/4/25, with an open-ended end date. R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. On 4/29/26, at 4:02 p.m. R53 was seated in her room watching television. TD entered the room and received permission to assist R53 with her exercises. TD completed all exercises from the PT and OT FMP program. R53 was smiling and cooperative throughout the exercises. After completion of the exercises, TD stated she did not find a decline in R53's function since she was last seen by therapy. R53 stated she was unsure how often staff assisted	F0688		06/12/2026

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F0688 SS = E	Continued from page 4 her with her exercises or when they were last done. R53 stated she wished it were more often. R40 R40's quarterly MDS dated 2/4/26, identified R40 had moderately impaired cognition and was independent with ADLs. R40 had full ROM of extremities and was able to ambulate independently. Diagnoses included dementia, traumatic subdural hemorrhage, repeated falls, dizziness and giddiness, disorder of the autonomic nervous system, and osteoarthritis of the knees. R40's undated Physician Orders report identified an order for PT and OT FMP one time per day with start date 12/5/25 and open-ended end date. R40's care plan revised 3/16/26, identified decreased physical mobility with potential for falls due to dementia, poor coordination and balance, history of falls, and poor sequencings skills. Staff were directed to provide limited assistance with transfer and ambulation and OT and PT FMP per plan of care. R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights.	F0688		06/12/2026

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F0688 SS = E	Continued from page 5 The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was non-ambulatory. A diagnosis of dementia was included. R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's care plan revised 3/16/26, identified falls and alteration in skin related to poor coordination/balance, pain, dementia with cognitive losses and poor sequencing skills manifested by inability to transfer, always wheel self, always turn and reposition self, sit up, lie down or get feet and legs into bed independently. Unable to ambulate. Occupational therapy (OT) and physical therapy (PT) functional maintenance program as ordered. R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R14 frequently refused to do restorative exercises, however, the documentation did not reflect R14 had refused or had been offered. R66 R66's MDS dated 3/3/26, identified R66 was cognitively intact and required substantial/maximal assistance with upper body dressing and personal hygiene, partial/moderate assistance with eating,	F0688		06/12/2026

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F0688 SS = E	Continued from page 6 and was dependent on staff for all other care areas. Diagnoses included dementia, anxiety and diabetes. R66's care plan revised 3/16/26, identified decreased physical mobility with potential for falls and alterations in skin r/t Diabetes, Dementia, Alzheimer's disease, Heart failure, poor balance at times and poor sequencing skills manifested by need for staff assist with mobility needs at times. R66 was to participate in a functional maintenance program as ordered by therapy. R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R66 frequently refused to do restorative exercises, however, the documentation did not reflect R66 had refused or had been offered. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assist with bed mobility and transfers and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's medical record contained the following information on the restorative program: R32's provider orders dated 11/19/25, identified Functional Maintenance Plan (FMP) was ordered with special instruction for walking program as part of FMP. R32's progress noted dated 11/19/25, identified R32 was discharged from PT services on 11/7/25. PT	F0688		06/12/2026

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F0688 SS = E	Continued from page 7 FMP in place with walking program apart of her FMP. Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H stated they were only able to provide FMP services to R32 twice and that did not include ambulation services. The nursing assistants on the floor would be responsible for ambulation. During an interview on 4/29/26 at 9:49 a.m., TD stated the restorative aide would provide the exercise services and nursing and NAs provided ambulation services on the floor. R32's program for the exercises #1-6 (above) would be completed by the restorative aide and #7 would be completed by NAs on the floor. During an interview on 4/29/26 at 10:39 a.m., a trained medication aide (TMA)-C stated there was a list of residents who required ambulation and would be updated regularly by the nurse manager. If there were concerns on ability of the resident to continue walking, then we would let the nurse manager know	F0688		06/12/2026

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F0688 SS = E	Continued from page 8 and she would have ordered a screening from therapy to see if changes needed to be made with the program. I think there was a screening done for R32 that stated she was not to ambulate. During a follow up interview on 4/29/26 at 10:47 a.m., the TD stated when a request came in it would be charted and documented in their system. R36 had never received a request to rescreen her regarding ambulation. This was also verified by the physical therapist (PT)-A. During interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:07 p.m., the director of nursing (DON) stated when residents were started on an FMP the restorative aide would work on the range of motion aspect of the plan and the NA's on the unit would do the ambulation portion of the plan. R36 should have received the ordered FMP to maintain their level of function related to activities of daily living. During interview on 4/29/26, at 4:30 p.m. TD stated therapy completed the functional maintenance program form to initiate restorative nursing exercises when they discharged a resident from therapy. Therapy did not oversee the program. If a resident was not being seen or refusing restorative services, they would report to the charge nurse, and the charge nurse would notify therapy, if they needed to be re-evaluated. TD thought nursing oversaw the restorative program. When interviewed on 4/29/26, at 5:36 p.m. the interim DON stated she did not know if the previous restorative aide had documented her work correctly, but the facility did pull the restorative aide from time to time to work on the floor assisting with resident care. The facility had two restorative aides who each worked two days per week, and one worked every	F0688		06/12/2026

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F0688 SS = E	Continued from page 9 other weekend and the other, one weekend a month, for resident restorative program. The facility policy Quality of Care reviewed 10/2023, identified the facility would ensure a resident with limited range of motion or mobility would receive appropriate treatment and services to increase range of motion and mobility and/or prevent further decrease in range of motion or mobility. The facility policy Restorative Care dated 7/19/21, identified it was the intent of the restorative program to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The resident would be assessed by physical therapy and recommendations for restorative care therapy were submitted on the restorative therapy form. A nursing assistant trained to perform restorative care therapy would complete 15 minutes daily with the resident. Time would be documented by the therapy aide. The restorative care lead nurse would maintain documentation of residents who received restorative care and would make progress notes on therapy, minutes of therapy provided and plan review.	F0688		06/12/2026
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F0725	Failure to have sufficient staffing to carry out care planned interventions has the potential to affect all residents residing at the facility. R20, R53, R40, R14, R66 and R32 will have had their maintenance therapy programs reviewed, and revised if indicated by 6/5/26. An internal review of facility needs was completed by key leadership staff on 5/22/26 and included a review of staffing levels. The facility staffing structure was changed to no longer include specific daily rehab aid services. ROM programs will be conducted by staff CNA's under the direction of charge nurses and included as part of daily cares for residents who are assessed as having a need. This service will be conducted 1-2/week and on either day or evening shift as scheduled by the overseeing RN. The facility policy for Quality of Care notes the facility will ensure that a resident who enters the facility without limited range of motion or mobility difficulties does not experience reduction in range of motion or mobility unless the resident's clinical condition demonstrates that a reduction in range of motion or mobility is unavoidable. A resident with limited range of motion or mobility will receive appropriate treatment and services to increase range of motion and mobility and/or to	06/12/2026

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F0725 SS = E	Continued from page 10 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and document review, the facility failed to provide sufficient staffing to provide exercise services for the restorative nursing program for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: See also F688: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. R20: R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle	F0725	Continued from page 10 prevent further decrease in range of motion or mobility. The policy was updated to include that this may be accomplished via services provided by therapy staff, nursing staff or both and may include formal therapy programs, AAROM/PROM, and scheduled exercise groups Education will be provided to all nursing, activity and therapy staff on the facility policy for Quality of Care and expectations for completion of AAROM/ROM and exercise classes by 6/5/26. Education will be provided to all nursing staff on completion of PROM and AAROM. Education will include an explanation of benefits of PROM/AAROM and competency of performing PROM/AAROM for dependent residents. Additionally, education will include importance of facilitating attendance and encouraging all residents who are able to attend and participate in group exercise classes offered at the facility. Audits for AAROM/PROM program and exercise group participation/documentation will be completed by Director of Nursing or designee at a rate of 3x/wk for 2 weeks, 2x/wk for 2 weeks and 1x/wk for 2 weeks and as needed afterwards and will begin on 6/10/26. Audits will be completed via chart review to ensure completed and/or offered per care plan along with appropriate documentation. Results of audits will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

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F0725 SS = E	Continued from page 11 weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. R53: R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. R40 R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions	F0725		06/12/2026

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F0725 SS = E	Continued from page 12 using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. R66 R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with	F0725		06/12/2026

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F0725 SS = E	Continued from page 13 movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed. R32: R32's Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed. The restorative program documentation was reviewed and identified the following: 1/19/26-1/25/16, 6 of 39 residents received services. 1/26/26-2/1/26, 0 of 38 residents received services. 2/2/26-2/8/26, 25 of 39 residents received services. 2/9/26-2/15/26, 9 of 40 residents received services. 2/16/26-2/22/26, 28 of 38 residents received services. 2/23/26-3/1/26, 6 of 39 residents received services.	F0725		06/12/2026

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F0725 SS = E	Continued from page 14 3/2/26-3/8/26, 2 of 38 residents received services. 3/9/36-3/15/26, 0 of 38 residents received services. 3/16/26-3/22/26, 0 of 37 residents received services. 3/23/26-3/29/26, 1 of 37 residents received services. 3/30/26-4/5/26, 3 of 40 residents received services. 4/6/26-4/12/26, 0 of 40 residents received services. 4/13/26-4/19/26, 27 of 40 residents received services. 4/20/26-4/26/26, 26 of 41 residents received services. 4/27/26-5/3/26, 30 of 38 residents received services. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H, who was a restorative aide, stated initially she was going to be just doing functional maintenance programs for the residents today (4/28/26) but was only able to work until about noon. She was then instructed to stop working on the FMP's and was pulled to the floor to work as a NA. NA-H stated being pulled to the floor happened a lot. There was another NA who would help with FMPs, but they also called to work as an NA on the floor. When NA-H is working as the restorative aide she reviewed the lists of residents and decide which ones could be done on that day. NA-H can't get through the list and there are residents who do not get the FMP services. Most of the residents on an FMP had not received services on a regular basis or not even at all. Most of the residents were not receiving their ordered FMP due to having to be pulled to the floor all the time and only working a couple of days a week. During a follow up interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had	F0725		06/12/2026

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F0725 SS = E	Continued from page 15 been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:04 p.m. the director of nursing (DON) stated there are two aides who worked the restorative nursing program and they are both part time. For about 6 months the facility only had one part-time restorative aide. The restorative aides would start with the FMPs right away when they get to the facility, but they are frequently called out to floor to work as a NA. This is because of call-ins or short staffing on the floor. She stated it was not acceptable to be pulling the restorative aides to the floor all the time, because they have close to fifty residents to assist and are unable to get to all of them in a week and the residents go without their FMP. A staffing policy was not obtained.	F0725		06/12/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure staff served meals	F0812	Failure to serve food on Walnut Grove in a manner that maintains sanitary and safe consumption has the potential to affect all residents residing on that unit. On 4/28/26, DA-A placed a hairnet when it was identified that it was missing immediately rectifying the noncompliance. A review of resident complaints indicate no concerns with food being served in a sanitary manner. The facility policy for Employee Sanitary Practices was reviewed on 5/19/26 and is up to date with current expectations and best practices. Education will be provided to all dietary staff by 6/1/26 with a review of the policy and expectations for compliance with hairnet use when serving food and/or in areas where food is prepared. Education will be completed verbally and/or in writing with signature indicating receipt of education and understanding. Audits for hairnet use will begin on 6/1/26 and will include direct observation of food service and/or prep to ensure proper hairnet use. Audits will be conducted by the Dietary Manager or designee across both day and PM shift at a rate of 20/week for 2 weeks, 10/week for 2 weeks and 5/week for 2 weeks. Results of audits will be brought to QAPI for review and determination of ongoing auditing needs.	06/12/2026

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F0812 SS = E	Continued from page 16 while securing their hair with a hair covering on1 of 2 units Walnut Unit) . This had the potential to affect all 23 residents who ate meals on the Walnut Unit. Findings include: According to section 2-402.11 of the Food and Drug Administration (FDA) Food code dated 2017: “A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair." This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps. During an observation on 4/28/26 at 12:06 p.m., dietary aide (DA)-A was serving meals from the Walnut Grove kitchenette. DA-A leaned over the steam table food containers while setting up the individual resident plates for the noon meal. DA-A was not wearing a hairnet. At 12:15 p.m., DA-A left the kitchenette to deliver food to a resident and then began to clean off tables where residents had finished. During an interview on 4/28/26 at 12:20 p.m., DA-A stated hairnets were required whenever in the kitchen and/or while serving food. DA-A touched her head and stated “I don’t have one on? Oh no, I thought I had one on.” DA-A left the Walnut Grove kitchenette and went into the main kitchen. When DA-A returned a moment later, DA-A was wearing a hair net. During an interview on 4/29/26 at 3:17 p.m., the dietary manager (DM)-A stated staff should always wear a hairnet, especially while serving food to ensure hair does not get into the food to prevent illness and for palatability. The facility policy Employee Sanitary Practices dated 2019, identified all food and nutrition services employees will practice good personal hygiene and safe food handling procedures. All employees will: wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food	F0812		06/12/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F0585	Failure to follow the facility procedure for missing items has the potential to affect all residents residing at the facility. On 4/19/26 R14’s missing item was located and returned to the resident. To identify other missing items for which the facility	06/12/2026

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F0585 SS = D	Continued from page 17 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal	F0585	Continued from page 17 policy was not followed, an interview of all current residents and/or representatives will be conducted by the social worker or designee between the dates of 5/25/26 and 5/29/26. Reports of missing items in the last 3 months not having a corresponding missing item report will have proper documentation and follow up completed. The facility Missing Items Report was reviewed and was not revised. Education for all staff will occur by 6/5/26 with an explanation of expectations for follow up on reports of missing items. This includes completion of a missing item form, determination of potential theft and actions to take if theft is suspected or reported, and notification to the social worker for additional follow up. Audits for compliance will be completed by the social worker or designee starting 6/10/26. Audits will be conducted via chart review for notes on missing items and random interviews with staff and residents to assess for proper procedure being followed including filling out a form. Missing item forms identified in audits will be completed by social worker or designee and follow up per facility policy will begin immediately. Ongoing education will be completed if/when it is noted the facility policy was not followed. Progress note review and random interviews with residents and staff will be completed at a rate of 5x/week for a period of 2 weeks, 3x/week for a period of 2 weeks, and weekly for a period of 2 weeks. Results of audits will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

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F0585 SS = D	Continued from page 18 agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a report of missing personal property was followed up on for 1 of 3 residents (R14) reviewed for resident rights. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment. Diagnoses included dementia, edema, restlessness and agitation. R14 required set up/clean up assistance with eating, maximal/substantial assistance with dressing, bathing and personal hygiene and was dependent on staff with toileting and putting on and taking off	F0585		06/12/2026

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F0585 SS = D	Continued from page 19 footwear. During an interview on 4/28/26 at 6:09 p.m., family member (FM)-A stated R14's wedding ring went missing a "few months" ago. FM-A reported the missing wedding ring to the nursing assistants, the cart nurses, registered nurse (RN)-A who was the unit manager and the previous director of nursing (DON) who was no longer at the facility. FM-A stated she was simply told no staff had seen the ring. After the wedding ring was missing for a week, FM-A reported the missing ring to the police. FM-A had received no further information about the missing ring. FM-A stated she was concerned a staff member had taken the ring and the facility was not investigating the concern. During an interview on 4/29/26 at 3:22 p.m., trained medication aide (TMA)-B stated she had heard "something" about R14 was missing a wedding ring a "few months" prior but really didn't recall anything else about it. During an interview on 4/29/26 at 3:22 p.m., RN-A stated she didn't recall anyone reporting R14 had a missing wedding ring. During an interview on 4/29/26 at 3:25 p.m., RN-C stated she was unaware of R14's missing wedding ring. Any missing item should be documented in a progress note, and it should be documented on the report sheet in the binder at the desk. The report sheet was kept in the binder for two weeks and then the report sheets were filed away by the director of nursing (DON). Then, an investigation would be done to try to find the missing item: laundry, housekeeping and nursing staff would be told to look for the item and be aware that it was missing. R14's medical record failed to identify R14 was missing a wedding ring. R14's Missing Item form was requested but not received. During an interview on 4/29/26 at 3:27 p.m., the social services (SS)-A stated she was unaware R14 was missing a wedding ring and there was no missing item report completed. During an interview on 4/29/26 at 3:28 p.m., licensed practical nurse (LPN)-A stated she didn't know anything about R14 missing a wedding ring. When a resident was admitted, staff really encouraged family to swap out any expensive or meaningful jewelry like a wedding for another ring,	F0585		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

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F0585 SS = D	Continued from page 20 so the resident was still able to wear a ring but the likelihood of getting lost was not there. Staff report to social services and then an investigation was done to look in the room etc. During an interview on 4/29/26 at 3:31 p.m., the DON stated she was unaware R14 was missing a wedding ring. Staff were expected to complete a missing item report and, if possible, the resident was interviewed to determine when the item was last seen. Laundry, housekeeping, activities and nursing staff were informed to look for the item, and, on certain items, a police report may be filed. The DON stated she honestly did not know if a report had been filed for R14's missing ring because she was unaware it was missing. At 5:25 p.m., the DON stated R14's wedding ring had been found. It was found in laundry back in December 2025 and kept in the safe until 4/29/26 when the SA began asking about it. Staff did not complete a missing item report. The DON stated she expected staff to follow the procedure for a missing item and to report the concern to ensure all were aware of the missing item. If staff had been aware of R14's missing wedding ring, they would have known who the found wedding ring belonged to and R14 would have gotten it back sooner. The facility. The facility Missing Items Report revised 11/18/18, included information for staff to collect and identified the following: the resident's name, date, description of item(s) missing, date/time last seen, date/time noticed missing, thinks misplaced details, thinks taken and, if so, by whom, who it was reported to and who reported the missing item(s). Staff were instructed to complete the form immediately and give the report to the unit manager. The unit manager would search probably places immediately and list the employee(s) assigned to search. If the item was not found, family would be contacted. If the family was unaware of the item(s) location, the item was to be treated as a misappropriated item and reported to law enforcement and the state agency (SA).	F0585		06/12/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	Failure to timely update care plans with relevant goals and interventions has the potential to affect all residents residing at the facility. All care plans for those receiving EBP and ROM or exercise services, including R20 and R32 will be reviewed, and, if needed, updated to include resident specific interventions and goals by 6/5/26. On 5/19/26 a policy was developed specific to care plan revision to include updates to the care plan	06/12/2026

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F0657 SS = D	Continued from page 21 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include ordered functional maintenance program (FMP) with goals and interventions for 2 of 6 residents (R20, R32) who received exercises, in addition, the facility include enhanced barrier precautions (EBP) including measurable goals and interventions for 1 of 6 residents (R66) whose care plans were reviewed for EBP. Findings include: R20: R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, anxiety, weakness and history of hand and hip fractures. R20's undated Physician Orders report identified an order for physical therapy FMP with a start date	F0657	Continued from page 21 with changes in services being provided and safety needs. Education on the new policy will be provided to all nursing staff by 6/5/26 and will include policy review and include an emphasis on expectations for care plan updates with changes in services and/or EBP. Director of Nursing or designee will audit for timely care plan updates for changes services being provided and EBP needs 5x/week for a period of 6 weeks beginning on 6/10/26. Failure to update care plans with relevant changes will result in re-education to nurse responsible. Following initial 6 weeks of audits, results will be reviewed in QAPI for ongoing auditing needs.	06/12/2026

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F0657 SS = D	Continued from page 22 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. R20's care plan dated 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP), with goals and staff interventions. During interview on 4/29/26, at 5:36 p.m. the director of nursing (DON) stated if a resident was being seen by the restorative aide for the FMP, that should be addressed in their plan of care. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assistance with bed mobility and transfers	F0657		06/12/2026

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F0657 SS = D	Continued from page 23 and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's undated Physicians Orders report identified an order for a FMP with walking as part of the FMP with a start dated of 11/19/25, with no end date identified. R32's Restorative Care Program dated 11/7/25, identified R32 was discharged from PT and was to start a FMP to maintain lower extremity strength and range of motion to decrease the burden of care with transfers and ambulation. The FMP identified the resident was to do each exercise 15 times. The exercises included: Seated chair march Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out) Hip adduction with a ball. (squeezing your knees together with a ball between them) Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it) Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart) Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's care plan with the last review date of 3/13/26, identified R32 had decreased physical mobility with potential for falls due to recent left knee replacement. Staff were directed to assist R32 to turn and reposition, pivot transfer and to assist with	F0657		06/12/2026

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F0657 SS = D	Continued from page 24 sit up and lay down in bed and get leg and feet in and out of bed. R32's care plan lacked any documentation related to a FMP with goals and interventions. During an interview on 4/29/26, registered nurse (RN)-B stated when a resident was started on an FMP the care plan for the resident should be updated. R32's care plan lacked any documentation of an FMP. During an interview on 4/29/26 at 4:07 p.m., the DON stated the FMP for a resident was ordered by PT and should be placed on the resident's care plan. R32's FMP lacked any documentation related to an FMP or ambulation. R66: R66's quarterly MDS dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastrostomy tube (g-Tube), tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should wear with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C stated R66 was at risk for infection because of her g-tube and staff wore PPE including a gown and gloves during direct patient cares. During interview on 4/29/26 at 5:26 p.m., DON stated staff were instructed to wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility policy Quality of Care dated 10/2023, identified the facility would strive to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. A policy for resident care plan was not received.	F0657		06/12/2026

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F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely cares to dependent residents for 2 of 7 residents (R14, R18) who's activities of daily living cares were observed. Findings include: R14: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was dependent on staff for toileting. R14 diagnoses included dementia, edema, restlessness and agitation. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 8/21/25, identified the CAA was triggered due to R14's needing extensive assistance with toileting and frequent incontinence of urine. Staff offer to assist R14 to the restroom or to use his urinal every 2-3 hours and as needed. R14 was at risk for alterations in skin, offensive body odor, falls and bladder infections. Complicated by history of falls, dementia, R14's care plan revised 4/29/26, identified R14 had an alteration in elimination related to dementia with cognitive losses, receiving diuretic, poor sequencing skills, history of retention of urine and constipation manifested by need for staff assistance with toileting, R14 was incontinent of bladder and bowel. Staff will check brief for incontinence q 2-3 hours and as needed, change brief as needed with incontinence. Provide total assistance of 1 staff to change brief. May require 2 staff to change brief at times. Provide total assistance of 1-2 staff to pull up/down pants and provide peri rectal care after elimination. A continuous observation of R14 was completed on 4/29/26 starting at 8:04 a.m., through 11:10 a.m. At 8:04 a.m. R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was	F0677	Failure to provide ADLs for residents who are unable to do so themselves places all residents with impaired ADL abilities at risk for unmet needs. R14 was provided incontinence cares on 4/29/26 at around 1100. R18 was assisted with shaving on 4/29/26. An audit was completed to identify all residents with assistance with toileting and shaving tasks identifying 45 residents requiring toileting assistance and 20 residents requiring shaving assistance. Care plans of those residents identified as having ADL assistance needs will be reviewed by 6/5/26 to ensure inclusion of those needs. The policy for Quality of Care was reviewed on 5/20/26 and is up to date with no changes being made. Procedural changes for direct care staff include expectations to document last toileting on rounding sheets kept at nurses station. Education for nursing staff will be completed by 6/5/26 and include explanation for expectations of toileting and ADL assistance, benefits to the resident and importance of adhering to care planned interventions. Audits for compliance with toileting schedules and shaving will be conducted by the Director of Nursing or designee at a rate of 21/week for 2 weeks, 14/week for 2 weeks and 7/week for 2 weeks beginning on 6/10/26. Noncompliance with toileting schedules or shaving will be corrected in the moment by competing the task and re-education by auditor. Results of audits will be brought to QAPI for review and determination of ongoing auditing needs.	06/12/2026

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F0677 SS = D	Continued from page 26 dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. [It was unknown what time R14 was placed in the wheelchair] At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat. At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered toileting. At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on.	F0677		06/12/2026

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F0677 SS = D	Continued from page 27 At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually toileted R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while. R14 was not offered nor placed on the commode to attempt to void. At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously toileted that morning and would have to ask the nursing assistants. RN-C stated R14 was due to a bowel movement that morning and had received a laxative. When the laxative "kicked in", staff would place R14 on the commode. However, when R14 was already incontinent staff laid him down and provided incontinence care. R14 was not placed on the commode every time he was toileted because staff did not want to cause R14 agitation. At 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last toileted. TMA-B stated she was told R14 had been assisted with morning cares by the night shift staff and had toileted before	F0677		06/12/2026

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F0677 SS = D	Continued from page 28 day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's toileting so staff really had "no idea". R14 should have been toileted at 9:00 a.m. at the latest because R14 was care planned to be toileted every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of toileting times differently. TMA-B used her care sheet and wrote down the times and whether the resident was incontinent or had voided. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last toileting time and staff just kept a mental note when they resident was due again. Yea, some staff did write it down on the care sheet but "to each his own I guess". NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated toileting times were given during shift report. For R14, staff should offer toileting every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been toileted that morning. R14 had been incontinent around midnight the night before and R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done, she did it as observed. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be toileted between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be toileted every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation on how staff tracked toileting times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged toileting times which could lead to prolonged exposure to moisture and skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been toileted before 9:00 a.m. or earlier. During an interview on 4/29/26 at 3:31 p.m., the	F0677		06/12/2026

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F0677 SS = D	Continued from page 29 director of nursing (DON) stated R14 should have been toileted immediately after breakfast or within his care planned timeframe to prevent incontinence/skin breakdown and to lessen R14's behaviors/agitation. Additionally, staff should always offer R14 to sit on the commode even when R14 was incontinent as care planned. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. R18: R18's five-day MDS dated 3/3/26, identified R18 had severe cognitive impairment and required maximum to total assistance with activities of daily living (ADLs). Diagnoses included dementia, kidney disease, cerebral infarction (stroke), anxiety and diabetes. R18's care plan dated 3/31/26, identified R18 had a self-care deficit with a goal to remain clean and free of odor daily. Staff were directed to comb R18's hair, brush his teeth and shave him. R18's Resident Care Sheet dated 4/22/26, directed staff in bold and capitalized text to shave daily, family request. During observation on 4/27/26, at 11:17 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 had 1/4-inch grey whiskers scattered over his chin, cheeks, neck and below his nose. R18 was unable to recall if he had shaven that day. During observation on 4/28/26, at 10:38 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 continued to have grey whiskers scattered over his face and neck and remained unshaven. During observation on 4/29/26, at 8:59 a.m. R18 was seated in his wheelchair in the hallway. R18's was clean shaven.	F0677		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

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F0677 SS = D	Continued from page 30 When interviewed on 4/29/26, at 9:00 a.m. LPN-B stated she was not sure why the aides would not have shaved R18 on 4/27/26, or 4/28/26, but he was shaved today. There were different nursing assistants on then there were the other two days. R18 was supposed to be shaved every day. When interviewed on 4/29/26, at 9:53 a.m. RN-B stated R18 should be shaven daily. RN-B was not sure why R18 was not shaved the other two days. RN-B was aware R18's shaver battery was very low when he was shaved that morning, so perhaps that was the reason, but the goal was to shave him every day. R18 could have refused, however the point of care documentation did not indicate R18 refused care. During interview on 4/29/26, at 9:54 a.m. NA-B stated she was not sure why R18 was not shaved the previous two days, but he was shaven now. R18 was supposed to be shaven every day. Some of the younger NA's just did not notice or didn't know better. R18 never refused assistance with cares and always allowed them to assist hiem to shave daily without any problems. During interview on 4/29/26, at 4:36 p.m. the DON stated she would have expected staff to shave R18 as care planned or document why it could not be completed. The facility Quality of Care Policy reviewed 10/2023, identified based on the comprehensive assessment of a resident the facility strove to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with State and Federal Regulations.	F0677		06/12/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F0686	Failure to provide services that would prevent the development of pressure ulcers and skin breakdown places all residents who are dependent on staff for repositioning at risk. On 4/29/29 at around 1100, R14 was assisted with repositioning. An audit was completed between the dates of 5/21/26 and 5/22/26 to identify all residents who	06/12/2026

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F0686 SS = D	Continued from page 31 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents received timely repositioning for 1 of 3 residents (R14) reviewed for pressure ulcers. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment was dependent on staff for repositioning. Diagnoses included dementia, edema, restlessness and agitation. R14's Braden Scale (prediction for pressure ulcer scale) dated 2/13/26, identified R14 was a moderate risk for pressure injury/ulcer. R14's care plan revised 4/29/26, included an intervention to provide assist of one staff to turn and reposition every 2-3 hours. A continuous observation was conducted on 4/29/26 at starting at 8:04 a.m., R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. It was unknown when R14 was seated in his wheelchair. At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat. At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered repositioning.	F0686	Continued from page 31 are dependent on staff for proper offloading and repositioning to prevent the development of facility acquired pressure ulcers and skin breakdown. This audit identified 45 residents who require assistance with completing this task. Care plans for those residents identified in the audit will be reviewed by 6/5/26 to ensure inclusion of those needs and interventions to be carried out to meet goals of minimizing risk for pressure ulcer/skin breakdown development. The policy for Skin Care Management was reviewed on 5/20/26 and is up to date with no changes being made. Procedural changes for direct care staff include expectations to document last turn/repo on rounding sheets at the nurses station. Education for nursing staff will be completed by 6/5/26 and include explanation for expectations of adherence to turning/repositioning schedules and benefits to the resident. Audits for compliance with turning/repositioning will be conducted by the Director of Nursing or designee at a rate of 21/week for 2 weeks, 14/week for 2 weeks and 7/week for 2 weeks beginning on 6/10/26. Noncompliance with turning/repositioning will be corrected in the moment by completing the task and re-education by auditor. Results of audits will be brought to QAPI for review and determination of ongoing auditing needs.	06/12/2026

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F0686 SS = D	Continued from page 32 At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. Staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. RN-C did not offer to reposition R14. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on. At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually repositioned R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while.	F0686		06/12/2026

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F0686 SS = D	Continued from page 33 At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. R14's skin was pink, dry and intact. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously repositioned that morning and would have to ask the nursing assistants. During an interview on 4/29/26 at 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last repositioned. TMA-B was told R14 was assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's repositioning so staff really had "no idea". R14 should have been repositioned at 9:00 a.m. at the latest because R14 was care planned to be repositioned every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of repositioning times differently. TMA-B used her care sheet and wrote down the times. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last repositioning time and staff just kept a mental note when they resident was due again. Some staff wrote it down, but not everyone. NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated repositioning times were given during shift report. For R14, staff should offer repositioning every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been repositioned that morning. R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be repositioned between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A	F0686		06/12/2026

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F0686 SS = D	Continued from page 34 stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be repositioned every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation of how staff tracked times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged repositioning times which could lead to skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been repositioned before 9:00 a.m. or earlier. That is a large time span and, because it wasn't kept track of, staff don't know. During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been repositioned immediately after breakfast or within his care planned timeframe to prevent skin breakdown and to lessen R14's behaviors/agitation. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. The facility policy Skin Care reviewed 6/2023, identified staff would ensure proper identification of residents at risk for skin breakdown, prevention of development of pressure ulcers, and determining appropriate treatment of pressure ulcers and/or impaired skin for residents. Care plans will be individualized to address resident specific needs.	F0686		06/12/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F0755	Failure to clarify medication orders has the potential to affect residents receiving orders with unclear instructions. On 4/28/26, the stop date for R12's enoxaparin was clarified by facility RN with PCP via phone and verified entered stop date was correct. An audit of all enoxaparin orders going back 45 days was completed between the dates of 5/22/26 to ensure all orders had correctly entered stop dates with no other similar instances being identified. The policy for Pharmacy Services was reviewed on 5/20/26 with no changes being made. All licensed nurses will be re-educated on expectations for clarification on orders with unclear directions or stop dates. Education will be completed by 6/5/26. Audits will be conducted beginning 6/10/26 at a rate of 5x/week by the Director of Nursing or designee for 6 weeks and will be completed via	06/12/2026

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F0755 SS = D	Continued from page 35 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a stop date for medication was confirmed by the primary care provider for temporary medications that required an end date for 1 of 6 residents (R12) reviewed for medication management. Findings include:R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition. R12 received injectable medication for all seven days of the observation period and received anticoagulant medication. A complete drug regimen review was completed, and no potentially clinically significant medication issues were noted. Diagnoses included diabetes, fracture of the right femur, altered mental status, calculus of the kidney, hydronephrosis and metabolic encephalopathy. R12's Interagency Transfer Orders dated 4/15/26, identified an order for enoxaparin (a blood thinner) 40 milligram (mg) syringe, inject 0.4 millimeters (ml) under the skin every night to prevent deep vein thrombosis for diagnosis of total right hip arthroplasty. The quantity listed 13.6 ml with no refills. R12's Medication Administration Record (MAR) for April 2026, identified enoxaparin syringe 40 mg/0.4 ml: subcutaneous (SQ) at bedtime for fracture of right femur. Start/End date 4/15/26 to 5/18/26. Special Instructions were listed as RX for 13.6 ml/ 0.4 ml per dose=34 doses total. The medication was recorded as administered as ordered starting 4/15/26. When interviewed on 4/28/26, at 4:13 p.m. licensed practical nurse (LPN)-C stated the pharmacy had	F0755	Continued from page 35 chart review for new enoxaparin orders to ensure stop dates were obtained on the original order and/or communication to clarify occurred. Any missed opportunity for clarification will be noted by DON and re-education will occur verbally. Results of audits will be reviewed in QAPI to determine ongoing auditing needs.	06/12/2026

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F0755 SS = D	Continued from page 36 filled the enoxaparin in 40 mg / 0.4 ml prefilled single use syringes. Nursing staff administered the one prefilled syringe every evening. LPN-A was unsure what the special instructions on P12's MAR meant. During interview on 4/28/26, at 4:36 p.m. registered nurse (RN)-B stated the special instructions were to demonstrate how the end date of the medication was determined. The medication was filled for 13.6 ml quantity with no refills, so she did the math, versus contacting the medical provider, to determine 34 doses were ordered and figured out the end date from there. RN-B stated she had not contacted R12's primary care provider to verify the stop date of the medication and no verbal order had been obtained to stop the medication. During telephone interview on 4/29/26, at 9:06 a.m. the consulting pharmacist (CP)-D stated if a medication required an end date, either the pharmacist would call the provider to obtain it or nursing would do it. The quantity of medication with no refills could mean that the med should be stopped when ran out of medication, but not always. CP-D thought she would probably just check with the provider to make sure. It was better to double check with the provider rather than just assume. When interviewed on 4/29/26, at 4:27 p.m. the director of nursing (DON) stated usually medication orders such as enoxaparin had a stop date, especially when discharging from the hospital. She would expect staff to reach out to the provider to notify of the need for an end date to the enoxaparin and verification the dose was completed when the medication was gone. No refills on a medication did not always mean to discontinue the medication and needed to be verified by the primary care provider. The facility policy Pharmacy Services dated 10/2022, identified prescription medications were dispensed only upon receipt of clear, complete, and signed orders of a person lawfully authorized to prescribe. Any dose or order that appeared inappropriate, considering the resident's age, allergies, diagnosis or current medication regimen would be verified with the prescriber.	F0755		06/12/2026
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides-	F0805	Failure to provide food in forms that meet the residents needs places residents who reside at the facility at risk for poor nutritional intake and/or other complications in relation to food consumption. On 5/8/26 R12 was assessed by ST and diet was changed to regular textures/consistency with thin liquids. Order was updated in medical record to	06/12/2026

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F0805 SS = D	Continued from page 37 §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was prepared and served to meet resident needs for 1 of 2 residents (R12) reviewed for nutrition. Findings include: R12's Speech Therapy Daily Note dated 3/16/25, recommended general precautions to include resident seated at 90 degrees for all oral intake, one to one assist to follow safe swallow strategies of small bites/sips, slow rate, alternate bites/sips and only feed resident when she is alert. R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition and required set up assistance with eating. R12's care plan dated 4/27/26, identified a potential for alteration in nutrition with a goal to maintain independence with eating after set up. Staff were directed to assist to setup meals as needed. R12 should be sitting upright as close to 90 degrees as possible when eating in bed. Staff were to encourage R12 to sit up in wheelchair with eating. R12's Physician Orders with print date 4/29/26, identified a dietary order 4/15/26, for a heart healthy/cardiac diet. Special instructions included to cut food into small bite size pieces, resident to sit at 90 degrees for all intake, slow rate of intake, small bites/sips, alternate bites/sips, assist of one and to only feed when alert. R12's Dietary Menu card,Tuesday dinner dated 4/28/26, identified a heart healthy diet and to cut P12's food into bite sized pieces. During observation on 4/28/26, at 12:19 p.m. R12 was in bed in her room, watching television and eating her lunch. R12's lunch tray was on her bedside table over her bed and R12 was in a semi upright position in bed, with the head of the bed raised to an approximately 75-degree angle. R12's lunch consisted of a half of a submarine sandwich on a white hoagie roll with lunch meat and cheese. Three large pieces of lettuce and a large slice of tomato was also on the plate. R12 had the half-consumed sandwich in her hand and was taking	F0805	Continued from page 37 reflect upgraded diet d/t improving condition. By 6/5/26 all resident diet orders will be audited to ensure accuracy. Any discrepancy found will be rectified in cooperation with PCP and ST. The policy for Diet Orders was reviewed and remains accurate. Licensed nurses and dietary staff will receive education on the policy and procedural expectations for verification of diet consistencies and textures prior to serving. This will be completed by 6/5/26 via verbal instruction. Audits will be completed by the assistant administrator or designee beginning 6/10/26 at a rate of 21/week for a period of 2 weeks, followed by 14/week for a period of 2 weeks, and then 7/week for a period of 2 weeks and an emphasis will be placed on modifications (such as cut into bite size pieces) being followed through and served appropriately in conjunction with the diet order.	06/12/2026

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F0805 SS = D	Continued from page 38 bites from it. No one was in the room with R12 as she ate. During interview on 4/28/26, at 12:28 p.m. trained medical assistant (TMA)-A entered R12's room and stated R12 was not positioned at a 90-degree angle as ordered and TMA-A stated she was not aware R12 had orders for her food to be cut into bite size pieces. TMA-A knew R12 had eaten a full sweet roll the day prior that had not been cut up for her. R12 should be seated at a 90-degree angle and food cut up in bite size pieces if that was what was ordered, as it would have been ordered to assist R12 to eat safely and prevent choking. TMA-A thought the order stemmed from when R12 had been more acutely ill and less alert. When interviewed on 4/28/26, at 12:33 a.m. nursing assistant (NA)-A stated the nurse aide care plan did identify R12's food was to be cut into bite size pieces but did not direct staff to ensure R12 was at a 90-degree angle to eat. NA-A stated R12's head of bed was elevated but was not fully at a 90-degree angle. NA-A stated usually the dietary staff was responsible to make sure resident food was cut up as ordered but if it wasn't, then the NA's should be doing it, kind of like a second check. During interview on 4/28/26, at 12:44 p.m. dietary aide (DA)-A stated dietary staff were supposed to cut up resident food when it was ordered, but if it wasn't, then the NA's should do it. DA-A felt sure she had cut up R12's sandwich into bite size pieces and thought maybe the NA"s had given her the wrong tray instead, but she could not be entirely sure of that. DA-A stated R12's dietary slip identified her food needed to be cut up in small bite size pieces. During interview on 4/28/26, at 12:52 p.m. registered nurse (RN)-B stated it was not an official order to keep R12's diet as small bite size pieces and to be seated at a 90-degree angle when eating. RN-A left those special instructions on her chart as an additional note and R12's family had requested that as well. RN-A felt it was important to keep the special instructions listed when R12 had returned from the hospital on 4/15/26, but now R12's diet may need to be re-evaluated as she has improved since her return. The facility policy Diet Orders dated 2/2025, identified all meals provided to residents would have a written physician order. No further information was received.	F0805		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2026

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F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	Failure to properly implement proper infection prevention and control procedures has the potential to impact all residents who reside in the facility. R25 and R66 both continue to have indwelling devise that require the use of EBP during all high contact activities with caregivers. The current facility policy for EBP was reviewed on 5/20/26 and includes when EBP is indicated and was not revised Education for all staff covering expectations of compliance with EBP for residents with indwelling devices including wearing gowns and gloves when high contact direct care is being provided will be completed by 6/5/26. Beginning on 6/10/26 the Director of Nursing or designee will audit high contact activities with staff 21/week for a period of 2 weeks, followed by 14/week for a period of 2 weeks, and then 7/week for a period of 2 weeks with an emphasis on those residents with indwelling medical devices. If at such time staff observation results in inadequate EBP practice, DON or designee will provide real time feedback and education to specific staff member. Results of all EBP audits will be reported to the QAPI for determination of ongoing auditing needs.	06/12/2026

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F0880 SS = D	Continued from page 40 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) according to CDC guidelines during direct cares for 2 of 4 residents (R25, R66) reviewed who were on enhanced barrier precautions. Findings include: R25 R25's annual Minimum Data Set (MDS) dated 2/11/26, identified R25 had an indwelling Foley catheter and was dependent on staff for activities of daily living (ADL's) including catheter care. R25's had a diagnosis of renal insufficiency. R25's care plan dated 3/6/25, identified R25 was at risk for infection due to his indwelling catheter and staff were to wear PPE, including gown and gloves, when caring for R25. On 4/27/26 at 1:45 p.m., nursing assistant (NA)-C exited R25's bathroom wearing gloves and was holding a urine collection graduate. NA-C bent down next to R25 and drained urine from the catheter drainage bag into the graduate. NA-C stood, walked into the bathroom and emptied the urine into the toilet. NA-C failed to wear a gown during catheter	F0880		06/12/2026

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F0880 SS = D	Continued from page 41 cares. During interview, NA-C stated when he emptied a resident's catheter, he always wore gloves and if there was a risk of infection then he would also wear a gown. NA-C stated he had worn gloves but not a gown when he emptied R25's catheter. NA-C stated there was a risk of splashing urine onto his clothes and potentially spreading bacteria to another resident. NA-C stated he should have worn a gown with R25's catheter cares. R66 R66's quarterly Minimum Data Set (MDS) dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastric tube, tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should where with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C was at R66's bedside and administering medication through the resident's gastrostomy tube (G-tube). Nursing assistant (NA)-D entered the room, put on a pair of gloves and walked to the resident's bedside. RN-C and NA-D were on either side of the bed. RN-C was wearing a gown and gloves. NA-D was wearing gloves, however, was not wearing a gown. R66's bed was thigh-height, and the resident was lying in bed with a lift sheet behind her hips and back, and her legs were resting on pillows behind her calves. RN-C and NA-D leaned over the bed and used the lift sheet to scoot the resident up towards the top of the bed. RN-C and NA-D walked to the foot of the bed and lifted and repositioned the pillows behind R66's lower legs. NA-D walked into the bathroom, removed her gloves, washed her hands and then exited the room. RN-C stated R66 was at risk for infection because of her g-tube and NA-D should have worn a gown and gloves while assisting with direct care. During interview on 4/29/26 at 10:35 a.m., NA-D stated she usually wears a gown when caring for residents with any type of tubes including g-tubes, although forgot to put on a gown when she repositioned R66. NA-D stated wearing a gown was important to prevent bringing in and spreading bacteria to R66, as well as to help prevent spreading bacteria to/from other residents. During interview on 4/29/26 at 5:26 p.m., director of	F0880		06/12/2026

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F0880 SS = D	Continued from page 42 nursing (DON) stated staff should wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility Enhanced Barrier Precautions policy dated 3/26, 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 organism (MDRO)’s to staff hands and clothing. MDRO’s may indirectly be transferred from resident to resident during high contact care activities. Resident 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.	F0880		06/12/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/27/26 through 4/29/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed H53971679C (2698495), H53971680C (2664268), H53971678C	20000		06/12/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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20000	Continued from page 1 (2990355) H53971681C (2562021) and H53977660C (2792289) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		06/12/2026
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven	20570	Corrected	06/12/2026

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20570	Continued from page 2 days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include ordered functional maintenance program (FMP) with goals and interventions for 2 of 6 residents (R20, R32) who received exercises, in addition, the facility include enhanced barrier precautions (EBP) including measurable goals and interventions for 1 of 6 residents (R66) whose care plans were reviewed for EBP. Findings include: R20: R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, anxiety, weakness and history of hand and hip fractures. R20's undated Physician Orders report identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated.	20570		06/12/2026

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20570	Continued from page 3 R20's care plan dated 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP), with goals and staff interventions. During interview on 4/29/26, at 5:36 p.m. the director of nursing (DON) stated if a resident was being seen by the restorative aide for the FMP, that should be addressed in their plan of care. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assistance with bed mobility and transfers and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's undated Physicians Orders report identified an order for a FMP with walking as part of the FMP with a start dated of 11/19/25, with no end date identified. R32's Restorative Care Program dated 11/7/25, identified R32 was discharged from PT and was to start a FMP to maintain lower extremity strength and range of motion to decrease the burden of care with transfers and ambulation. The FMP identified the resident was to do each exercise 15 times. The exercises included: Seated chair march Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out) Hip adduction with a ball. (squeezing your knees together with a ball between them) Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it) Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart) Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait	20570		06/12/2026

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20570	Continued from page 4 belt (a belt to place around a resident to assist with standing and balance). R32's care plan with the last review date of 3/13/26, identified R32 had decreased physical mobility with potential for falls due to recent left knee replacement. Staff were directed to assist R32 to turn and reposition, pivot transfer and to assist with sit up and lay down in bed and get leg and feet in and out of bed. R32's care plan lacked any documentation related to a FMP with goals and interventions. During an interview on 4/29/26, registered nurse (RN)-B stated when a resident was started on an FMP the care plan for the resident should be updated. R32's care plan lacked any documentation of an FMP. During an interview on 4/29/26 at 4:07 p.m., the DON stated the FMP for a resident was ordered by PT and should be placed on the resident's care plan. R32's FMP lacked any documentation related to an FMP or ambulation. R66: R66's quarterly MDS dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastrostomy tube (g-Tube), tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should wear with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C stated R66 was at risk for infection because of her g-tube and staff wore PPE including a gown and gloves during direct patient cares. During interview on 4/29/26 at 5:26 p.m., DON stated staff were instructed to wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility policy Quality of Care dated 10/2023, identified the facility would strive to ensure residents received treatment and care in accordance with professional standards of practice, their	20570		06/12/2026

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20570	Continued from page 5 comprehensive care plan and their personal preferences. A policy for resident care plan was not received. SUGGESTED METHOD OF CORRECTION: The DON could review policies on the care plan process and assessments and ensure it aligns with requirements, make changes where needed, educate staff on the process, audit charts and ensure resident care plans are updated to reflect care and services received and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		06/12/2026
20800	Nursing Personnel; Staffing requirements CFR(s): MN Rule 4658.0510 Subp. 1 Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and document review, the facility failed to provide sufficient staffing to provide exercise services for the restorative nursing program for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: See also 20890: Rehab - Range of Motion: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. R20: R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in	20800	Corrected	06/12/2026

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20800	Continued from page 6 self-care and functional tasks of choice. The restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. R53: R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had	20800		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

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20800	Continued from page 7 received restorative exercises five times and refused one time during the 15-week time period. R40 R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's Restorative Program log dated 1/19/26	20800		06/12/2026

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20800	Continued from page 8 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. R66 R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15 repetitions, and Encourage R66 to assist with movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed. R32: R32's Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand, and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed.	20800		06/12/2026

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20800	Continued from page 9 The restorative program documentation was reviewed and identified the following: 1/19/26-1/25/16, 6 of 39 residents received services. 1/26/26-2/1/26, 0 of 38 residents received services. 2/2/26-2/8/26, 25 of 39 residents received services. 2/9/26-2/15/26, 9 of 40 residents received services. 2/16/26-2/22/26, 28 of 38 residents received services. 2/23/26-3/1/26, 6 of 39 residents received services. 3/2/26-3/8/26, 2 of 38 residents received services. 3/9/36-3/15/26, 0 of 38 residents received services. 3/16/26-3/22/26, 0 of 37 residents received services. 3/23/26-3/29/26, 1 of 37 residents received services. 3/30/26-4/5/26, 3 of 40 residents received services. 4/6/26-4/12/26, 0 of 40 residents received services. 4/13/26-4/19/26, 27 of 40 residents received services. 4/20/26-4/26/26, 26 of 41 residents received services. 4/27/26-5/3/26, 30 of 38 residents received services. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H, who was a restorative aide, stated initially she was going to be just doing functional maintenance programs for the residents today (4/28/26) but was only able to work until about noon. She was then instructed to stop working on the FMP's and was pulled to the floor to work as a NA. NA-H stated being pulled to the floor happened a lot. There was another NA who would help with FMPs, but they also called to work as an NA on the floor. When NA-H is working as the restorative aide she reviewed the lists of residents and decide which ones could be done on that day. NA-H can't get through the list and there are residents who do not get the FMP services. Most of the residents on an FMP had not received services	20800		06/12/2026

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20800	Continued from page 10 on a regular basis or not even at all. Most of the residents were not receiving their ordered FMP due to having to be pulled to the floor all the time and only working a couple of days a week. During a follow up interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return. NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:04 p.m. the director of nursing (DON) stated there are two aides who worked the restorative nursing program and they are both part time. For about 6 months the facility only had one part-time restorative aide. The restorative aides would start with the FMPs right away when they get to the facility, but they are frequently called out to floor to work as a NA. This is because of call-ins or short staffing on the floor. She stated it was not acceptable to be pulling the restorative aides to the floor all the time, because they have close to fifty residents to assist and are unable to get to all of them in a week and the residents go without their FMP. A staffing policy was not obtained.	20800		06/12/2026
20850	Adequate and Proper Nursing Care; Shaving CFR(s): MN Rule 4658.0520 Subp. 2 D Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely cares to	20850	Corrected	06/12/2026

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20850	Continued from page 11 dependent residents for 2 of 7 residents (R14, R18) who's activities of daily living cares were observed. Findings include: R14: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was dependent on staff for toileting. R14 diagnoses included dementia, edema, restlessness and agitation. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 8/21/25, identified the CAA was triggered due to R14's needing extensive assistance with toileting and frequent incontinence of urine. Staff offer to assist R14 to the restroom or to use his urinal every 2-3 hours and as needed. R14 was at risk for alterations in skin, offensive body odor, falls and bladder infections. Complicated by history of falls, dementia, R14's care plan revised 4/29/26, identified R14 had an alteration in elimination related to dementia with cognitive losses, receiving diuretic, poor sequencing skills, history of retention of urine and constipation manifested by need for staff assistance with toileting, R14 was incontinent of bladder and bowel. Staff will check brief for incontinence q 2-3 hours and as needed, change brief as needed with incontinence. Provide total assistance of 1 staff to change brief. May require 2 staff to change brief at times. Provide total assistance of 1-2 staff to pull up/down pants and provide peri rectal care after elimination. A continuous observation of R14 was completed on 4/29/26 starting at 8:04 a.m., through 11:10 a.m. At 8:04 a.m. R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. [It was unknown what time R14 was placed in the wheelchair] At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat.	20850		06/12/2026

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20850	Continued from page 12 At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered toileting. At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on. At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually toileted R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the	20850		06/12/2026

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20850	Continued from page 13 full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while. R14 was not offered nor placed on the commode to attempt to void. At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously toileted that morning and would have to ask the nursing assistants. RN-C stated R14 was due to a bowel movement that morning and had received a laxative. When the laxative "kicked in", staff would place R14 on the commode. However, when R14 was already incontinent staff laid him down and provided incontinence care. R14 was not placed on the commode every time he was toileted because staff did not want to cause R14 agitation. At 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last toileted. TMA-B stated she was told R14 had been assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's toileting so staff really had "no idea". R14 should have been toileted at 9:00 a.m. at the latest because R14 was care planned to be toileted every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of toileting times differently. TMA-B used her care sheet and wrote down the times and whether the resident was incontinent or had voided. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last toileting time and staff just kept a mental note when they resident was due again. Yea, some staff did write it down on the care sheet but "to each his own I guess". NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated toileting times were given during shift report. For R14, staff should offer toileting every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C	20850		06/12/2026

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20850	Continued from page 14 stated she did speak with the nursing assistants to determine when R14 had been toileted that morning. R14 had been incontinent around midnight the night before and R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done, she did it as observed. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be toileted between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be toileted every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation on how staff tracked toileting times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged toileting times which could lead to prolonged exposure to moisture and skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been toileted before 9:00 a.m. or earlier. During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been toileted immediately after breakfast or within his care planned timeframe to prevent incontinence/skin breakdown and to lessen R14's behaviors/agitation. Additionally, staff should always offer R14 to sit on the commode even when R14 was incontinent as care planned. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. R18: R18's five-day MDS dated 3/3/26, identified R18 had severe cognitive impairment and required maximum to total assistance with activities of daily living (ADLs). Diagnoses included dementia, kidney disease, cerebral infarction (stroke), anxiety and diabetes. R18's care plan dated 3/31/26, identified R18 had a self-care deficit with a goal to remain clean and free of odor daily. Staff were directed to comb R18's hair, brush his teeth and shave him. R18's Resident Care Sheet dated 4/22/26, directed staff in bold and capitalized text to shave daily, family request. During observation on 4/27/26, at 11:17 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 had 1/4-inch grey whiskers scattered over his chin,	20850		06/12/2026

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20850	Continued from page 15 cheeks, neck and below his nose. R18 was unable to recall if he had shaven that day. During observation on 4/28/26, at 10:38 a.m. R18 was seated in his wheelchair in the Walnut Grove wing's television room. R18 continued to have grey whiskers scattered over his face and neck and remained unshaven. During observation on 4/29/26, at 8:59 a.m. R18 was seated in his wheelchair in the hallway. R18's was clean shaven. When interviewed on 4/29/26, at 9:00 a.m. LPN-B stated she was not sure why the aides would not have shaved R18 on 4/27/26, or 4/28/26, but he was shaved today. There were different nursing assistants on then there were the other two days. R18 was supposed to be shaved every day. When interviewed on 4/29/26, at 9:53 a.m. RN-B stated R18 should be shaven daily. RN-B was not sure why R18 was not shaved the other two days. RN-B was aware R18's shaver battery was very low when he was shaved that morning, so perhaps that was the reason, but the goal was to shave him every day. R18 could have refused, however the point of care documentation did not indicate R18 refused care. During interview on 4/29/26, at 9:54 a.m. NA-B stated she was not sure why R18 was not shaved the previous two days, but he was shaven now. R18 was supposed to be shaven every day. Some of the younger NA's just did not notice or didn't know better. R18 never refused assistance with cares and always allowed them to assist hiem to shave daily without any problems. During interview on 4/29/26, at 4:36 p.m. the DON stated she would have expected staff to shave R18 as care planned or document why it could not be completed. The facility Quality of Care Policy reviewed 10/2023, identified based on the comprehensive assessment of a resident the facility strove to ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive care plan and their personal preferences. The facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with State and Federal Regulations. SUGGESTED METHOD OF CORRECTION: The DON could review policies on resident dependent care and toileting and ensure it aligns with requirements, make changes where needed. Educate staff on the process, ensure staff are providing care to residents as care planned, audit charts and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20850		06/12/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20890	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2 A Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide exercise programs as ordered for 6 of 6 residents (R14, R20, R32, R40, R53, R66) reviewed for restorative exercise program. This had the potential to affect all 38 residents who had exercise programs. Findings include: R20 R20's annual Minimum Data Set (MDS) dated 2/18/26, identified R20 had severe cognitive impairment and required moderate assistance with activities of daily living (ADLs), R20 was unable to ambulate. Diagnoses included osteoporosis, Alzheimer's disease, weakness and history of hand and hip fractures. R20's care plan reviewed 3/16/26, identified R20 had decreased physical mobility with a potential for falls due to a left hip fracture. Staff were directed to assist R20 to turn and reposition and transfer to her wheelchair. R20's care plan lacked documentation of a functional maintenance program (FMP). R20's undated Physician Orders identified an order for physical therapy FMP with a start date 10/1/25, and the end date was open ended. An order for physical and occupational therapy FMP was also listed with start date 9/26/25 with an open-ended end date. R20's Restorative Care Program identified the following: 9/19/25, identified R20 was discharged from occupational therapy (OT) and was to have a restorative program to maintain her upper extremity strength and range of motion of participation in self-care and functional tasks of choice. The	20890	Corrected	06/12/2026

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20890	Continued from page 17 restorative aide was directed to completed ten repetitions of shoulder flex, chest press and side to side with a two-pound weight, ten repetitions of elbow flexion and extension with a red TheraBand and ten repetitions of pro/supination with a yellow TheraBand. 10/1/25, identified R20 was discharged from physical therapy (PT) and was to have a restorative program to maintain lower extremity strength and range of motion for continued level of ambulation and transfers to decrease burden of care. The restorative aide was directed to complete 15 repetitions of marching, lower ankle and hip abduction, and leg curl with a two-pound ankle weight and ball squeezes and ball press. R20 was also to stand with her four wheeled walker for two, one-minute sets or as long as R20 tolerated. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R20 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R20 had received restorative exercises one time and refused three times during the 15-week time period. On 4/29/26, at 3:23 p.m. physical therapist (PT)-A and therapy director (TD) assisted R20 to complete the full OT and PT FMP program exercises in the therapy room. R20 became visibly weak, shaky toward the end of the exercises. PT-A and TD both stated R20 had no decline since P20 was last seen by therapy. R53 R53's quarterly MDS dated 3/20/26, identified R53 had intact cognition and was dependent on staff for most ADLs, mobility and transfers. R53 had impaired range of motion (ROM) to both lower extremities and was unable to ambulate. Diagnoses included paraplegia (paralysis lower half of body), spondylosis (degenerative spinal condition) and chronic pain. R53's care plan revised 3/16/26, identified R53 had decreased physical mobility with potentials for falls due to low back pain with bilateral sciatica, spinal stenosis, weakness and limited functional ROM. Staff were directed to assist R53 with mobility, transfers and repositioning. R53 was to participate in FMP per her plan of care. R53's undated Physician Orders report identified an order for FMP dated 9/4/25, with an open-ended end date.	20890		06/12/2026

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20890	Continued from page 18 R53's Restorative Care Program identified the following: 9/4/25, identified R53 was discharged from OT, and an FMP program was setup with goals to maintain both upper extremity ROM in order to complete self-cares. The restorative aide was directed to perform active and passive ROM to all upper extremity wrist, shoulder, elbow planes as well as digit extension. 12/9/25, identified R53 was discharged from PT, and an FMP program was setup with goals to maintain lower extremity ROM, to prevent further contractures. The restorative aide was directed to complete passive ROM to R53's hips, knees and ankles in all planes. The restorative aide was also to assist R53 with two thirty second sets of hamstring and heel cord stretch. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R53 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R53 had received restorative exercises five times and refused one time during the 15-week time period. On 4/29/26, at 4:02 p.m. R53 was seated in her room watching television. TD entered the room and received permission to assist R53 with her exercises. TD completed all exercises from the PT and OT FMP program. R53 was smiling and cooperative throughout the exercises. After completion of the exercises, TD stated she did not find a decline in R53's function since she was last seen by therapy. R53 stated she was unsure how often staff assisted her with her exercises or when they were last done. R53 stated she wished it were more often. R40 R40's quarterly MDS dated 2/4/26, identified R40 had moderately impaired cognition and was independent with ADLs. R40 had full ROM of extremities and was able to ambulate independently. Diagnoses included dementia, traumatic subdural hemorrhage, repeated falls, dizziness and giddiness, disorder of the autonomic nervous system, and osteoarthritis of the knees. R40's undated Physician Orders report identified an order for PT and OT FMP one time per day with start date 12/5/25 and open-ended end date.	20890		06/12/2026

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20890	Continued from page 19 R40's care plan revised 3/16/26, identified decreased physical mobility with potential for falls due to dementia, poor coordination and balance, history of falls, and poor sequencings skills. Staff were directed to provide limited assistance with transfer and ambulation and OT and PT FMP per plan of care. R40's Restorative Care Program identified the following: 12/3/25, identified R40 was discharged from OT, and an FMP program was setup with goals to maintain upper extremity strength and ROM in order to participate self-cares. The restorative aide was directed to perform upper extremity exercises for three minutes, use a two pound therapy bar for 15 repetitions for shoulder flexion, chest press, shoulder circumduction forward and backward, The restorative aide was to assist with elbow extensions using the green TheraBand for 15 repetitions two times as well as using the red flex bar for 10 repetitions of pronation, supination and wrist flexion and extensions. 12/9/25, identified R40 discharged from PT and an FMP program was setup with goals to maintain lower extremity strength and ROM to assist staff during her ADL's. The restorative aide was directed to assist R40 with seated exercises with ball presses, knee flexes, ankle pumps, hip abductions and adductions with small therapy ball and hip flexions. R40 was to stand with a four wheeled walker and march twenty times with two-pound ankle weights. The Restorative Program logs dated 1/19/26 through 4/29/26, identified R40 in the list of residents who were to receive exercise one to two times per week. Next to each resident name was columns for each day of the week. The logs documented R40 had not received restorative exercises at all and refused three times during the 15-week period. R14 R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment and was non-ambulatory. A diagnosis of dementia was included. R14's Restorative Care Program dated 12/15/23, directed to maintain lower extremity range of motion/strength to assist staff during activities of daily living. Approaches/recommendations included: NuStep level 5, seat 9, arms at 8 for 5 minutes	20890		06/12/2026

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20890	Continued from page 20 Seated exercises with 3-pound ankle weights for 15 repetitions. Left knee flex with geriatric Thera-band, Hip abduction with geriatric Thera-band, Hip adduction with small yellow t-ball, Ball presses and standing with front wheeled walker. Marching 20 times with contact guard assist R14's care plan revised 3/16/26, identified falls and alteration in skin related to poor coordination/balance, pain, dementia with cognitive losses and poor sequencing skills manifested by inability to transfer, always wheel self, always turn and reposition self, sit up, lie down or get feet and legs into bed independently. Unable to ambulate. Occupational therapy (OT) and physical therapy (PT) functional maintenance program as ordered. R14's Restorative Program log dated 1/19/26 through 4/29/26, identified R14 had 105 opportunities to receive restorative exercises. R14 received the exercises 3 times and refused 3 times during the period reviewed. During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R14 frequently refused to do restorative exercises, however, the documentation did not reflect R14 had refused or had been offered. R66 R66's MDS dated 3/3/26, identified R66 was cognitively intact and required substantial/maximal assistance with upper body dressing and personal hygiene, partial/moderate assistance with eating, and was dependent on staff for all other care areas. Diagnoses included dementia, anxiety and diabetes. R66's care plan revised 3/16/26, identified decreased physical mobility with potential for falls and alterations in skin r/t Diabetes, Dementia, Alzheimer's disease, Heart failure, poor balance at times and poor sequencing skills manifested by need for staff assist with mobility needs at times. R66 was to participate in a functional maintenance program as ordered by therapy. R66's Restorative Care Program dated 4/15/26, identified R66 was to maintain range of motion to decrease incidence of contractures and bedsores. Approach/recommendations included: Supine in bed: 2 sets of 15 repetitions of passive range of motion, SLR, hip abduction, hip flexion/extension, knee flexion/extension, ankle passive range of motion in all planes, hamstring stretch 2 x 15 repetitions, heel-cord strength 2 x 15	20890		06/12/2026

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20890	Continued from page 21 repetitions, and Encourage R66 to assist with movements if she is awake/alert. R66's Restorative Program log dated 4/15/26 through 4/29/26, identified there were 15 opportunities for R66 to receive the exercise. R66 received restorative exercises twice during the period reviewed During an interview on 4/28/26 at 1:26 p.m., nursing assistant (NA)-H, who is also the restorative aide, stated R66 frequently refused to do restorative exercises, however, the documentation did not reflect R66 had refused or had been offered. R32: R32's quarterly MDS dated 3/13/26, identified R32 was cognitively intact. R32 was substantial to maximal assist with bed mobility and transfers and did not walk. R32's had a diagnosis of joint replacement of left knee. R32's medical record contained the following information on the restorative program: R32's provider orders dated 11/19/25, identified Functional Maintenance Plan (FMP) was ordered with special instruction for walking program as part of FMP. R32's progress noted dated 11/19/25, identified R32 was discharged from PT services on 11/7/25. PT FMP in place with walking program apart of her FMP. Restorative Care Program dated 11/7/25, identified R32 was placed on the program to maintain lower extremity (legs) strength and range of motion to decrease burden of care with transfers and ambulation (walking). The program identified which exercises to complete to help maintain R32's level of function. The exercises include doing them 15 times in a row once: Seated chair march, Long Arc Quad (big muscle on the front of the leg) stretch (sitting in a chair and lifting your foot straight out), Hip adduction with a ball. (squeezing your knees together with a ball between them), Hamstring (main muscle on back of leg) curls (the restorative aide would hold R32 up with a green TheraBand and would have to pull against it), Hip abduction with a green TheraBand (placing the band around both knees and spreading your knees apart), Hamstring and heel cord stretch (with leg straight out you would pull your toes back towards your body) and With a physical therapist, assist R32 to stand,	20890		06/12/2026

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20890	Continued from page 22 and they may ambulate up to 100 feet or up to R32 tolerance using the front wheel walker and a gait belt (a belt to place around a resident to assist with standing and balance). R32's Restorative Program documentation identified from 1/29/26 through 4/26/26, R32 only received FMP exercises twice and did not include any ambulation services during period of time reviewed. During an interview on 4/28/26 at 12:26 p.m., nursing assistant (NA)-H stated they were only able to provide FMP services to R32 twice and that did not include ambulation services. The nursing assistants on the floor would be responsible for ambulation. During an interview on 4/29/26 at 9:49 a.m., TD stated the restorative aide would provide the exercise services and nursing and NAs provided ambulation services on the floor. R32's program for the exercises #1-6 (above) would be completed by the restorative aide and #7 would be completed by NAs on the floor. During an interview on 4/29/26 at 10:39 a.m., a trained medication aide (TMA)-C stated there was a list of residents who required ambulation and would be updated regularly by the nurse manager. If there were concerns on ability of the resident to continue walking, then we would let the nurse manager know and she would have ordered a screening from therapy to see if changes needed to be made with the program. I think there was a screening done for R32 that stated she was not to ambulate. During a follow up interview on 4/29/26 at 10:47 a.m., the TD stated when a request came in it would be charted and documented in their system. R36 had never received a request to rescreen her regarding ambulation. This was also verified by the physical therapist (PT)-A. During interview on 4/29/26, at 2:30 p.m. NA-H stated she had only been back working in the facility for the last two weeks and had been off for six months prior to that. NA-H stated she mainly worked restorative nursing but was pulled to the floor a lot to help with resident care due to short staffing and/or call ins. NA-H tried to document on the restorative logs when she was pulled off restorative to help on the floor. NA-H did not know if the nursing assistant who covered while she was gone was pulled off the restorative program as the aide had not documented, but few exercises had been documented in the logbook, prior to her return.	20890		06/12/2026

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20890	Continued from page 23 NA-H stated even if she was not pulled off to work on the floor, it would be very difficult to see every resident on the FMP program. During an interview on 4/29/26 at 4:07 p.m., the director of nursing (DON) stated when residents were started on an FMP the restorative aide would work on the range of motion aspect of the plan and the NA's on the unit would do the ambulation portion of the plan. R36 should have received the ordered FMP to maintain their level of function related to activities of daily living. During interview on 4/29/26, at 4:30 p.m. TD stated therapy completed the functional maintenance program form to initiate restorative nursing exercises when they discharged a resident from therapy. Therapy did not oversee the program. If a resident was not being seen or refusing restorative services, they would report to the charge nurse, and the charge nurse would notify therapy, if they needed to be re-evaluated. TD thought nursing oversaw the restorative program. When interviewed on 4/29/26, at 5:36 p.m. the DON stated she did not know if the previous restorative aide had documented her work correctly, but the facility did pull the restorative aide from time to time to work on the floor assisting with resident care. The facility had two restorative aides who each worked two days per week, and one worked every other weekend and the other, one weekend a month, for resident restorative program. The facility policy Quality of Care reviewed 10/2023, identified the facility would ensure a resident with limited range of motion or mobility would receive appropriate treatment and services to increase range of motion and mobility and/or prevent further decrease in range of motion or mobility. The facility policy Restorative Care dated 7/19/21, identified it was the intent of the restorative program to promote the residents ability to adapt and adjust to living as independently and safely as possible. The resident would be assessed by physical therapy and recommendations for restorative care therapy were submitted on the restorative therapy form. A nursing assistant trained to perform restorative care therapy would complete 15 minutes daily with the resident. Time would be documented by the therapy aide. The restorative care lead nurse would maintain documentation of residents who received restorative care and would make progress notes on therapy, minutes of therapy provided and plan review.	20890		06/12/2026

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20890	Continued from page 24 SUGGESTED METHOD OF CORRECTION: The DON)could review policies on restorative nursing and the functional maintenance program and ensure it aligns with requirements, make changes where needed. Educate staff on the process, ensure a restorative aide is assigned daily to assist residents with their ordered exercises, assign a staff member to supervise and manage the program, have therapy review each resident's program for appropriateness, audit charts and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20890		06/12/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents received timely repositioning for 1 of 3 residents (R14) reviewed for pressure ulcers. Findings include: R14’s quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment was dependent on staff for repositioning. Diagnoses included dementia, edema, restlessness and agitation. R14’s Braden Scale (prediction for pressure ulcer scale) dated 2/13/26, identified R14 was a moderate risk for pressure injury/ulcer. R14’s care plan revised 4/29/26, included an intervention to provide assist of one staff to turn	20900	Corrected	06/12/2026

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20900	Continued from page 25 and reposition every 2-3 hours. A continuous observation was conducted on 4/29/26 at starting at 8:04 a.m., R14 was seated in his wheelchair and was pedaling himself with his feet up and down the hallway in front of the nurses' station. R14 was dressed and groomed for the day. R14 stated he didn't know if he had eaten breakfast yet and pointed at the other residents in the dining room through the dining room doors. It was unknown when R14 was seated in his wheelchair. At 8:40 a.m., nursing assistant (NA)-E stepped out of the dining room and told NA-F R14 still needed to eat breakfast. NA-F approached R14 and asked R14 if he was ready to eat breakfast, R14 nodded yes and NA-F wheeled R14 to his table in the dining room where NA-E assisted R14 to eat. At 8:51 a.m., R14 finished with his meal and was wheeled to the hallway in front of the nurses' station. R14 was not offered repositioning. At 8:56 a.m., R14 began pulling himself down the hall using the handrail and his left hand while pedaling with his feet. Staff including the director of nursing walked past R14 but did not greet or approach R14. At 9:01 a.m., R14 pulled himself along the handrail until R14 was blocked by the medication cart. Registered nurse (RN)-C assisted R14 to his room where RN-C applied a topical pain medication to R14's knees. RN-C asked R14 if he wanted to lie down and rest before the noon meal. R14 replied yes and smiled. RN-C provided R14 with his call light, tv remote, his overbed table then turned on R14's call light. RN-C then requested staff to assist R14 to lie down over the walkie. RN-C told R14 "I'll go let someone know you're ready to lie down for a rest, ok?" and exited the room. RN-C did not offer to reposition R14. At 9:15 a.m., housekeeping was vacuuming the hallway carpet outside R14's room. R14 backed his wheelchair to the doorway and sat with this back to the hallway. At 9:32 a.m., RN-C walked past R14 sitting in his doorway and, again, asked for staff to lie R14 down over the walkie. A response was heard of the walkie that it would be a "few minutes". At 9:38 a.m., R14 wheeled himself to sit in front of his tv. R14's call light was still on.	20900		06/12/2026

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20900	Continued from page 26 At 9:41 a.m., activity aide (AA)-A entered R14's room and offered the sing-along activity for R14. AA-A wheeled R14 to the activity room. R14 was not offered toileting. AA-A did not turn off R14's call light. At 10:54 a.m., the sing-along activity was done and trained medication aide (TMA)-A obtained R14's blood pressure while he was seated in his wheelchair in the activity office. R13 approached TMA-A and asked if R14 was going to stay for exercises and that staff usually repositioned R14 before the noon meal. TMA-A stated she would talk to the nursing assistants and find out. At 11:02 a.m., TMA-A returned with R14's medications with RN-C. R14 was given his medications and RN-C wheeled R14 to his room. At 11:06 a.m., RN-A entered R14's room with the full body mechanical lift. RN-A and RN-C transferred R14 into his bed and told R14 he could rest for a while. At 11:10 a.m., trained medication aide (TMA)-B entered R14's room and RN-A exited. RN-C and TMA-B changed R14's incontinence brief which was saturated with urine and provided perineal care. R14's skin was pink, dry and intact. During an interview on 4/29/26 at 11:20 a.m., RN-C stated she did bring R14 to his room at 10:00 a.m. and asked for him to be toileted but R14 went to activities instead. RN-C nor TMA-B knew what time R14 had been previously repositioned that morning and would have to ask the nursing assistants. During an interview on 4/29/26 at 11:33 a.m., TMA-B stated she asked the nursing assistants when R14 was last repositioned. TMA-B was told R14 was assisted with morning cares by the night shift staff and had toileted before day shift started at 6:00 a.m. The night shift staff had not reported the time of R14's repositioning so staff really had "no idea". R14 should have been repositioned at 9:00 a.m. at the latest because R14 was care planned to be repositioned every 2-3 hours. "We try our best." TMA-B stated every staff person kept track of repositioning times differently. TMA-B used her care sheet and wrote down the times. Then, at the end of her shift she entered those times into the electronic system. However, TMA-B could not say what other staff did. During an interview on 4/29/26 at 2:48 p.m., NA-G stated the previous shift reported the residents' last	20900		06/12/2026

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20900	Continued from page 27 repositioning time and staff just kept a mental note when they resident was due again. Some staff wrote it down, but not everyone. NA-G was able to keep it in his mind and kept track that way. During an interview on 4/29/26 at 2:51 p.m., licensed practical nurse (LPN)-A stated repositioning times were given during shift report. For R14, staff should offer repositioning every hour. During an interview on 4/29/26 at 2:54 p.m., RN-C stated she did speak with the nursing assistants to determine when R14 had been repositioned that morning. R14's morning cares were completed between 4:00 a.m. and 6:00 a.m. RN-C stated she did ask staff to toilet R14 at 10:00 a.m. and when RN-C saw it had not been done. RN-C stated, if she had known R14 got up that morning between 4:00 a.m. and 6:00 a.m., RN-C would have expected R14 to be repositioned between 6:00 a.m. and 7:00 a.m. to prevent skin breakdown. During an interview on 4/29/26 at 2:58 p.m., RN-A stated she did hear RN-C ask for R14 to be assisted with toileting over the walkie that morning. R14 should be repositioned every 2-3 hours as care planned to prevent skin breakdown. RN-C stated there was no expectation of how staff tracked times. Some staff wrote times on their care sheet, but others did not. Not keeping track could lead to prolonged repositioning times which could lead to skin breakdown. If R14 was assisted with morning care between 4:00 a.m. and 6:00 a.m., R14 should have been repositioned before 9:00 a.m. or earlier. That is a large time span and, because it wasn't kept track of, staff don't know. During an interview on 4/29/26 at 3:31 p.m., the director of nursing (DON) stated R14 should have been repositioned immediately after breakfast or within his care planned timeframe to prevent skin breakdown and to lessen R14's behaviors/agitation. During an interview on 4/29/26 at 4:18 p.m., the assistant administrator stated staff were expected to follow the care plan as written and to document times and reapproach for refusals or resistance. The facility policy Skin Care reviewed 6/2023, identified staff would ensure proper identification of residents at risk for skin breakdown, prevention of development of pressure ulcers, and determining appropriate treatment of pressure ulcers and/or impaired skin for residents. Care plans will be individualized to address resident specific needs.	20900		06/12/2026

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20900	Continued from page 28 SUGGESTED METHOD OF CORRECTION: The DON or designeed could audit to ensure residents who are at risk/or have current pressure ulcers are implementing the interventions in place. The DON or designee could review and revise policies and educate staff on the requirements and then audit for compliance. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) days.	20900		06/12/2026
20945	Assistance with Eating - Nursing Personnel CFR(s): MN Rule 4658.0530 Subp. 1 Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was prepared and served to meet resident needs for 1 of 2 residents (R12) reviewed for nutrition. Findings include: R12's Speech Therapy Daily Note dated 3/16/25, recommended general precautions to include resident seated at 90 degrees for all oral intake, one to one assist to follow safe swallow strategies of small bites/sips, slow rate, alternate bites/sips and only feed resident when she is alert. R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition and required set up assistance with eating. R12's care plan dated 4/27/26, identified a potential for alteration in nutrition with a goal to maintain independence with eating after set up. Staff were directed to assist to setup meals as needed. R12	20945	Corrected	06/12/2026

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20945	Continued from page 29 should be sitting upright as close to 90 degrees as possible when eating in bed. Staff were to encourage R12 to sit up in wheelchair with eating. R12's Physician Orders with print date 4/29/26, identified a dietary order 4/15/26, for a heart healthy/cardiac diet. Special instructions included to cut food into small bite size pieces, resident to sit at 90 degrees for all intake, slow rate of intake, small bites/sips, alternate bites/sips, assist of one and to only feed when alert. R12's Dietary Menu card,Tuesday dinner dated 4/28/26, identified a heart healthy diet and to cut P12's food into bite sized pieces. During observation on 4/28/26, at 12:19 p.m. R12 was in bed in her room, watching television and eating her lunch. R12's lunch tray was on her bedside table over her bed and R12 was in a semi upright position in bed, with the head of the bed raised to an approximately 75-degree angle. R12's lunch consisted of a half of a submarine sandwich on a white hoagie roll with lunch meat and cheese. Three large pieces of lettuce and a large slice of tomato was also on the plate. R12 had the half-consumed sandwich in her hand and was taking bites from it. No one was in the room with R12 as she ate. During interview on 4/28/26, at 12:28 p.m. trained medical assistant (TMA)-A entered R12's room and stated R12 was not positioned at a 90-degree angle as ordered and TMA-A stated she was not aware R12 had orders for her food to be cut into bite size pieces. TMA-A knew R12 had eaten a full sweet roll the day prior that had not been cut up for her. R12 should be seated at a 90-degree angle and food cut up in bite size pieces if that was what was ordered, as it would have been ordered to assist R12 to eat safely and prevent choking. TMA-A thought the order stemmed from when R12 had been more acutely ill and less alert. When interviewed on 4/28/26, at 12:33 a.m. nursing assistant (NA)-A stated the nurse aide care plan did identify R12's food was to be cut into bite size pieces but did not direct staff to ensure R12 was at a 90-degree angle to eat. NA-A stated R12's head of bed was elevated but was not fully at a 90-degree angle. NA-A stated usually the dietary staff was responsible to make sure resident food was cut up as ordered but if it wasn't, then the NA's should be doing it, kind of like a second check. During interview on 4/28/26, at 12:44 p.m. dietary	20945		06/12/2026

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20945	Continued from page 30 aide (DA)-A stated dietary staff were supposed to cut up resident food when it was ordered, but if it wasn't, then the NA's should do it. DA-A felt sure she had cut up R12's sandwich into bite size pieces and thought maybe the NA"s had given her the wrong tray instead, but she could not be entirely sure of that. DA-A stated R12's dietary slip identified her food needed to be cut up in small bite size pieces. During interview on 4/28/26, at 12:52 p.m. registered nurse (RN)-B stated it was not an official order to keep R12's diet as small bite size pieces and to be seated at a 90-degree angle when eating. RN-A left those special instructions on her chart as an additional note and R12's family had requested that as well. RN-A felt it was important to keep the special instructions listed when R12 had returned from the hospital on 4/15/26, but now R12's diet may need to be re-evaluated as she has improved since her return. The facility policy Diet Orders dated 2/2025, identified all meals provided to residents would have a written physician order. No further information was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the dietician could review policies on resident diet orders and assistance provided residents to eat and ensure it aligns with requirements, make changes where needed. Educate staff on the process, ensure dietary is following diet orders for type and texture and ensure staff are assisting residents with meals as directed in each resident's plan of care, ensure residents have been assessed to meet their dietary needs and audit charts and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20945		06/12/2026
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21385	Corrected	06/12/2026

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21385	Continued from page 31 Based on observation, interview and document review the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) according to CDC guidelines during direct cares for 2 of 4 residents (R25, R66) reviewed who were on enhanced barrier precautions. Findings include: R25 R25's annual Minimum Data Set (MDS) dated 2/11/26, identified R25 had an indwelling Foley catheter and was dependent on staff for activities of daily living (ADL's) including catheter care. R25's had a diagnosis of renal insufficiency. R25's care plan dated 3/6/25, identified R25 was at risk for infection due to his indwelling catheter and staff were to wear PPE, including gown and gloves, when caring for R25. On 4/27/26 at 1:45 p.m., nursing assistant (NA)-C exited R25's bathroom wearing gloves and was holding a urine collection graduate. NA-C bent down next to R25 and drained urine from the catheter drainage bag into the graduate. NA-C stood, walked into the bathroom and emptied the urine into the toilet. NA-C failed to wear a gown during catheter cares. During interview, NA-C stated when he emptied a resident's catheter, he always wore gloves and if there was a risk of infection then he would also wear a gown. NA-C stated he had worn gloves but not a gown when he emptied R25's catheter. NA-C stated there was a risk of splashing urine onto his clothes and potentially spreading bacteria to another resident. NA-C stated he should have worn a gown with R25's catheter cares. R66 R66's quarterly Minimum Data Set (MDS) dated 3/3/26, identified R66 required extensive assistance from staff for all activities of daily living (ADL's) and diagnoses included colostomy, diabetes, and Alzheimer's disease. R66's care plan dated 8/27/21, identified R66 was at risk for alteration in nutrition due to gastric tube, tube feedings and not taking nutrition by mouth. The care plan did not address what PPE staff should where with cares. On 4/29/26 at 10:00 a.m., registered nurse (RN)-C was at R66's bedside and administering medication	21385		06/12/2026

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21385	Continued from page 32 through the resident's gastrostomy tube (G-tube). Nursing assistant (NA)-D entered the room, put on a pair of gloves and walked to the resident's bedside. RN-C and NA-D were on either side of the bed. RN-C was wearing a gown and gloves. NA-D was wearing gloves, however, was not wearing a gown. R66's bed was thigh-height, and the resident was lying in bed with a lift sheet behind her hips and back, and her legs were resting on pillows behind her calves. RN-C and NA-D leaned over the bed and used the lift sheet to scoot the resident up towards the top of the bed. RN-C and NA-D walked to the foot of the bed and lifted and repositioned the pillows behind R66's lower legs. NA-D walked into the bathroom, removed her gloves, washed her hands and then exited the room. RN-C stated R66 was at risk for infection because of her g-tube and NA-D should have worn a gown and gloves while assisting with direct care. During interview on 4/29/26 at 10:35 a.m., NA-D stated she usually wears a gown when caring for residents with any type of tubes including g-tubes, although forgot to put on a gown when she repositioned R66. NA-D stated wearing a gown was important to prevent bringing in and spreading bacteria to R66, as well as to help prevent spreading bacteria to/from other residents. During interview on 4/29/26 at 5:26 p.m., director of nursing (DON) stated staff should wear a gown and gloves when providing direct cares for a resident with indwelling tubes including catheters and tube feedings. Direct care included anytime staff touched the residents and included emptying a catheter and repositioning residents in bed. The facility Enhanced Barrier Precautions policy dated 3/26, 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 organism (MDRO)'s to staff hands and clothing. MDRO's may indirectly be transferred from resident to resident during high contact care activities. Resident 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. SUGGESTED METHOD OF CORRECTION: The DON, ICP, or designee could review facility	21385		06/12/2026

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21385	Continued from page 33 policies/procedures regarding isolation and or/enhanced barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take that findings to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		06/12/2026
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a stop date for medication was	21535	Corrected	06/12/2026

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21535	Continued from page 34 confirmed by the primary care provider for temporary medications that required an end date for 1 of 6 residents (R12) reviewed for medication management. Findings include:R12's five-day Minimum Data Set (MDS) dated 4/21/26, identified R12 had intact cognition. R12 received injectable medication for all seven days of the observation period and received anticoagulant medication. A complete drug regimen review was completed, and no potentially clinically significant medication issues were noted. Diagnoses included diabetes, fracture of the right femur, altered mental status, calculus of the kidney, hydronephrosis and metabolic encephalopathy. R12's Interagency Transfer Orders dated 4/15/26, identified an order for enoxaparin (a blood thinner) 40 milligram (mg) syringe, inject 0.4 millimeters (ml) under the skin every night to prevent deep vein thrombosis for diagnosis of total right hip arthroplasty. The quantity listed 13.6 ml with no refills. R12's Medication Administration Record (MAR) for April 2026, identified enoxaparin syringe 40 mg/0.4 ml: subcutaneous (SQ) at bedtime for fracture of right femur. Start/End date 4/15/26 to 5/18/26. Special Instructions were listed as RX for 13.6 ml/ 0.4 ml per dose=34 doses total. The medication was recorded as administered as ordered starting 4/15/26. When interviewed on 4/28/26, at 4:13 p.m. licensed practical nurse (LPN)-C stated the pharmacy had filled the enoxaparin in 40 mg / 0.4 ml prefilled single use syringes. Nursing staff administered the one prefilled syringe every evening. LPN-A was unsure what the special instructions on P12's MAR meant. During interview on 4/28/26, at 4:36 p.m. registered nurse (RN)-B stated the special instructions were to demonstrate how the end date of the medication was determined. The medication was filled for 13.6 ml quantity with no refills, so she did the math, versus contacting the medical provider, to determine 34 doses were ordered and figured out the end date from there. RN-B stated she had not contacted R12's primary care provider to verify the stop date of the medication and no verbal order had been obtained to stop the medication. During telephone interview on 4/29/26, at 9:06 a.m. the consulting pharmacist (CP)-D stated if a medication required an end date, either the	21535		06/12/2026

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21535	Continued from page 35 pharmacist would call the provider to obtain it or nursing would do it. The quantity of medication with no refills could mean that the med should be stopped when ran out of medication, but not always. CP-D thought she would probably just check with the provider to make sure. It was better to double check with the provider rather than just assume. When interviewed on 4/29/26, at 4:27 p.m. the director of nursing (DON) stated usually medication orders such as enoxaparin had a stop date, especially when discharging from the hospital. She would expect staff to reach out to the provider to notify of the need for an end date to the enoxaparin and verification the dose was completed when the medication was gone. No refills on a medication did not always mean to discontinue the medication and needed to be verified by the primary care provider. The facility policy Pharmacy Services dated 10/2022, identified prescription medications were dispensed only upon receipt of clear, complete, and signed orders of a person lawfully authorized to prescribe. Any dose or order that appeared inappropriate, considering the resident's age, allergies, diagnosis or current medication regimen would be verified with the prescriber. SUGGESTED METHOD OF CORRECTION: The DON in conjunction with the pharmacist or designee could review policies on medication orders and ensure it aligns with requirements, make changes where needed. Educate staff on the process, audit charts and ensure orders are verified and have end dates when needed and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		06/12/2026
21880	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 20 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman	21880	Corrected	06/12/2026

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21880	Continued from page 36 pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a report of missing personal property was followed up on for 1 of 3 residents (R14) reviewed for resident rights. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/17/26, identified R14 had severe cognitive impairment. Diagnoses included dementia, edema, restlessness and agitation. R14 required set up/clean up assistance with eating, maximal/substantial assistance with dressing, bathing and personal hygiene and was dependent on staff with toileting and putting on and taking off footwear. During an interview on 4/28/26 at 6:09 p.m., family member (FM)-A stated R14's wedding ring went missing a "few months" ago. FM-A reported the missing wedding ring to the nursing assistants, the cart nurses, registered nurse (RN)-A who was the unit manager and the previous director of nursing (DON) who was no longer at the facility. FM-A stated she was simply told no staff had seen the ring. After the wedding ring was missing for a week, FM-A reported the missing ring to the police. FM-A had received no further information about the missing	21880		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
21880	Continued from page 37 ring. FM-A stated she was concerned a staff member had taken the ring and the facility was not investigating the concern. During an interview on 4/29/26 at 3:22 p.m., trained medication aide (TMA)-B stated she had heard “something” about R14 was missing a wedding ring a “few months” prior but really didn’t recall anything else about it. During an interview on 4/29/26 at 3:22 p.m., RN-A stated she didn’t recall anyone reporting R14 had a missing wedding ring. During an interview on 4/29/26 at 3:25 p.m., RN-C stated she was unaware of R14’s missing wedding ring. Any missing item should be documented in a progress note, and it should be documented on the report sheet in the binder at the desk. The report sheet was kept in the binder for two weeks and then the report sheets were filed away by the director of nursing (DON). Then, an investigation would be done to try to find the missing item: laundry, housekeeping and nursing staff would be told to look for the item and be aware that it was missing. R14’s medical record failed to identify R14 was missing a wedding ring. R14’s Missing Item form was requested but not received. During an interview on 4/29/26 at 3:27 p.m., the social services (SS)-A stated she was unaware R14 was missing a wedding ring and there was no missing item report completed. During an interview on 4/29/26 at 3:28 p.m., licensed practical nurse (LPN)-A stated she didn't know anything about R14 missing a wedding ring. When a resident was admitted, staff really encouraged family to swap out any expensive or meaningful jewelry like a wedding for another ring, so the resident was still able to wear a ring but the likelihood of getting lost was not there. Staff report to social services and then an investigation was done to look in the room etc. During an interview on 4/29/26 at 3:31 p.m., the DON stated she was unaware R14 was missing a wedding ring. Staff were expected to complete a missing item report and, if possible, the resident was interviewed to determine when the item was last seen. Laundry, housekeeping, activities and nursing staff were informed to look for the item, and, on certain items, a police report may be filed. The DON	21880		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

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21880	Continued from page 38 stated she honestly did not know if a report had been filed for R14's missing ring because she was unaware it was missing. At 5:25 p.m., the DON stated R14's wedding ring had been found. It was found in laundry back in December 2025 and kept in the safe until 4/29/26 when the SA began asking about it. Staff did not complete a missing item report. The DON stated she expected staff to follow the procedure for a missing item and to report the concern to ensure all were aware of the missing item. If staff had been aware of R14's missing wedding ring, they would have known who the found wedding ring belonged to and R14 would have gotten it back sooner. The facility. The facility Missing Items Report revised 11/18/18, included information for staff to collect and identified the following: the resident's name, date, description of item(s) missing, date/time last seen, date/time noticed missing, thinks misplaced details, thinks taken and, if so, by whom, who it was reported to and who reported the missing item(s). Staff were instructed to complete the form immediately and give the report to the unit manager. The unit manager would search probably places immediately and list the employee(s) assigned to search. If the item was not found, family would be contacted. If the family was unaware of the item(s) location, the item was to be treated as a misappropriated item and reported to law enforcement and the state agency (SA). SUGGESTED METHOD OF CORRECTION: The director of social services or administrator could review policies and procedures on missing items, educate all appropriate staff members on the process of reporting missing personal items. The director of social services or administrator could develop monitoring systems to ensure ongoing compliance and follow up ion missing items is being done and bring the results to QAPI TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21880		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING **01 - NURSING HO...** B. WING	**04/28/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/28/2026. At the time of this survey, Havenwood Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		06/12/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **04/28/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Havenwood Care Center was built in 4 stages. The 1968 original building is 1- story, without a basement and was determined to be Type II (111) construction. In 1971 an addition to the south of the original building was built, is 1-story with a partial basement and was determined to be of a Type II (222) construction. The 1974 addition was built to the south of the 1971 addition, is 1-story without a basement and was determined to be of Type II (111) construction. In 1992 additions were built to the west of the 1968 building and east of the 1971 building. They are separated with 2-hour fire barriers and determined to be Type II(111) construction. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		06/12/2026
K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K0372	Failure to maintain smoke barriers has the potential to affect all residents residing in the facility. On 4/29/26 the penetration above the doors near the activity room and S50 was sealed with fire resistant foam. Beginning on 5/20/26, a visual inspection will	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **04/28/2026**

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K0372 SS = F Bldg. 01	Continued from page 2 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/28/2026 at 09:15am, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors by activities room and by room S50. An interview with the Maintenance Director and HR Representative verified these deficient findings at the time of discovery.	K0372	Continued from page 2 be completed of smoke barriers that may be compromised during vendor work in the facility within 24 hours of work completion. Penetrations noted will be sealed upon identification by the maintenance director or designee.	06/12/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K0353	Failure to complete the required 5-year sprinkler system testing has the potential to affect all residents. On 5/18/26 and 5/19/26 the required 5-year sprinkler system testing was completed. Records for testing completion will be retained by the maintenance director for 5 years in the PM binder. Presence of documentation will be audited annually by the facility administrator or designee on an ongoing basis.	06/12/2026

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K0353 SS = D Bldg. 01	Continued from page 3 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/28/2026 at 08:41am it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. An interview with the Maintenance Director and HR Representative verified these deficient findings at the time of discovery.	K0353		06/12/2026
K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel.	K0918	Failure to maintain records of essential generator fuel testing has the potential for isolated impact on residents residing in the facility. On 4/30/26 and 5/18/26, a copy of the required fuel testing was requested from the vendor who completes regular service on the generator. Per correspondence with the vendor, this testing is completed annually as required during the annual inspection and generator service/testing. The annual inspection was completed for the generator on 4/1/26. Following annual inspection and generator testing a copy of the fuel test will be provided by the vendor for facility records. Upon receipt of the fuel test results, the document will be maintain within the PM binder. The maintenance director will audit the annual service report annually following completion for review an identification of required records.	06/12/2026

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K0918 SS = D Bldg. 01	Continued from page 4 Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2. This deficient finding could have an isolated on the residents within the facility. Findings include On 04/28/2026 at 09:09am, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability and/or a fuel testing document from a fuel company. An interview with the Maintenance Director and HR Representative verified these deficient findings at the time of discovery.	K0918		06/12/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards.	K0920	Failure to ensure proper use of power cords, extension cords and multiplug adapters has the potential for isolated effect on residents residing in the facility. On 5/5/26 an electrical receptacle was installed, eliminating the need for a multiplug adapter in that area. Additionally, on 4/29/26 the space heater in the DON office was removed from use. Beginning on 5/27/26 weekly audits for 6 weeks will be completed of office spaces within the facility to ensure proper use of extension cords and multiplug devices. Misuse identified during audits will be immediately rectified with education being provided to those who use the space.	06/12/2026

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K0920 SS = D Bldg. 01	Continued from page 5 All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/28/2026 at 09:18am, it was revealed by observation that there were several electrical devices plugged into multi-plug adapters in the following areas; 1) Multi-plug adapter above ceiling that is not UL listed and not hospital grade device. 2) Space heater pugged into a multi-plug device in DON Office. An interview with the Maintenance Director and HR Representative verified these deficient findings at the time of discovery.	K0920		06/12/2026
K0921 SS = D Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and	K0921	Failure to complete and maintain records of PCREE testing has the potential to affect all residents, staff and visitors within the facility. On 5/19/26 a policy was developed to guide PCREE testing completion. By 5/30/26 a full facility inventory and log of all PCREE owned by the facility will be developed. Upon completion of inventory, all items will be tested according to standards laid out in 10.5.3.1.1 by an outside vendor who will train facility staff on task completion. PCREE testing will be completed at least annually, with any modifications/repairs and/or when problems are identified. All initial testing will be completed by 6/12/26 with records being maintained for a period of 3 years.	06/12/2026

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K0921 SS = D Bldg. 01	Continued from page 6 procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a policy for appliances not supped by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/28/2026 at 08:53am, it was revealed by a review of available documentation that the facility could not provide documentation for the testing of electrically powered medical equipment. An interview with the Maintenance Director and HR Representative verified these deficient findings at the time of discovery.	K0921		06/12/2026