#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 813H Facility ID: 00017

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1. STATE CHANGE OF CONNERSHIP   1. PROVIDED RECEIVED AS   1. PROVIDED RECEIVED RECEIVED AS   1. PROVIDED RECEIVED		NO.				(L6) <b>56601</b>	5. Validation	6. Complaint
8. ACCREDITATION STATUS(110)		OWNERSHIP				. ,		
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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00017

**C&T REMARKS - CMS 1539 FORM** 

STATE AGENCY REMARKS

CCN: 24 5397

On May 18, 2017, the Departments of Health and Public Safety completed revisits to verify correct of deficiencies issued pursuant to the March 23, 2017 standard survey. Based on the revisits the facility achieved compliance, effective May 2, 2017.

As a result of the revisit findings, the Category 1 remedy of State monitoring has been discontinued.

In addition, the following enforcement remedy has been rescinded:

- Mandatory denial of payment for new Medicare and Medicaid Admissions (DPNA).

Since DPNA did not go into effect, the two year loss of NATCEP is also rescinded.

Furthermore, the Department recommended to the CMS Region V office that the following enforcement remedy be imposed:

- Civil money penalty for deficiency cited at F323.

Effective May 2, 2017, the facility is certified for 90 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245397

September 5, 2017

Mr. Brandon Bjerke, Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, MN 56601

Dear Mr. Bjerke:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 2, 2017 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 5, 2017

Mr. Brandon Bjerke, Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, MN 56601

RE: Project Number S5397027

Dear Mr. Bjerke:

On April 10, 2017 and May 25, 2017, as authorized by the CMS Region V Office, the Department informed you that the following enforcement remedies were being imposed:

- State Monitoring effective April 15, 2017. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 23, 2017. (42 CFR 488.417 (b))

Further, the Department notified you in our letter of May 25, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 23, 2017.

Furthermore, we recommended to the CMS Region V Office the following additional enforcement remedy for imposition:

• Civil money penalty for deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on March 23, 2017, and lack of verification of compliance of the health and life safety code deficiencies, at the time of our May 25, 2017 notice. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On May 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 17, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2017. Based on our visits, we determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 23, 2017, effective May 2, 2017.

Havenwood Care Center September 5, 2017 Page 2

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring as of May 2, 2017

In addition, the Department recommended to the CMS Region V Office the enforcement action as it relates to the remedy in our letter of May 25, 2017. CMS Region V Office concurs, and has authorized this Department to notify you of the following:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 23, 2017, be rescinded. (42 CFR 488.417 (b))

Further, in our letter of May 25, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 23, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 2, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Furthermore, the Department is recommending the following enforcement action related to the remedy recommended in our letters of April 10, 2017 and May 25, 2017:

• Civil money penalty for deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedy and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 5, 2017

Mr. Brandon Bjerke, Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, MN 56601

Re: Reinspection Results - Project Number S5397027

Dear Mr. Bjerke:

On May 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 23, 2017. At this time, these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: <u>mark.meath@state.mn.us</u>

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 25, 2017

Mr. Brandon Bjerke, Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, MN 56601

RE: Project Number F5397026, S5397027

Dear Mr. Bjerke:

On April 10, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 15, 2017. (42 CFR 488.422)

In addition, on April 10, 2017, the Department informed you that we were recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on March 23, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On May 17, 2017, the Minnesota Department of Public Safety a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2017. Based on our visit, we have determined that your facility has achieved compliance with the life safety code deficiencies issued pursuant to our standard survey, completed on March 23, 2017.

However, compliance with the health deficiencies issued pursuant to the March 23, 2017 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

Havenwood Care Center May 25, 2017 Page 2

In addition, this Department recommended to the CMS Region V Office the following action related to the remedy recommended in our letter of April 10, 2017:

• Civil money penalty for deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

Futhermore, regardless of any other remedies that may be imposed, denial of payment for new Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following additional remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 23, 2017. (42 CFR 488.417 (b))

Also, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Havenwood Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 23, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 23, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 23, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 23, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

Havenwood Care Center May 25, 2017 Page 3

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: <u>mark.meath@state.mn.us</u>

Phone: (651) 201-4118 Fax: (651) 215-9697

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 813H

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY	AGENCY	F	acility ID: 00017
MEDICARE/MEDICAID PROVII     (L1)					ı	(L6) <b>56601</b>	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGORY	09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY  8. ACCREDITATION STATUS:  0 Unaccredited 1 T. 2 AOA 3 O		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDING 12/31	DATE: (L35)
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14. LTC CERTIFIED BED BREAKD  18 SNF 18/19  90  (L37) (L38	SNF 19 SNF	ICF (L42)	IID (L43)		15. FACILI 1861 (e) (	TY MEETS 1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REN	MARKS (IF APPLICABLE S	SHOW LTC CANCELI	LATION DATE):		18. STATE	SURVEY AGENCY AP	PROVAL	Date:
Theresa Gulling	gsrud, HFE NE	II	05/01/2017	(L19)	Kate J	JohnsTon, Pro	ogram Specialis	05/17/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE (	OR SINGLE STAT	TE AGENCY	
DETERMINATION OF ELIGIB     1. Facility is Eligible     2. Facility is not Eligible	to Participate		MPLIANCE WITH C	IVIL	21.		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	1513)
22. ORIGINAL DATE  OF PARTICIPATION  12/01/1986  (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		VOLUNTA 01-Merger, 02-Dissatisf	Closure action W/ Reimburseme	INVOLUNT 05-Fail to Mo	ARY  eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27	27. ALTERNATIV  A. Suspension  B. Rescind Sus	of Admissions:	(L44) (L45)			nvoluntary Termination ason for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMAF	RKS		
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION	OF APPROVAL DAT	(L33)	DETERM	IINATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5842

April 10, 2017

Mr. Brandon Bjerke, Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, Minnesota 56601

RE: Project Number S5397027

Dear Mr. Bjerke:

On March 23, 2017, a standard survey was completed at your facility by the Minnesota Departments 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### **DEPARTMENT CONTACT**

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

#### NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; <u>OR</u>
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective April 15, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, and appeal rights.

#### PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

### 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 June 23, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 23, 2017 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. 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.

#### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

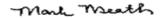
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

DEPA	ARTMENT OF HEALTH	AND HUMAN SERVICES	į.	-,2-	Note that the second se		ED: 04/10/201
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES	۴		RECHIVED		RM APPROVE 10. 0938-039
STATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) E	DATE SURVEY COMPLETED
		245397	B. WING		Misneston Department of Mealth		00/00/0047
NAMEC	OF PROVIDER OR SUPPLIER		5	S	TREET ADDRESS, CITY, STATE, ZIP, CODE	<u> </u>	03/23/2017
HAVE	WOOD CARE CENTER				633 DELTON AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			EMIDJI, MN 56601		
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F 00	INITIAL COMMENT	S	Foo	00			
	as your allegation of Department's acceptenced in ePOC, you at the bottom of the	f correction (POC) will serve compliance upon the tance. Because you are our signature is not required first page of the CMS-2567 submission of the POC will on of compliance.					
F 225 SS=D	on-site revisit of your validate that substant regulations has been your verification.	cceptable electronic POC, an facility may be conducted to tial compliance with the attained in accordance with (4) INVESTIGATE/REPORT		5	F 225		
	483.12(a) The facility	must-			R64's fall dated 3/2/2017 was		
	who-  (i) Have been found g exploitation, misappro mistreatment by a cou				reported to the SA on 4/20/2017. The Disposition Letter from MDH was received on 4/26/17 stating that the information has been reviewed and it has been determined that no further action by this office is necessary at this time.		
	nurse aide registry cor exploitation, mistreatm misappropriation of the (iii) Have a disciplinary or her professional lice	eir property; or  y action in effect against his ense by a state licensure nding of abuse, neglect, ent of residents or	<i>LB</i> //addendui 5/1/17	ms	All incidents of potential abuse/mistreatment and/or neglect will be reported to the SA immediately.  The Abuse Prevention/Prohibition Program was reviewed on 4/20/2017.		
		1		1		1	ľ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID:813H11

Facility ID: 00017

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245397	B. WING	à		03	/23/2017
NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE BEMIDJI, MN 56601	,	,10,1011
PREFIX   (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
licensing authorities actions by a court of which would indicate nurse aide or other f  (c) In response to all exploitation, or mistre  (1) Ensure that all all abuse, neglect, explointed including injuries of a misappropriation of reported immediately after the allegation is cause the allegation serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures.  (2) Have evidence that thoroughly investigated  (3) Prevent further post exploitation, or mistred investigation is in procedures.	ate nurse aide registry or any knowledge it has of always and against an employee, a unfitness for service as a facility staff.  Idegations of abuse, neglect, reatment, the facility must:  Ideged violations involving obtation or mistreatment, unknown source and resident property, are y, but not later than 2 hours and involve abuse or result in or not later than 24 hours if the allegation do not involve sult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides at all alleged violations are law through established  at all alleged violations are end.	F 2	225	Education will be provided to all charge nursing staff regarding Vulnerable Adult reporting requirements for unwitnessed falls resulting in injury.  The Administrator or designee will audit all falls to ensure proper reporting protocols are followed.  Results of these audits will be reported to the QAPI Committee for review and recommendations. These audits will continue until the QAPI Committee has determined that compliance has been achieved.  The Administrator is responsible for compliance with this requirement.  Completion Date: 5/2/17		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		LTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER  245397  NAME OF PROVIDER OR SUPPLIER		DENTI TOATION NORIBEA.	A. BUILD	DING		COMPLETED	
		1	B. WING			03/23/2017	
	VOOD CARE CENTE	R		STREET ADDRESS, CITY, STATE, Z 1633 DELTON AVENUE BEMIDJI, MN 56601	IP CODE		
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F 225	if the alleged violat corrective action m This REQUIREME by: Based on interview facility failed to immabuse/mistreatmen agency (SA) for 1 co	ion is verified appropriate	F 2	25			
	Findings include:						
	12/20/16 indicated I impairment and dia Alzheimer's disease anxiety disorder and MDS also indicated inattention symptom wandering behavior R64 required extensibed mobility, transfepersonal hygiene ar	imum Data Set (MDS) dated R64 had severe cognitive gnoses which included e, depression, bipolar disorder, dipsychotic disorder. The R64 exhibited fluctuating as of delirium and daily. The MDS further indicated sive assistance of one staff for er, dressing, toilet use, and and required limited assistance anbulation and locomotion on					
	3/2/17, at 2:05 a.m. bathroom by the TV indicated R64 had b when the nursing as from R64's room. WTV room bathroom, the floor. R64 was sfor an evaluation and	ent dated 3/2/17, indicated on R64 had a fall in the room. The Assessment een left alone on the toilet sistant (NA) obtained a brief /hen the NA returned to the R64 was found face down on tent to the emergency room d was found to have a vrist. The Assessment					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1633 DELTON AVENUE BEMIDJI, MN 56601	, CODE	<u> </u>	
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	included the questic constitute abuse or adult?" A choice of Assessment directe "Yes" response. In a indicated the fall wa committee on 3/2/17 not indicated.  Review of Vulnerabl October 2016, throu report for R64's fall of CDON) and registere R64's fall on 3/2/17, at 3:08 processed in the factor of nursing (Ewith fractures was not SA, as required. The aware a fall with serie reported.  The Assessment After directed all falls would Committee on a daily filled to the SA, if indicating indicators of abuse of adults of the series of a daily filled to the SA, if indicating indicators of abuse of adults.	on "Does this fall appear to neglect of a vulnerable "No" was circled. The d notification of the SA for a addition, the Assessment s reviewed by the fall 7, and report to the SA was e Adult (VA) reports from gh March 2017, lacked a with serious injury.  o.m. director of nursing d nurse (RN)-B confirmed was unwitnessed.  o.m. the administrator and DON) confirmed R64's fall of immediately reported to the e DON stated she was not ous injury was required to be er a Fall policy dated 4/2015, d be reviewed by the Fall of basis and reports would be cated.	F 2	225			

STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) D.	O. 0938-039 ATE SURVEY OMPLETED
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	unknown origin whe was not observed by the injury could not and the injury or the lonumber of injuries of point in time or the ir. The policy further dir. The policy further dir. The policy further dir. In eglect, suspicious is misappropriation of reported immediately 483.12(b)(1)-(3), 483.12(b)(1)-(3), 483.12(b) The facility must of written policies and prevention of resident property,  (1) Prohibit and prevention of resident property,  (2) Establish policies investigate any such and set in se	n both the source of the injury any person or the source of the explained by the resident; picious because of the extent cation of the injury or the coserved at one particular neidence of injuries over time. The ected allegations of abuse, injury of unknown origin and resident property would be at the SA.  3.95(c)(1)-(3)  NT ABUSE/NEGLECT, ETC  develop and implement rocedures that:  The ent abuse, neglect, and and misappropriation of and procedures to	F 22	225	t	

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A144		245397	B. WING	ā		3/00/0047
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	resident property  (c) (3) Dementia mar prevention. This REQUIREMEN' by: Based on interview a facility failed to opera and procedures relat reporting of potential neglect to the State a residents (R64) reviewho had a fall with selection in the state of the injury of unknown of the injury of unknown of the injury of unknown of the injury of th	at § 483.12.  It reporting incidents of abuse, or the misappropriation of agement and resident abuse.  This not met as evidenced and document review, the ationalize their abuse policy ed to the immediate abuse/mistreatment or agency (SA) for 1 of 3 wed for abuse prohibition erious injury.  In/Prohibition Program policy fication section indicated a indicator of abuse or be promptly reported. The indicated the facility would aknown origin as a possible glect or maltreatment or further investigation.  Inigin would be classified as origin when both the source beserved by any person or yould not be explained by	F 2.		red. ettee ons. til the ined ieved.	

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F 226	investigation would administrator or dir designee. Staff wer any incident or sus abuse or neglect in unknown origin and the facility to begin	normally be conducted by the ector of nursing (DON) or se directed to promptly report pected incident of resident cluding suspicious injuries of to report internally to allow to initiate an investigation, and neediately to the State	F 22	26		
	12/20/16, indicated impairment and diag Alzheimer's disease anxiety disorder and MDS also indicated inattention symptom wandering behavior. R64 required extens for bed mobility, tran personal hygiene an	mum Data Set (MDS) dated R64 had severe cognitive gnoses which included, depression, bipolar disorder, psychotic disorder. The R64 exhibited fluctuating s of delirium and daily. The MDS further indicated ive assistance of one person sfer, dressing, toilet use, and d required limited assistance abulation and locomotion on				
F F F F fi T	164 had a fall in the 2:05 a.m. on 3/2/17. R64 had been left alchursing assistant (NAR64's room. When the common bathroom, R64 loor. The assessme esulted in an emerge was found to have a the Assessment include:	ent dated 3/2/17, indicated bathroom by the TV room at The Assessment indicated one on the toilet when the A) obtained a brief from the NA returned to the TV was found face down on the nt also indicated the fall ency room visit where R64 fractured nose and wrist. Uded the question "Does this te abuse or neglect of a				

	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	SS=D	vulnerable adult?" // The Assessment dir for a "Yes" response indicated the fall wa committee on 3/2/17 not indicated.  Review of Vulnerabl October 2016 throug report for R64's fall volumerable on 3/22/17, at 1:03 purse (RN)-B confirmulation of the fall was a sinjury was required to 483.20(d);483.21(b) (COMPREHENSIVE 483.20 (d) Use. A facility mulassessments complemenths in the resider results of the assess	A choice of "No" was circled. Tected notification of the SA and addition, the Assessment is reviewed by the fall and report to the SA was a serviewed by the fall and report to the SA was a serviewed by the fall and report to the SA was a serviewed a service and report and registered and R64's fall on 3/2/17, was a service and read with fractures was not a to the SA as required. The service and reported. The service and reported and resident reted within the previous 15 and record and use the ments to develop, review and service record and use the ments to develop, review and service record and use the ments to develop, review and service record and use the ments to develop, review and service record and use the ments to develop, review and service record and use the ments to develop, review and service record and use the ments to develop, review and record and use the ments to develop, review and record and use the ments to develop, review and record and use the ments to develop, review and record and use the ments to develop, review and record and use the ments to develop, review and record and use the ments to develop.	F 25	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	(1) The facility must comprehensive perseach resident, consiset forth at \$483.10 includes measurable to meet a resident's and psychosocial necomprehensive associate plan must describe the facility of the services that or maintain the resident's and psychosocial necomprehensive associate plan must describe the facility of the services that or maintain the resident's physical, mental, and required under \$483.24, \$483 provided due to the funder \$483.24, \$483 provided due to the funder \$483.10, inclutreatment under \$48 (iii) Any specialized sere abilitative services provide as a result of recommendations. If findings of the PASA rationale in the resident's representationale in the resident's representational findings of the passociate outcomes.  (B) The resident's prefuture discharge. Fact whether the resident's prefuture discharge.	develop and implement a son-centered care plan for istent with the resident rights (c)(2) and §483.10(c)(3), that e objectives and timeframes medical, nursing, and mental eds that are identified in the essment. The comprehensive cribe the following -  are to be furnished to attain lent's highest practicable d psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required 8.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6).  Services or specialized as the nursing facility will f PASARR a facility disagrees with the RR, it must indicate its ent's medical record.	F 2	279	On 3/22/17, resident 88's care plan was updated to identify the presence, goal, and approaches related to two stage two pressure ulcers. Resident 88's pressure ulcers were healed on 4/18/17 so his/her care plan now identifies his/her risk/goals for pressure ulcers. On 3/24/17 resident 88's care plan was updated to reflect his/her diagnosis of insomnia. A goal and non-pharmacological interventions related to the prescribed hypnotic medication were included on his/her care plan. A new tissue tolerance test was completed on resident 88 on 4/20/17.  On 3/22/17, resident 69's care plan was updated to include goals and medical management interventions for his/her cardiac pacemaker.  All residents care plans will be reviewed and revised prior to 5/2/17 for the risk of pressure ulcer development, non-pharmacological interventions for hypnotics, as well as cardiac pacemaker medical management.  Education will be provided to all charge nurses regarding care plan development prior to 5/2/17.  The facility's policy on nursing care plans was revised on 4/17/17.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	local contact agence entities, for this pur  (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMENT by:  Based on observator review, the facility for related to the identifulcers in order to prodevelopment for prodevelopment for prodevelop a care plan non-pharmacological implemented for 1 conformed for 1 conformed for a cardiac pagoals and medical in 1 of 1 resident (R69 pacemaker.  Finding included:  R88 was at risk for proceived medication diagnosed sleep discheveloped to identify	ies and/or other appropriate pose.  s in the comprehensive care e, in accordance with the rth in paragraph (c) of this  IT is not met as evidenced ion, interview and document ailed to develop a care plan fied risk/goals for pressure event the risk for the essure ulcers and failed to which included a goal and al interventions to be of 4 residents (R88) reviewed and hypnotic medication use. In observation, interview, and efacility failed develop a care accemaker which included management interventions for or reviewed who had a soressure related ulcers and to induce sleep for a corder and a care plan was not or these areas.  Sheet included diagnoses of	F 2	279	Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are revised appropriately. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.  The Director of Nursing is responsible for compliance with this regulation.  Completion Date: 5/2/17		
	of left clavicle and se	havioral disturbance, fracture eventh vertebra, obstructive					

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AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	Continued From page cancer), and anxiety	-	F 2	79				
	12/18/16, indicated limpairment, required one to two staff for a balance impairment in range of motion in MDS further indicate incontinent of urine, upon admission, was and had a turning an 14 day Medicare MD R69 had trouble fallis sleeping too much.  Physician's orders in milligrams by mouth one additional dose a	nimum Data Set (MDS) dated R88 had severe cognitive dextensive assistance from activities of daily living, had and had functional limitations one upper extremity. The ed R69 was frequently did not have a pressure ulcers at risk for pressure ulcers, and repositioning program. The DS dated 12/25/16, indicateding asleep, staying asleep, or cluded, Trazodone 50 at bedtime, and may give as needed after the lose prior to 3:00 a.m.						
	related to urinary incomobility that required staff, cognitive loss, for motion, diagnosis weakness, fracture of The CAA indicated Reschedule of turning a reposition every two hindicated a care plan	risk for pressure ulcers continence, and impaired extensive assistance from unctional limitation in range of dementia, pain, f clavicle, and poor nutrition. 69 required a regular nd staff would turn and nours while in bed. The CAA would be developed and et skin and continue to						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245397	B. WING		03/23/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1633 DELTON AVENUE BEMIDJI, MN 56601		/23/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 279	R88's current care pidentify R88 was at lacked a goal for provided in the pidentify R88 was at lacked a goal for provided in the pidentify R88 had a was incontinent more and directed staff to two staff to transfer hours, staff check who needed, and provided elimination. The care decreased physical and directed staff to one to turn and report of turn and report of the pidentified in the pide	plan dated 12/28/16, did not risk for pressure ulcers and eventing or decreasing the ressure ulcer. The care plan alteration in elimination and re than seven times per week provide extensive assist of on and off toilet every two with toileting and change as e peri rectal care after e plan also indicated R88 had mobility with potential for falls provide extensive assist of esition every two hours. The R88 was at risk for extending the provide extensive assist of esition every two hours. The rected staff to monitor skin for each staff to monitor skin for	F 27	'9			
	confirmed a specific nor was an assessed ulcers, however, stated the problem statemed RN-E stated a specifical ulcers would be developressure ulcer or his -At 4:27 p.m. the direct confirmed there should be developed the stated as pecifically as a specifical transfer of the stated as pecifically as a specifical transfer of the stated as a specifical transfer of the st	co.m. registered nurse (RN)-E care plan was not developed digoal identified for pressure ted the interventions to ressure ulcers were added to ent that was causing the risk. Fic care plan for pressure eloped if there was an actual tory of pressure ulcers.  Sector of nursing (DON) and have been a care plan are ulcers and for sleep.					

DEPAR	TIMENT OF HEALTH	I AND HUMAN SERVICES				PRINTE	ED: 04/10/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	RM APPROVE NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DAT	
		245397	B. WING	à			
NAME OF	PROVIDER OR SUPPLIER			Γ_	STREET ADDRESS, CITY, STATE, ZIP COD	0	03/23/2017
H W/EW	WOOD CARE CENTER				1633 DELTON AVENUE		
11544 F141	WOOD CARE CENTER			1	BEMIDJI, MN 56601		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE	CTION.	1
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	Continued From page	20.10					
, 0			F2	279	<b>∍</b>		
	the care plan.	ker which was not identified on					
	diagnoses of atrial fi hypertension, and hi indicated R69 had m and required extens complete activities of Face Sheet indicated myocardial infarction hospital Discharge S indicated R69 had a  R69's care plan date of atrial fibrillation an	OS dated 1/20/17 included ibrillation, heart failure, istory of stroke. The MDS noderate cognitive impairment ive assistance from staff to of daily living. R69's undated d R69 had a diagnosis of old in (heart attack). R69's Summary dated 1/20/17, pacemaker.					
	was observed on R6 explained the purpos pacemaker clinic coufunctionality of the paabnormal heart rhyth	o.m. a pacemaker monitor 9's nightstand. R69 se of the monitor was so the ald continuously monitor the acemaker and monitor for ms. R69 stated he was s pacemaker checked every					
	(LPN)-D stated was r information pertaining not sure what arrhyth to correct, and did no parameters. LPN-D s (RN) obtained informatics.	to R69's pacemaker, was mia the pacemaker was set tknow R69's pulse tated the registered nurses					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING	(X3) DATE SURVE COMPLETED	
		245397	B. WING	B. WING		3/23/2017
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 1633 DELTON AVENUE BEMIDJI, MN 56601		720/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
F 279	-At 10:51 a.m., pace (RN)-F indicated R6 bradycardia (slow hodefibrillator, the low minute, RN-F explai under 70 beats for a and the staff at the f pacemaker clinic to appropriately. RN-F expected facility staff pacemaker settings, and of recommender -At 11:00 a.m., the Enacemaker.  -At 12:27 p.m., RN-Enacemaker.  -At 12:27 p.m., RN-Enacemaker.  -At 12:27 p.m., RN-Enacemaker.  -At 12:27 p.m., RN-Enacemaker.  -At 12:27 p.m., RN-Enacemaker.	emaker clinic registered nurse 19's pacemaker was for eart rate), was not a end setting was 70 beats per ned if R69's pulse should go full minute, it was a concern, acility would need to call the ensure pacer was functioning stated the pacemaker clinic for the to contact the clinic, do pacemaker checks.  ON indicated there should an developed for the estated she did not know maker and thought the care cemaker, and was not aware ould have been on the care	F2	279		II
F 280 SS=D	reviewed 4/2015 incl and Rationale 1. to p independence and q directing staff efforts appropriate utilization services and avoid d 7. To meet accountal intermediaries. The requirements for the 483.10(c)(2)(i-ii,iv,v)(	uded: Planning Objectives romote optimal resident uality of care by focusing and to individuals, 2. To promote and coordination of uplication and wasted efforts, bility requirements for fiscal policy lacked direction and/or	F 28	F 280 On 4/26/17 resident 64's care p was reviewed and revised to include new fall interventions.	lan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245397	B. WING			03/23/2017	
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE SEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	and implementation plan of care, including the right to be included in the plan revisions to the persistence of care.  (ii) The right to particulate the included in the plan revisions to the persistence of care.  (iii) The right to particulate of care of care.  (iv) The right to receincluded in the plan of care.  (v) The right to see the right to sign after sign of care.  (c) (3) The facility sharight to participate in shall support the resign planning process must be resident representation.  (ii) Facilitate the inclures included an assess strengths and needs.  (iii) Include an assess strengths and needs.	articipate in the development of his or her person-centered ing but not limited to:  cipate in the planning process, or identify individuals or roles to anning process, the right to ad the right to request con-centered plan of care.  Cipate in establishing the outcomes of care, the type, and duration of care, and any to the effectiveness of the  ive the services and/or items of care.  the care plan, including the inficant changes to the plan  all inform the resident of the his or her treatment and ident in this right. The ist  sion of the resident and/or ve.  sment of the resident's	F2	280	On 4/17/17, resident 88's care plan was reviewed and revised to include non-pharmacological interventions for pain management.  All resident's care plans will be reviewed and revised prior to 5/2/17 regarding fall interventions as well as non-pharmacological interventions for pain management.  Education will be provided to all charge nurses regarding care plan revision prior to 5/2/17.  The facility's policy on nursing care plans was revised on 4/17/17.  Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are revised appropriately. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.  The Director of Nursing is responsible for compliance with this regulation.  Completion Date: 5/2/17		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	(X3) DATE SURVEY COMPLETED		
		245397	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	<u> </u>	/23/2017
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	(b) Comprehensive (2) A comprehensive (i) Developed within the comprehensive (ii) Prepared by an ir includes but is not line (A) The attending phase (B) A registered nursure resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the part An explanation must medical record if the and their resident reprot practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the comprehensive and quassessments. This REQUIREMENT by:	Care Plans e care plan must be- 7 days after completion of assessment. Interdisciplinary team, that mited to aysician. It is with responsibility for the and nutrition services staff. It is citicable, the participation of resident's representative(s). It is included in a resident's participation of the resident or esentative is determined and evelopment of the staff or professionals in ined by the resident's needs are resident. It is a the care plan must be a c	F 280			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILE		(X3) DATE SURVEY COMPLETED			
		245397	B. WING	B. WING			/23/2017
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			16	REET ADDRESS, CITY, STATE, ZIP CODE 33 DELTON AVENUE EMIDJI, MN 56601	1 03	/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	facility failed to revise additional fall preversal incidents for 1 or for accidents. In additional fall preverses the care plan non-pharmacological residents (R88) revise medications.  Findings include:  R64's care plan was additional fall preversal incidents.  R64's Face Sheet [undiagnoses included Addizziness, seizures, additional disorder addizziness] and the fall Risk Assemble for the fall R	se the care plan to include ntion interventions following f 4 residents (R64) reviewed dition, the facility failed to for pain to include al interventions for 1 of 5 ewed for unnecessary  not revised to include ntion interventions following indated], indicated R64's Alzheimer's disease, anxiety, depression, obesity, macular rision), cataracts, psychosis	F2	80			
-	ncluded: provide assist of one off the unit	e staff to ambulate on and					

STATEMENT OF DEFICIENCIES (X1) PRO IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		245397	B. WING	3. WING 03/23/2017				
	NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZI 1633 DELTON AVENUE BEMIDJI, MN 56601	P CODE	720/2017		
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F 280	- provide limited ass also transfers self a	sist of one staff to transfer, t times ace wheelchair for comfort, ety	F 28	80				
	through 2/9/17, the finterventions were in identified on the care	d the ears for relaxation twice 3/15) with cut out (initiated						
	(DON) confirmed pri only fall prevention ir R64's physician orde lavender oil behind tl day (initiated 11/23/1	o.m. the director of nursing or to R64's fall on 3/2/17, the nterventions documented on ers or R64's care plan were he ears for relaxation twice a 5); contour mattress with cut 5); and 30 minute checks						
	facility would identify risk for falls and deve precautions for those assessment would be and any changes in it on the form, in the re	y dated 4/2015, indicated the residents who were at high elop individual fall e residents. A post fall e completed after each fall nterventions would be noted sidents nursing orders, ed to the care plan, and staff						

I AND PLAN OF CORRECTION I INFINITIFICATION NUMBER 1		1	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED	
245397		B. WING	i	03	3/23/2017	
NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER				STREET ADDRESS, CITY, STATE, 1633 DELTON AVENUE BEMIDJI, MN 56601	, ZIP CODE	1/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 280	R88's care plan wanon-pharmacologic control which could administration of all R88's Face Sheet if dementia without be of left clavicle and smyelodysplastic synanxiety disorder.  R88's admission M 12/18/16, indicated impairment, had or interfere with activiting pain medications, rescale, used as need non-pharmacologic A Care Area Assess triggered or complete R88's care plan for R88 had a potential related to a cervical fracture and low bad directed staff to medication of the staff to medicate and service of the staff to service of	as not revised to include cal interventions for pain I be attempted prior to as needed pain medication.  Included diagnoses of ehavioral disturbance, fracture seventh vertebra, androme, diverticulitis, and inimum Data Set (MDS) dated R88 had severe cognitive casional pain which did not ies or sleep, had scheduled ated pain at a 5 on a 0-10 ded pain medications, and al interventions were not used. Sement for pain was not ted.  pain dated 12/28/16, indicated for alteration in comfort spine fracture, left clavicle ck pain. The care plan dicate as ordered, use a pain	F 2	280		
	comfort and to keep plan lacked non phat be attempted prior t R88's physician ord Neurontin solution 2	n, assist to positron for physician updated. The care armacological interventions to the use of pain medication.  ers revealed an order for 50mg/5ml (milliliters) give 50 as needed for pain, anxiety,				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF	BBOWEE OF CUENCY	245397	B. WING			03,	/23/2017
HAVENV	PROVIDER OR SUPPLIER  VOOD CARE CENTER			1633	EET ADDRESS, CITY, STATE, ZIP CODE 3 DELTON AVENUE MIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	restlessness. Max of hours.  On 03/23/2017, at 4	of six as needed doses in 24 ::27 p.m. director of nursing	F 2	80			
	non-pharmacologica attempted prior to a pain medication.	care plan should include al interventions that could dministration of an as needed					
	Procedure last revier plans were to be revenue. RN. If changes in a occurred between sucharge nurse and definithe revision must the care plan.	ent Care Planning Policy and wed 4/2015, indicated care riewed every 30 days by an problem, goal, or approach cheduled review times the epartment member involved meet informally and revise					
	483.21(b)(3)(ii) SER PERSONS/PER CA	VICES BY QUALIFIED RE PLAN	F 28	32	F 282		
	(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-				Resident 15 is receiving repositioning and toileting per his care plan. Resident 89 is receiving repositioning per her care plan and is wearing her Prevalon boots per		
	(ii) Be provided by quaccordance with each care.	ualified persons in the resident's written plan of			orders.		
	by: Based on observation review, the facility farepositioning assistate cares as directed by residents (R15, R89)	T is not met as evidenced on, interview and document iled to provide turning and nce and/or incontinence the care plan 2 of 2 who required assist with ontinence cares. In addition,			All NA's were educated and made aware of resident 15's care plan regarding repositioning and toileting. All NAs were educated regarding resident 89's care plan for repositioning and Prevalon boot placement.		-

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŀ		LE CONSTRUCTION	(X3) DATE SURVEY		
		Service Report No.	A. BUILI	DING		CO	MPLETED	
NAME OF	PROVIDER OR SUPPLIER	245397	B. WING			03	/23/2017	
	VOOD CARE CENTER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE BEMIDJI, MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	the facility failed to a Prevalon pressure restricted to the elements of the care plan for 1 of heel breakdown.  Findings include:  R15 was at risk for princontinent and did repositioning and incomplete plan.  R15's Care Plan date had decreased physe extremity amputation turn/reposition or site required two staff extremity amputation turn/repositioning every homplete personal hymposition and bladd indicated R15 requires two staff to check and product and provide every two hours.  The untitled and undaworksheets indicated repositioning assistant toileting/incontinent complete in the control of the co	ensure the placement of eduction boots as directed by of 2 (R89) residents at risk for or 2 (R89) residents and or 2 (R89) residents at risk for directed as directed or 2 (R89) residents and or 3 (R89) residents and or 3 (R89) residents at risk for turning and or 3 (R89) residents at risk for turning and or 3 (R89) residents at risk for turning and or 3 (R89) residents at risk for turning and at residents at risk for a continuous observations from 3 (R89) residents at risk for 2 (R89) residents at risk for a continuous observations from 3 (R89) residents at risk for 2 (R89) resi	F2	282	All residents care plans will be reviewed and updated for repositioning and toileting if indicated prior to 5/2/17.  Education will be provided to all NA's prior to 5/2/17 to stress the importance of following care plans for toileting, repositioning, and Prevalon boot placement.  Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.  The Director of Nursing is responsible for compliance with this regulation.  Completion Date: 5/2/17			
	7:15 a.m. to 11:00 a.r	m. R15 was observed to wheelchair without receiving						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
		245397	B. WING			(00)(00)
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1633 DELTON AVENUE BEMIDJI, MN 56601	· CODE	/23/2017
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	-At 7:45 a.m. R15 wheelchair to the direturned to her room-At 9:04 a.m. license entered R15's room LPN-A did not offer or toileting assistanc-At 9:53 a.m. R15's -At 9:58 a.m. nursing entered R15's room immediately exited the result of the NA stated she who because she was but -At 10:00 a.m. R15 and the NA stated she who because she was but -At 10:18 a.m. NA-C proceeded to assist -At 10:35 a.m. NA-C asked her what she informed R15 she was stated she did not was stopped assisting R1 lot. When asked by the down so staff could continent cares. Who product, R15 stated she light on in the first plate -At 10:45 a.m. NA-C incontinent cares. Who product was observe with urine. NA-C consaturated. NA-C proceeded to get the number of the applied a tegaderm of the applied a	vas observed to propel her ning room for breakfast and n. ed practical nurse (LPN)-A to administer medication. nor provide R15 repositioning ce. call light was observed on. g assistant (NA)-C was turned the call light off and he room. Stated she had told the NA ontinent product changed and ould be back to help her asy with another resident. Teturned to R15's room and R15's roommate. began to assist R15. R15 was doing and NA-C as going lay her down. R15 and to lie down. NA-C 5 and stated R15 refused a he surveyor if she would lay change her incontinent that was why I turned the call ace. proceeded to provide R15 hen removed, the incontinent d to be extremely saturated	F2	282		

AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING	(510) 2711		
		245397	B. WING			3/23/2017	
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, Z 1633 DELTON AVENUE BEMIDJI, MN 56601	ZIP CODE	3/23/2017	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	(	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	from scratching. LP measured approxim by 0.50 cm. LPN-A scratched her body resulting in open are stated she applied the infections. LPN-A further incontinence and we frequently falls off.  -At 10:58 a.m. R15's NA-C confirmed R1's with urine and her sland not provided R1 repositioning and inconow.  -At 10:59 a.m. NA-B stated she had assist pointed to a white mand stated staff documere provided on the a.m. was noted on the a.m. was noted on the she had not provided repositioning assista (three hours and 30 referred to the nursing she removed from he was to be repositioned product checked and NA-B stated even the needed help, it was sprovide the cares with	Il open area on her bottom N-A stated the open area nately 0.25 centimeters (CM) stated R15 frequently including her peri area eas and scratch marks. LPN-A he dressing to help prevent rther stated, due to R15's et skin, the dressing cares were completed. 5's brief was very saturated kin was wet. NA-C stated she 5 with turning and continence cares until just entered R15's room. NA-B sted R15 up at 7:00 a.m. and arker board in R15's room umented the last time cares e board. NA-B verified 7:00 he board. NA-B confirmed d incontinence care or nice to R15 since 7:00 a.m. minutes earlier). NA-B ag assistant work sheet which er pocket and verified R15 ed every hour and incontinent I changed every two hours. Dugh R15 could tell us she staff's responsibility to hout R15 having to ask us.	F2	282			
1	(DON) confirmed R1: repositioned every ho and change incontine	a.m. the director of nursing 5 should have been bur and provided with check ence care every two hours as blan. The DON stated it was					

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	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, Z 1633 DELTON AVENUE BEMIDJI, MN 56601	IP CODE	/23/2017		
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F 282	Continued From pa her expectation for R15's care plan, as	staff to follow and implement	F2	282				
	Prevalon boots (hee	two observations and el offloading device/boots) or 1 hour 30 minutes on						
	potential for alteration	Plan indicated R89 had on in skin integrity related to the heel and directed staff to:						
	neededprovide peri rectal episodemonitor for persiste registered nurse (RNmaintain adequate providing dietary decwound care/dressirkeep skin clean anAPP [alternating pr	nutrition and hydration by cub [decubitus] program ng change as ordered.						
	Prevalon (blue) heel	er Report dated uded an order to wear lift boots at all times except eel is in proper position.						
	25 minutes) R89 was sleeping bed, lying or	3 a.m. until 8:28 a.m. (1 hour continuously observed her back with her slightly to the right. R89						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245397	B. WING	à	03	03/23/2017		
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, 2 1633 DELTON AVENUE BEMIDJI, MN 56601				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 282	was not repositione during this time.  -From 9:16 a.m. to continuously observe without staff enterined the continuously observed the c	d or offered repositioning  10:47 a.m. R89 was red in bed, lying on her back g her room for repositioning.  was observed awake and while in bed, positioned on red she liked to sleep in in the had come in to get her up for  sed practical nurse (LPN)-A	F 2	282				

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(Y2) MULTIPLE CONCERNICATION			(X3) DATE SURVEY COMPLETED	
		245397	B. WING		_	00	1001001=
	PROVIDER OR SUPPLIER  WOOD CARE CENTER			STREET ADDRESS, CITY, ST 1633 DELTON AVENUE BEMIDJI, MN 56601	ATE, ZIP CODE	03	/23/2017
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLA X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD E D TO THE APPROPRI ICIENCY)	RF.	(X5) COMPLETION DATE
F 282	the wheelchair. R88 equipped with a sea positioned across the wheelchair foot/leg raised slightly less the wheeled R89 out of room at approximate Prevalon boots were On 3/22/2017, at 1:3	e's wheelchair was observed to cushion and a padded board e calf support area of the rests. The foot/leg rests were nan parallel to the floor. NA-C her room and to the dining ely 12:00 p.m. R89's e not reapplied.	F2	82			
	ner room, seated in lastated she had just a Prevalon boots. LPN them on and confirm at all times due to issasked LPN-A, "Aren"	her wheelchair. LPN-A assisted R89 to put on her N-A verified R89 had not had ed she should have them on sues with her heels. NA-C t we supposed to release ?" LPN-A stated the hoots					
	not put H89's Prevalo	m. NA-C confirmed she had on boots on when she got and should have done so. ots were off for our and 30 minutes.					1
	should have been turi one hour and should l	a.m. RN-A confirmed R89 ned and repositioned every have worn the Prevalon ept for bathing, as directed					
	eviewed 4/2015, indic	ning Policy and Procedure, cated the care plan was to ent independence and					

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245397	B. WING		03/23/2017			
	PROVIDER OR SUPPLIER  VOOD CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE  BEMIDJI, MN 56601					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 309 SS=D	quality of care by for efforts to individual appropriated utilizar services.  483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of life is a furth applies to all care a residents. Each residents. Each residents. Each residents are sidents at a treatment of the comprehensive ass 483.25 Quality of care is a furth applies to all treatment facility residents. Basessment of a residents received accordance with propriatice, the comprehensive and the resident of the comprehensive and the residents who requires to individual to the comprehensive and the residents of the comprehensive and the residents who requires the comprehensive and the residents of the comprehensive and the comprehensive and the compr	procusing and directing staff needs and to promote tion and coordination of a PROVIDE CARE/SERVICES of the provided to facility sident must receive and the enteressary care and maintain the highest and the resident's essment and plan of care.  Are fundamental principle that ent and care provided to assed on the comprehensive sident, the facility must ensure by treatment and care in offessional standards of enensive person-centered esidents' choices, including e following:	F3	F 309	e			

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Va) MULTI		OMB NO. 0938-039		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		245397	B. WING _		02	/22/2017	
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	03/23/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) RE	(X5) COMPLETION DATE	
	care plan, and the repreferences. This REQUIREMENT by: Based on observate review, the facility farmonitoring and coordinate pacemaker clinic to checks were complete reviewed who a had checks had conduct. Findings included:	nprehensive person-centered residents' goals and NT is not met as evidenced ion, interview and document ailed to provide ongoing redination of care with a ensure routine pacemaker eted for 1 of 1 resident (R69) I pacemaker without routine ted.  Inimum Data Set (MDS) dated 69 had diagnoses of atrial heart rhythm, often time's art failure, hypertension, and at MDS also indicated R69 tive impairment and required at from staff to complete and R69's undated facility uded diagnosis of old at (heart attack). R69's summary dated 1/20/17, pacemaker.  Sion Assessment dated 59 had a pacemaker and was k sometime this month while at home, R69 cks wirelessly. The include or identify the	F 309				
r	ate settings, pulse p	aker and/or type, pacemaker arameters, location, or				1	

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDEDICIPALIFACIONA				<u> DWR MC</u>	). 0938-039°
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		TE SURVEY MPLETED
NAME OF		245397	B. WING	ì		03	3/23/2017
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	7 00	120/2017
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa pacemaker check s		F3	309			
	diagnoses of atrial f	ed 2/8/17, indicated R69 had ibrillation and stroke, however hitify the presence of R69's					
	on taken on 1/20, 1/20, 1/3/8, and on 3/15/17. 1/20/17, R69's pulse medical record lacker clinic was notified of end setting of 70 bear	was reviewed since aled R69's pulse was taken 21 (4 times), 1/29, 2/1, 3/1, The record reflected on was 68. However, R69's ed evidence the pacemaker R69's pulse below the low ats per minutes as indicated inic registered nurse (RN)-F.					
	was observed on R6 the purpose of the m clinic could continuou of the pacemaker an heart rhythms. Howe had not worked since was not sure when it stated he was suppose	o.m. a pacemaker monitor 9's nightstand. R69 stated onitor was so the pacemaker usly monitor the functionality d to monitor for abnormal ver, R69 stated the monitor e admission to the facility and was going to get fixed. R69 sed to have his pacemaker months and thought he had duled check.					
	(LPN)-D stated was r information pertaining was not sure what an set to correct, and dic	.m. licensed practical nurse not sure where to find to R69's pacemaker and rhythmia the pacemaker was a not know R69's pulse tated the registered purses					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY MPLETED
		245397	B. WING	i		03	/23/2017
	PROVIDER OR SUPPLIER	ı		16	REET ADDRESS, CITY, STATE, ZIP CODE 33 DELTON AVENUE EMIDJI, MN 56601	[	20/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	(RN) obtained information pacemakers and work and a pacemaker, have a reparameters. RN-C owas supposed to be January, however the monitor hooked up a adapters and the lace directions which the RN-C stated when a obtained the pacemassist with set-up ar RN-C stated the pacemas for bradycardia defibrillator and the per minute. RN-F copacemaker check was cheduled check. concern if R69's puls for a full minute and call the pacemaker was fund if the pacemaker was fund if the pacemaker itself wor information of irregulacemaker check. Felinic expected the spacemaker settings,	mation pertaining to build develop the care plan.  stated she was aware R69 nowever, was not aware of a pacemaker was supposed to were recommended pulse confirmed R69's pacemaker as checked sometime in the facility could not get the due to the lack of correct could be confirmed to the lack of correct could be confirmed to the lack of correct could be confirmed to the lack of correct could be a seen and to ensure functionality. The stated R69's pacemaker was checked on the lack of the equipment was aker clinic was called to and to ensure functionality. The lack of	F3	809			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF PROVIDER CONSTRUCTION OF CORRECTION OF CONSTRUCTION OF

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245397					
NAME OF	PROVIDER OR SUPPLIER	243397	B. WING			03	/23/2017
HAVENV	VOOD CARE CENTER			16	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE EMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BF	(X5) COMPLETION DATE
F 309	-At 11:00 a.m. the d stated there should developed for R69's -At 12:27 p.m., RN-I why R69 had a paceincluded the pacema pacemaker should be Facility policy/proced pacemaker care and received.	irector of nursing (DON) have been a care plan	F3	309	F 312		
SS=D	(a) (2) A resident who activities of daily livin services to maintain personal and oral hy This REQUIREMENT by: Based on observation review, the facility fail incontinence care as 1 of 1 resident (R15) and was not provided Findings include:  R15's quarterly Minimal 1/16/17, indicated R1 required extensive as toileting. The MDS further than the service of the servi	p is unable to carry out greceives the necessary good nutrition, grooming, and giene.  I is not met as evidenced on, interview and document led to provide timely bladder directed by the care plan for who was incontinent of urine it timely assistance.  I timely assistance.	F3	12	Resident 15 is receiving incontinent care per his/her care plan.  The facility's policy regarding perineal care was reviewed and revised on 4/21/17.  All residents care plans will be reviewed and revised if indicated prior to 5/2/17 regarding incontinence care.  Staff education will be provided to all NA's prior to 5/2/17 to stress the importance of following care plans in regards to timely incontinence care.  Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure residents are receiving incontinent care per their care plan.		

	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLTIE		<u>J. 0938-03</u>	9	
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY	
I							INIC LE LED	
ŀ	NAME OF	PROVIDER OR SUPPLIER	245397	B. WING		00	/22/204~	
l					STREET ADDRESS, CITY, STATE, ZIP CODE	103	3/23/2017	_
	HAVENY	VOOD CARE CENTER			1633 DELTON AVENUE			
	(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES		BEMIDJI, MN 56601			
	PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE	(X5) COMPLETION DATE	N
	F 312	Continued From pag associated skin dam of topical ointments.	ne 31 age and required application	F 312	The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.			
		coughing and sneezing due to blocked urethry and functional inconting to the toilet in time due R15's CAA further incontinent of urine, retoileting and was at ristrashes/breakdown, ar R15's Care Plan dates was unable to completing to completing to continence and requassist for toileting neestaff to check and chassist for toileting neestaff to the toileting neestaff toileting neestaff toilet	lated 10/23/15, indicated R15 ince which occurred with ing, overflow incontinence as or weak bladder muscles nence due to inability to get the to physical disability. It is always equired extensive assist with sk for infection, skin and offensive body odor.  d 1/18/17, indicated R15 interpretable in the personal hydrone.		The Director of Nursing is responsible for compliance with this regulation.  Completion date: 5/2/17			
	C	R15's Physician Order 2/22/17-3/22/17, direct change brief as soon a The untitled and undat vorksheets, indicated l hecks every two hours	ed staff to attempt to as it was wet.  ed nursing assistant R15 required toileting					
	07:	n 3/22/17, during con	tinuous observations from					

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	STATEMEN	T OF DEFICIENCIES	(V4) DDOV/IDED/OURDUSER			VIAID IAC	J. 0938-039
	NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTE  (X4) ID SUMMARY ST. (EACH DEFICIENCY REGULATORY OR IT)  TAG Continued From pay wheelchair without  -At 7:45 a.m. R15 wheelchair to the direturned to her roo  -At 9:04 a.m. license entered R15's room exited the room. Litered R15's room exited the room. Litered R15's room immediately exited  -At 9:58 a.m. nursimentered R15's room immediately exited  -At 10:00 a.m. R15 needed her incontinustated NA-C told he because she was but he had turned by informing the down. R15 stated down so NA-C stopp stated R15 refused of surveyor if she would product could be chawhy she had turned  -At 10:45 a.m. NA-C	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY	
HAVENWOOD CARE CENTE  (X4) ID PREFIX TAG  F 312  Continued From pure wheelchair without returned to her room. It repositioning or to -At 9:58 a.m. R15' -At 10:00 a.m. R15' needed her inconting stated NA-C told her because she was it -At 10:18 a.m. NA-proceeded to assist -At 10:35 a.m. NA-			245397	B. WING		00	/22/2017
I	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	3/23/2017
ļ	HAVENV				1633 DELTON AVENUE BEMIDJI, MN 56601		
	PRÉFIX	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BF	(X5) COMPLETION DATE
	i	wheelchair without i  -At 7:45 a.m. R15 w wheelchair to the dia returned to her room  -At 9:04 a.m. license entered R15's room exited the room. LP repositioning or toile  -At 9:53 a.m. R15's  -At 9:58 a.m. nursing entered R15's room, immediately exited the  -At 10:00 a.m. R15 s needed her incontine stated NA-C told her because she was bu  -At 10:18 a.m. NA-C proceeded to assist I  -At 10:35 a.m. NA-C asked NA-C what shi responded by informe her down. R15 state down so NA-C stoppe stated R15 refused c surveyor if she would broduct could be cha why she had turned to  At 10:45 a.m. NA-C incontinent brief. The	ras observed to propel her ning room for breakfast and n.  ed practical nurse (LPN)-A to administer medication and PN-A did not offer ting assistance to R15.  call light was observed on.  g assistant (NA)-C was turned off the call light and ne room.  etated, she had told NA-C she ent product changed. R15 she would be back to help sy with another resident.  returned to R15's room and R15's roommate.  began to assist R15. R15 e was doing and NA-C ed R15 she was going to lay d she did not want to lay ed assisting R15. NA-C ares a lot. When asked by lay down so her incontinent nged, R15 stated that was he light on in the first place.  proceeded to remove R15's brief was noted to be	F 312			
	b	rief was saturated a	nd proceeded to cleanse				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245397 B. WING 03/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HAVENWOOD CARE CENTER 1633 DELTON AVENUE** BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES מו PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 312 | Continued From page 33 F 312 R15's peri area with cleansing wipes. When cleansing, R15 asked NA-C what she was doing and NA-C responded by stating she needed to clean her well because of R15's scratch marks on her bottom. Upon completing the peri-rectal cares, NA-C retrieved LPN-A. LPN-A applied a Tegaderm dressing to R15's right buttock and informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 centimeters (CM) by 0.50 cm. and stated R15 frequently scratched her body and perineal area resulting in open areas and scratch marks. LPN-A stated she applied the Tegaderm to help prevent infection. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently fell off. -At 10:58 NA-C confirmed R15's incontinent product was heavily saturated and her skin was wet. NA-C verified she had not provided R15 with

incontinent cares prior now.

STATEMEI AND PLAN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	245397	B. WING		03/23/2017		
	WOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE  BEMIDJI, MN 56601		320,2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL)	DBE	(X5) COMPLETION DATE	
	(DON) confirmed Riwith incontinence cadirected by the care her expectation for sR15's care plan, as a Resident Care Plareviewed 4/2015, indepromote optimal resiquality of care by focefforts to individual nappropriated utilization services.  Although requested, incontinence care was 483.25(b)(1) TREATM PREVENT/HEAL PRIMED (b) Skin Integrity -  (1) Pressure ulcers. Incomprehensive assess facility must ensure the comprehensive assess facility must ensure the comprehensive and dulcers unless the individemonstrates that the concessary treatment approfessional standards pressure ulcers and dulcers unless that the concessary treatment approfessional standards pressional standards approfessional	Is should have been provided are every two hours, as plan. The DON stated it was staff to follow and implement directed.  Inning Policy and Procedure, licated the care plan was to dent independence and using and directing staff eeds and to promote on and coordination of  Ino policy related to sprovided.  MENT/SVCS TO ESSURE SORES  Based on the sament of a resident, the pat- care, consistent with sof practice, to prevent oes not develop pressure vidual's clinical condition y were unavoidable; and	F31	F 314			

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(20) 444 11 7 12 17			OMB NO. 0938-039	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF		245397	B. WING			' _	- 7
	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE	<u>  03</u>	3/23/2017
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			EMIDJI, MN 56601		
PRÉFIX TAG	(CACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 1	This REQUIREMEN by: Based on observation review, the facility fareview, the facility farepositioning in order pressure ulcer development and who required assistant with the facility farepositioning in order pressure ulcer development with the facility farepositioning in order pressure ulcer development who required assistant with the facility farepositioning included:  R88's undated Face Statement fareful fa	on, interview and document iled to prevent the stage 2 pressure ulcers for 1 who developed two pressure ission to the facility. In ailed to provide timely to minimize the risk of opment for 2 of 4 residents at risk for pressure ulcers sistance for repositioning.  Sheet included diagnoses of left clavicle and seventh astic syndrome, and anxiety mum Data Set (MDS) dated 38 had severe cognitive extensive assistance from lity and toileting, and	F3	14	5/2/17 for turning and repositioning.  The facility's policy on nursing care plans was revised on 4/17/17.  Education has been provided to all NAs regarding the importance of applying Prevalon boots per the wearing schedule described on the resident's care sheet. The NAs have also been educated on the importance of following resident's care plan regarding turning and repositioning.  The facility has implemented weekly skin inspections by a licensed nurse on the residents shower/bath day.  The LPNs/RNs will be educated on the weekly skin inspections prior to 5/2/17.  Random turning and repositioning audits as well as care planning audits will be completed by the Director of Nursing or designee		
tı fi p	equired extensive ass ransferring. The MDS requently incontinent	sist from one staff for further indicated R88 was of urine, did not have a dmission, was at risk for as on a turning and			weekly x 4 weeks. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.		
fc	DAA) dated 12/18/16, or pressure ulcers rela	Care Area Assessment indicated R88 was at risk ated to urinary mobility, cognitive loss			The Director of Nursing is responsible for compliance with this regulation.  Completion Date: 5/2/17		

STATE	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MII	I TIDI E	CONSTRUCTION		7. 0936-039
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:					
			1 2012			"	
		245397	B. WING	à			100/00:-
NAME	OF PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	] 03	3/23/2017
HAVE	NWOOD CARE CENTER				33 DELTON AVENUE		
	————				MIDJI, MN 56601		
	D SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
	JEON OF CORRECTION IDENTIFIED IN IDENTIFIED	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD	) BE	COMPLETION
		The second secon	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X3) DATE SURVEY COMPLETED  03/23/2017  CODE  ORRECTION N SHOULD BE EAPPROPRIATE  (X5) COMPLETION DATE	
				-			
F 3	14 Continued From pa	age 36	F.S	314			
	functional limitation	in range of motion and		''-			
	diagnoses of deme	entia, pain, weakness, fracture					
	of clavicle, and poc	or nutrition. The CAA indicated					
	Hos required a turn	ning schedule and staff would					
turn and reposition R88 every two hours while in bed. The CAA indicated R88 received no at risk							
	medications, howey	ver failed to identify the use of					
HAVENWOOD CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314 Continued From page 36 functional limitation in range of motion and diagnoses of dementia, pain, weakness, fracture of clavicle, and poor nutrition. The CAA indicated R69 required a turning schedule and staff would turn and reposition R88 every two hours while in bed. The CAA indicated R88 received no at risk medications, however failed to identify the use o antidepressant, antipsychotics, and narcotic pair medications that could increase the risk for pressure ulcers. The CAA indicated a care plan would be developed related to the risk for pressure related ulcers.  R88's Braden scale (tool used to help determine the risk for developing pressure ulcers) dated 3/20/17, indicated R88 was at risk for pressure ulcers.  R88's Tissue Tolerance Assessment (a tool to determine amount of time skin can tolerate pressure without change) dated 3/20/17, indicated R88 should be repositioned every two hours while in the wheelchair, reclining chair, and bed.  R88's care plan dated 12/28/16, indicated R88 had decreased physical mobility and directed staff to provide extensive assistance to turn and reposition every two hours, assist to sit up/lie							
	medications that could increase the risk for						
	pressure ulcers. Th	e CAA indicated a care plan					
	would be developed	related to the risk for					
	pressure related uic	cers.					
	R88's Braden scale	(tool used to help determine				l	
	the risk for developi	ng pressure ulcers) dated					
	3/20/17, indicated F	188 was at risk for pressure					
	uicers.						
	R88's Tissue Tolera	nce Assessment (a tool to					
	determine amount of	of time skin can tolerate					
	pressure without cha	ange) dated 3/20/17.					
	indicated R88 should	d be repositioned every two					
	nours while in the wi	heelchair, reclining chair, and					
	bed.					!	
	R88's care plan date	ed 12/28/16, indicated B88					
	had decreased phys	ical mobility and directed staff					
	to provide extensive	assistance to turn and					1
	down and get fact	hours, assist to sit up/lie					j
	one to ambulate and	ranefor Staff to wheel to					Ì
	destinations Monitor	for persistent red cross and					
	notify the registered	nurse. The care plan did not					
	Indicate H88 was at i	risk for pressure related					
	ulcers. R88 had alter	ation in elimination, was					
_	incontinent and direc	ted staff to provide extensive					1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER: (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245397	B. WING	i		03/23/2017	
	PROVIDER OR SUPPLIER			163	REET ADDRESS, CITY, STATE, ZIP CODE  33 DELTON AVENUE  MIDJI, MN 56601	03	0/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	toileting and chang rectal care after eli indicated R88 was directed staff to mo redness and break  R88's nursing assis staff to turn and rep  R88's quarterly diet 3/13/17, indicated F loss of 9% in 30 da approximately 30 dolinic stay and retur. The assessment inchimself and on 2/3/supplement was initrecorded weights reof 124 lbs. (pounds) and on 3/21/17, R86  R88's physician ord medication) three time and on 3/21/17, R86  R88's physician ord medication) three time and on 3/21/17, R86  R88's physician ord medication) three time arcotic, three time arcotic, three times are lease every evenirelease every evenire.	et every two hours, check with e as needed, and provide perimination. The care plan also at risk for dehydration and onitor R88's skin for hydration, down.  Stant (NA) care guide directed position R88 every two hours.  Stant (NA) care guide directed position, and position R88 every two hours.  Stant (NA) care guide directed position, and position R88 every two hours.  Stant (NA) care guide R88 every two hours.  Sta	F3	314			
	Administration Reco	rds (MAR) were reviewed					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 245397 B. WING 03/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1633 DELTON AVENUE** HAVENWOOD CARE CENTER BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 314 Continued From page 38 F 314 since admission and revealed the following: -Progress note dated 2/27 at 2:54 a.m. R88 slept in a recliner in the TV lounge and refused to go to his bed. Progress note entry at 10:16 a.m. indicated R88 had been yelling his back and bottom hurt, medications were given, and he was transferred to another chair with no relief. Documentation does not reflect evidence of a skin assessment which would have included a skin inspection. -Progress note dated 2/28/17, at 4:59 p.m. indicated R88 was demonstrating behaviors. R88 was more restless and his bottom hurt. As needed Seroquel and Trazodone were administered. Documentation does not reflect evidence of a skin assessment which would have included a skin inspection. -MAR dated 3/3/17, indicated on 3/3/17, at 3:04 p.m. as needed dose of Neurontin was

administered for buttocks pain and headache. Documentation indicated the dose was not effective. Corresponding progress note indicated staff had repositioned R88 every two hours and applied barrier cream, however, the note lacked evidence that a skin inspection was conducted.

- MAR dated 3/5/17, indicated at 4:51 p.m. as needed dose of Neurontin was administered for

Documentation indicated the dose was effective, however, the medical record lacked evidence of a skin inspection to rule out impaired skin integrity.

-Progress note dated 3/13/17, at 2:45 a.m. indicated R88 had been sleeping in the recliner for the first portion of the night. At 1:22 p.m. as

buttocks pain, anxiety, and agitation.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (ALL) PROVIDED (CHIRDLES)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245397	B. WING			02	/22/2017
HAVENV	PROVIDER OR SUPPLIER			16	REET ADDRESS, CITY, STATE, ZIP CODE 33 DELTON AVENUE EMIDJI, MN 56601	1 03/	/23/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	needed dose of Nei to R88 "screaming a Documentation indice However, the medical that a skin assessme would have included R88's medical recorsions, more for impaired skin integrity. The medical of open areas to the On 3/21/17, at 8:32 seated in his wheeld in a slumped position cushion was noted in Implementation date not be determined.  -At 8:36 a.m. R88 plant and adjusted himself upright position.  -At 9:19 a.m. R88 was position while seated unidentified staff medupright by moving be wrapping her arms unlifted/slid R88 to an united-At 2:03 p.m. physical registered nurse (RN and ambulate R88. F	carontin was administered due about butt pain." Cated dose was effective. Cal record lacked evidence ent was completed which da skin inspection.  Id lacked evidence of routine onitoring, and/or assessment egrity or changes to skin all record revealed no history skin.  In the wheelchair.  In the wheelchair of the seat cushion could enter the dining room table in the wheelchair.  In the wheelchair of the seat cushion could enter the wheelchair.  In the wheelchair of the wheelchair of the wheelchair.  In the wheelchair of the wheelchair, and the wheelchair and the wheelchair, and the wheelchair and the wheelchair.	F3	314			
	On 3/22/17, at 7:50 a.m. trained medication						

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245397	B. WING	i	0/	2/00/004=	
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	_ [ 03	3/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( TOTAL TOTAL NOTION OF TOO	LD BE	(X5) COMPLETION DATE	
	assistant (TMA)-B signals assistant (TMA)-B asked R88 in R88 had denied.  -At 7:52 a.m. license entered the room wistated "leave me alout had medications and TMA-B and LPN-D at a couple of times and LPN-D informed R88 he needed to sit up. edge of the bed, and administer medication hurt. R88 continued however cooperative would administer the R88 was up and drese exit the room.  -At 8:02 a.m. TMA-B assisted R88 to roll of TMA-B pulled R88's underneath R88, R88 hurting me, leave me started to wash R88's "ouch." TMA-B stated and continued to was then requested to inspection required approximately the inside right buttoor aised with an open of was not aware of the said anything about Failed and continued about Failed anything about Failed and Failed and Failed anything about Failed and Failed and Failed and Failed and Failed and Failed and Failed anything about Failed and Failed	ge 40 tated it was time to administer which included pain pills. R88 en TMA-B entered the room. If he had any pain in which ed practical nurse (LPN)-D the R88's medications. R88 ene", LPN-D explained she dere he needed to sit up. When attempted to assist R88 to sit ed, R88 stated "ouch" a cried "just leave me alone." If she had his pain pills and when R88 was sitting on the las LPN-D attempted to ens, R88 stated his bottom to be verbally resistive, en, and LPN-D stated she rest of the medications after essed. LPN-D proceeded to donned gloves, directed and ever onto his right side. As incontinent brief from the last pain pills and ensemble of the medications after essed. LPN-D proceeded to donned gloves, directed and ever onto his right side. As incontinent brief from the last pain yelled "ouch, you are estalone." When TMA-B is bottom, R88 again yelled the R88's bottom. Surveyor pect R88's skin on his vealed a stage two pressure he size of a pencil eraser on extended the analysis of the area was slightly enter. TMA-B indicated she open area and nobody had last having an open area, any cream in his room to	F3	114			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION MUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245397	B. WING		03	/23/2017	
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIF 1633 DELTON AVENUE BEMIDJI, MN 56601	, CODE	20/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	put on it either. TM. R88's morning care  -At 8:21 a.m. LPN-E LPN-D and TMA-B assisted him to his in the open area and in the pressure ulcer.  -At 12:02 p.m. RN-C been previously repostaff and had not be assessed and detern (partial thickness loss shallow open ulcer in without slough or produced bilister) presumed bilister) presumed bilister) presumed bilister (cm) 0.1 cm, and had scatunneling and no man pressure-relieving in R88's family was connotified, and a consumed bilister (cm) and in the open area and would reposted admission and with the NAs looked at eacares and would reposted bath days and would of skin concerns on the worksheet to the nur transcribe any skin concerns on in the open area of the open and the open area of the open and the open area of the open area of the open and the open area of the o	A-B proceeded to complete s.  Preturned to R88's room, both completed R88's cares and wheelchair where LPN-D gave bills. LPN-D did not observe to treatment was provided to control or identified by facility en treated. R88's wound was mined to be a Stage two as of dermis presenting as a with a red or pink wound bed, esented as an intact or assure ulcer which measured by 0.5 cm with a depth of antipink drainage, no concertion. RN-C stated a cattress was put in place, that the doctor would be all would be requested from that the doctor would be all would be requested from that the doctor would be all would be requested from that the concern to the NAs also looked at skin on document any noted areas the bath worksheets, give the see and the nurse would ondition concern onto a masked if staff kept records evidence that a skin ucted following the concern, RN-C stated no,	F 3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		TE SURVEY MPLETED	
11115.05		245397	B. WING	3	03	/23/2017
	NAME OF PROVIDER OR SUPPLIER    X49 ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 314   Continued From page 42   documented onto the progress note. RN-C state a resident progress note was only written when there was an area of concern identified. RN-C confirmed R88's medical record lacked evidence of routine skin monitoring and evaluations. RN-C stated when a wound was found, nurses were to complete a wound assessment worksheet and the resident would also be added to the facility's weekly wound rounds.  -At 1:46 p.m. LPN-D stated R88's scheduled bat day was Friday evenings and confirmed the NAs let the nurses know about any resident skin conditions. LPN-D stated the RNs usually completed a comprehensive skin assessment or admission but nurses did not perform whole bod skin inspections and did not know how often, if ever, whole body inspections by a nurse was conducted.  -At 1:58 p.m. NA-I stated residents' skin was checked daily with cares and on bath days and if she saw something, she would report it to the nurse right away.  On 3/23/17, at 8:39 a.m. R88 was observed seated in his wheelchair in the lobby area. R88 cried out, "oh God please help me, God please help me I have to go potty, I have to poop!"  Surveyor immediately communicated to facility staff R88 had to use the restroom. R88 continued to yell out and became increasingly agitated and fidgety until he was assisted to the bathroom at 8:44 a.m. by NA-H. Once in the bathroom R88 cried out, "Jesus my butt hurts." R88 utilized the grab bar to independently stand up with minimal			STREET ADDRESS, CITY, STATE, 1633 DELTON AVENUE BEMIDJI, MN 56601	ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	documented onto the a resident progress there was an area of confirmed R88's me of routine skin monistated when a wound atthe resident would a weekly wound round -At 1:46 p.m. LPN-D day was Friday ever let the nurses know conditions. LPN-D stompleted a compreadmission but nurse skin inspections and ever, whole body insconducted.  -At 1:58 p.m. NA-I stohecked daily with cashe saw something, nurse right away.  On 3/23/17, at 8:39 a seated in his wheeld cried out, "oh God plhelp me I have to go Surveyor immediatel' staff R88 had to use to yell out and becamfidgety until he was a 8:44 a.m. by NA-H. Ocried out, "Jesus my grab bar to independ physical assistance as	note was only written when of concern identified. RN-C edical record lacked evidence toring and evaluations. RN-C and was found, nurses were to assessment worksheet and also be added to the facility's dis.  I stated R88's scheduled bath hings and confirmed the NAs about any resident skin tated the RNs usually chensive skin assessment on s did not perform whole body did not know how often, if pections by a nurse was area and on bath days and if she would report it to the  a.m. R88 was observed hair in the lobby area. R88 ease help me, God please potty, I have to poop!" y communicated to facility the restroom. R88 continued he increasingly agitated and ssisted to the bathroom at Once in the bathroom R88 butt hurts." R88 utilized the	F3	314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
NAME OF	DDOVIDED OF OURTH	245397	B. WING			/23/2017	
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 1633 DELTON AVENUE BEMIDJI, MN 56601	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	dated 3/22/17, was and not covering the inside buttock. NA-I revealed another state coccyx which was son the right buttock. pink wound bed. NA worked on Monday was not there at that the other wound had stated the area wou applied and the next and in a couple of dagain. NA-H confirm when she found skir documentation shee any impaired skin incream to the coccyx direction from a nurse. At 8:55 a.m. RN-C acream was removed RN-C confirmed the previously reported to and had not been tree wound and stated it wanted another nurse assess the coccyx wo obtained for better viin the bathroom and flashlight, RN-C confiand assessed the workessure ulcer which with a depth of less to	located over the coccyx area be pressure ulcer on the right of removed the dressing which age two pressure ulcer on the lightly smaller than the wound. It was oval shaped with a land the wound on the coccyx of time. However, NA-H stated and the wound on the coccyx of time. However, NA-H stated always been there. NA-H lad get red, cream would be at day the area would be gone asys the areas would be back ned she reported to the nurse of problems and bath of the wound without obtaining sections.  The barrier from the coccyx by NA-H, wound had not been or identified by facility staff eated. RN-E looked at the was not open, however, we that had better eyes to ound. A flash light was ewing related to poor lighting once viewed under the immed the wound was open ound to be a stage two measured 0.5 cm by 0.2 cm than 0.1 cm. The area was beam dressing was applied to	F3	114			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

AND PLAN (	I OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
	•	245397	B. WING	i	03	/23/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 1633 DELTON AVENUE BEMIDJI, MN 56601	ZIP CODE	123/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	-at 9:51 a.m. RN-C wheelchair changes discomfort and conf skin each time the whowever had not do stated the skin show were reports of bottonursing (DON) state Tuesday 3/21/17, ar skin integrity. The Dresidents' skin on a days and reported a the nurses would inf something was broud DON verified the nur and completed the Eadmission and then then with change of -At 1:23 p.m. RN-C in implemented include repositioning R88 ev Mepliex dressing to inchange every three of the dressing every slinurse if the dressing Would also recomme look into changing secream to be applied,	stated R88 has had multiple in related to reports of immed she had observed the wheelchair was changed, cumented any findings. RN-C all be inspected when there can discomfort. The director of the she had toileted R88 on and had not noted any impaired ON stated the NAs looked at daily basis and also on bath any concerns to the nurse and formally look at the skin when aght to their attention. The reses looked at residents' skin braden Scale assessment on weekly for three weeks and condition.  Indicated interventions and a new mattress, wery hour, cleanse area, apply anner and upper right buttock, days and check position of hift and staff to inform the was not staying in place. The state of the physician, weat cushion, lanispetic barrier request a dietary consult realuated by the RN weekly	F3	314		
	failed to provide ever repositioning and fail	ressure ulcers and the staff y one hour turning and ed to ensure pressure applied at all times, as blan.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245397	B. WING	i		03	/23/2017
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			16	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE EMIDJI, MN 56601	1 03	/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	F 314 Continued From page 45		F3	314			
	R89 had diagnoses chronic kidney disease, pulmonary disease, MDS also indicated was non-ambulator two persons for bed extensive assist of chygiene and was to persons for transfer further indicated R8	S dated 1/15/17, indicated which included stage 3 ase, chronic obstructive anemia and diabetes. The R89 was cognitively intact, y, required extensive assist of mobility and dressing, one person for personal tally dependent on two s and toilet use. The MDS 9 had one unhealed, stage 2 ent on admission to the					
	indicated R89 required and was always incompleted from the CAA indicated from the CAA indic	er CAA dated 10/27/16, red total assist with bathing ontinent of bowel and bladder. R89 was at risk for pressure inary tract infections/sepsis, rt and weight loss which was ent cellulitis, severe pain, f for bed mobility and toileting chronic kidney disease.					
	potential for alteratic pressure sore on lef implement the follow turn and reposition needed provide perirectal c episode. monitor for persiste registered nurse (RN	every one hour and as care after each incontinent ent red areas and report to					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES			,	PRINTE	D: 04/10/20 <sup>-</sup> M APPROVE	17 -D
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	(X3) D	O. 0938-039 ATE SURVEY OMPLETED	)1
NAME OF		245397	B. WING	G _		0.	3/23/2017	
	PROVIDER OR SUPPLIER VOOD CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	1 0	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE PROPERTY OF T	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTION	) BE	(X5) COMPLETION DATE	-
	wound care/dressider-keep skin clean andkeep skin clean andkeep skin clean andAPP [alternating pre-pressure relief book directed staff to turn one hour and indicated prevalon boots (heel prevent the developminjuries) on at all times. R89's Physician Orde 2/23/17-3/23/17, including prevalon (blue) heel for bathing. Ensure her R89's Braden Scale of was at moderate risk. R89's Tissue Tolerand 10/15/16, directed state the wheelchair, chair and to turn and reposited. On 3/22/17, from 7:03/25 minutes) R89 was sleeping in bed, lying covers, with her should reposite the state of the state of the whole of the state of the wheelchair, chair and to turn and reposited.	cub [decubitus] programing change as ordered. d dry. essure pad] mattress on bed. ts on both feet as ordered.  Ing Assistant Care Worksheet and reposition R89 every ed R89 needed to have offloading device to help nent of heel pressure es except when bathing.  In Report dated uded an order to wear lift boots at all times except eel is in proper position.  In Assessment dated aff to reposition R89 while in or recliner every one hour ition every one hour when in the a.m. until 8:28 a.m. (1 hour continuously observed on her back under the ders positioned slightly to the repositioned or offered	F	314				

determine if R89's Prevalon boots were on, as

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
NAME OF	Province	245397	B. WING		03	/23/2017
HAVEN	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE  BEMIDJI, MN 56601	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	) BE	(X5) COMPLETION DATE
	directed. R89 was again contilying on her back frowithout staff assistationat 10:47 a.m. R89 positioned on her batelevision. R89 statemorning and no one the day yetat 10:52 a.m. LPN-administered R89's immediately exited the positioned on her batelevisioned every no more descriptioned every with the state of the batelevisioned every turned every hour where heel. NA-A enteremechanical lift and Natice with a mechanical lift and Natice without reductioned every hour where heel. NA-A enteremechanical lift and Natice with a mechanical lift and Natice without reductioned every hour where heel. NA-A enteremechanical lift and Natice without reductioned every hour where heel. NA-A enteremechanical lift and Natice without reductioned every hour where heel. NA-A enteremechanical lift and Natice without reductioned every hour where heel. NA-A enteremechanical lift and Natice without reductioned every hour where heel. NA-A enteremechanical lift and Natice without reductioned every hour where heels.	inuously observed in bed, om 9:16 a.m. to 10:47 a.m. nee to reposition.  was observed in bed ack, awake and watching ed she liked to sleep in in the had come in to get her up for A entered R89's room and insulin in the abdomen and he room. R89 remained ck. LPN-A did not offer nor assistance.  2 hours and 10 minutes) I last been in R89's room at me she checked R89's and asked R89 if she wanted in which R89 declined to get liry at that time. NA-C entered d a bathing supplies and R89 with morning cares. I and she was noted to be an boots on both feet. NA-C which revealed a gauze is heel. R89's right heel was liness. Following perirectal with turning by pulling her ne use of a grab bar. required to assist the turn by R89's hips and pushing her e bed. R89's buttocks were a sized light red area noted NA-C indicated R89 was to a two hours but used to be en R89 had an open sore to	F3			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			F		D: 04/10/2017
		& MEDICAID SERVICES			C		MAPPROVED 0. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245397	B. WING	_		03	/23/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		723/2017
HAVENV	OOD CARE CENTER				1633 DELTON AVENUE		
(X4) ID	SHMMADV STA	TEMENT OF DEFICIENCIES		E	BEMIDJI, MN 56601		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From page	ne 48	F3	1 1			
		ipped with a seat cushion and	F 3	14			
	a padded board was	s across the calf support area					
	were raised. NA-C	ot/leg rests. The leg rests assisted R89 to complete her					
	morning cares and t	then wheeled R89 out of her					
	room and to the dini	ing room at approximately revalon boots were not					
	reapplied.	revalori boots were not					
	On 3/22/2017, at 1:2	27 p.m. RN-A stated NA-C					
	had come to her after	er assisting R89 up for the					
	and repositioning sc	ne had thought R89's turning hedule was for every two					
	hours. RN-A verified	d R89's current repositioning					
	schedule was for eve	ery one hour.		Ì			
	0.00000						
	On 3/22/2017, at 1:3	37 p.m. R89 was observed in the wheelchair. LPN-A stated					
	she had just assisted	d R89 to put on her Prevalon					
	boots. LPN-A verifie	ed R89 did not have them on		İ			
	times due to issues	hould have them on at all with her heels. NA-C asked					
	LPN-A, "Aren't we su	upposed to release them					
	once in a while?" LF boots should be on a	PN-A informed NA-C the					
	On 3/22/17 at 1:40 n	.m. NA-C confirmed she had					
	not put R89's Prevak	on boots on when she					
	assisted R89 up for t	the day and should have fied the boots were off for					
	approximately one ho						
	On 3/23/2017, at 9:5	1 a.m. RN-A verified R89					
	was admitted to the f	acility with a left heel ulcer		1			1

which had recently healed and also had a history

A	STATEMEN ND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		TE SURVEY
L			245397	B. WING		03	3/23/2017
		PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601		0/20/2017
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
		of pressure ulcers to confirmed R89 shourepositioned every of the Prevalon boots of bathing, as directed.  R15 was at risk for prediction of the prevalon boots of bathing, as directed.  R15 was at risk for prediction of the prevalon of the prevalon boots.  R15's quarterly MDS R15 had intact cognitation assistance of two states as directed.  R15's Activity of Daily CAA dated 10/23/16, diagnosed with diabet obstructive pulmonar extremity amputation required extensive as was at risk for infection and pressure ulcers.  R15's care plan dated decreased physical materials are prevaled in the prevaled pressure ulcers.  R15's care plan dated decreased physical materials are prevaled pressure ulcers.  R15's care plan dated decreased physical materials are planted to staff were directed to	other bottom. RN-A and have been turned and one hour and should have had on at all times except for on the care plan.  Oressure related sores and y turning and repositioning and by the care plan.  Ored dated 1/16/17, indicated tion and required extensive aff for transfers, required to for bed mobility and had to for bed mobility and had to have a few or the care plan.  Ored 1/18/15 was better a few or the care plan and bilateral lower in the care plan	F 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245397  NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 50  R15's Braden Scale dated 3/20//17, indicated R15 was at risk for processed dated in a british.	039
NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE BEMIDJI, MN 56601  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 50 R15's Braden Scale dated 3/20//17, indicated	
NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER    1633 DELTON AVENUE   BEMIDJI, MN 56601	
HAVENWOOD CARE CENTER    1633 DELTON AVENUE   1633	
HAVENWOOD CARE CENTER  1633 DELTON AVENUE BEMIDJI, MN 56601  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 50 R15's Braden Scale dated 3/20//17, indicated	7
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314 Continued From page 50 R15's Braden Scale dated 3/20//17, indicated	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 50  R15's Braden Scale dated 3/20//17, indicated	
F 314 Continued From page 50 R15's Braden Scale dated 3/20//17, indicated REGULATORY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 314	
F 314 Continued From page 50 R15's Braden Scale dated 3/20//17, indicated	TION
F 314 Continued From page 50 F 314 R15's Braden Scale dated 3/20//17, indicated	
R15's Braden Scale dated 3/20//17, indicated	
R15's Braden Scale dated 3/20//17, indicated	
R15 was at risk for prossure ulcore due to include	
DID Was at fight for procedure disease due to the land to	
R15 was at risk for pressure ulcers due to inability	
to bear her own weight and make frequent or	
significant changes in position.	
On 3/22/17, during continuous observations from	
7:15 a.m. to 11:00 a.m. R15 was observed to	
remain seated in her wheelchair without receiving	
assistance.	
-At 7:45 a.m. R15 was observed to propel her	
wheelchair to the dining room for breakfast and	
returned to her room.	
-At 9:04 a.m. LPN-A entered R15's room to	
administer medication and exited the room.	
LPN-A did not offer nor provide R15 repositioning	
assistance.	
-At 9:53 a.m. R15's call light was observed on.	
-At 9:58 a.m. NA-C entered R15's room, turned	ı
the call light off and immediately exited the roomAt 10:00 a.m. R15 stated she had told the NA-C	
she needed her incontinent brief changed and the	
NA stated she would be back to help her because	
she was busy with another resident.	- 1
-At 10:18 a.m. NA-C returned to R15's room and	
proceeded to assist R15's roommate.	
-At 10:35 a.m. NA-C began to assist R15. R15	- 1
asked her what she was doing and NA-C	
informed R15 she was going lay her down. R15	ĺ
stated she did not want to lie down. NA-C	
stopped assisting R15 and stated R15 refused a	
lot. When asked by the surveyor if she would lay	
down so staff could change her incontinent brief,	
R15 stated that was why she had turned the call light on in the first place.	
-At 10:45 a.m. NA-C proceeded to provide R15	[
incontinent cares. When removed, the incontinent	
brief was observed heavily saturated with urine.	
NA-C confirmed the brief was saturated. NA-C	

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING	1, ,	TE SURVEY MPLETED
		245397	B. WING	à	03	/23/2017
HAVENV	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 1633 DELTON AVENUE BEMIDJI, MN 56601	DE O	(20)2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
	R15 asked NA-C what stated she needed to R15's peri area scraperi care, NA-C state nurse and would be the room with LPN-A dressing to R15's rigarea. LPN-A informed area on her bottom to the open area mease by 0.50 cm. LPN-A scratched her body is resulting in open area stated she applied the infection. LPN-A furth incontinence and we frequently fell off.  -At 10:58 a.m. R15's NA-C confirmed R15 with urine and her sked had not provided R15 repositioning and inconow.  -At 10:59 a.m. NA-B stated she had assist pointed to a white may and stated staff document of the amount of the and stated staff document of the amount of the amo	se R15's peri area with wipes. That are you doing, NA-C or cleanse R15 well due to obtobes. Upon completing the ed she needed to get the right back. NA-C returned to a who applied a Tegaderm ght buttock covering an open from scratching. LPN-A stated ured approximately 0.25 CM stated R15 frequently nocluding her peri area has and scratch marks. LPN-A he dressing to help prevent her stated, due to R15's to skin, the dressing	FS	314		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DESICIENCIES

AND PLAN	1 OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED
		245397	B. WING		0	3/23/2017
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZI 1633 DELTON AVENUE BEMIDJI, MN 56601	IP CODE	0,20,1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	On 3/22/17, at 11:10 R15 should have be directed by the care  A Resident Care Plate reviewed 4/2015, incompromote optimal residuality of care by for efforts to individual rappropriated utilization services.  The Pressure Ulcer 4/2015, indicated the prevention protocol it of development of turns.	a.m. the DON confirmed en repositioned every hour as	F3	14		
	Facility protocol Skin indicated on admissi assessment would b develop a comprehe components of the cincluded a Braden's weeks, skin assessment admission assessmerelieving devices and assessment. Other sincluded the Braden's significant change in	Care last reviewed 1/2015, on a comprehensive skin e completed and used to nsive care plan. The omprehensive assessment scale weekly times four nent-completed with the initial ent, assessment for pressure I a tissue tolerance test cheduled assessments is scale quarterly and with status, skin assessment with latus, weekly body audit on				

		AND HUMAN SERVICES			Р		: 04/10/2017 1APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES					QMB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245397	B. WING			03	/23/2017
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	103/	23/2017
HAVENV	VOOD CARE CENTER				633 DELTON AVENUE EMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From page to perirectal area da		F3	14			
F 323 SS=G	483.25(d)(1)(2)(n)(1	)-(3) FREE OF ACCIDENT	F3	23	F 323		
	(d) Accidents. The facility must end (1) The resident environ accident hazar	sure that - rironment remains as free ds as is possible; and			A new fall risk assessment was completed on resident 64 on 4/24/17. Resident 64's fall interventions were reviewed on		
	(2) Each resident reand assistance devi	ceives adequate supervision ces to prevent accidents.			4/26/17 and new interventions were added.  Resident 64's falls were re-assessed	ı	
	appropriate alternati bed rail. If a bed or	facility must attempt to use ves prior to installing a side or side rail is used, the facility installation, use, and			for causative factors on 4/26/17 and changes were made to his/her plan of care on 4/26/17.		G
	maintenance of bed to the following elem	rails, including but not limited			A new fall risk assessment was completed on 4/24/17 on resident 88. Resident 88's fall interventions		2
	(1) Assess the reside from bed rails prior to	ent for risk of entrapment			were reviewed on 4/26/17.		
	(2) Review the risks the resident or reside	and benefits of bed rails with			Resident 88's falls were re-assessed for causative factors on 4/26/17.		
	informed consent pri  (3) Ensure that the bappropriate for the re	İ			All resident's fall interventions will be reviewed prior to 5/2/17 to ensure appropriateness.		
	This REQUIREMEN' by: Based on observation review, the facility fair assess falls in order implement fall interventhe risk for falls and/or	T is not met as evidenced on, interview and document led to comprehensively to identify causal factors and entions in order to minimize or injury for 2 of 4 residents			All charge nurses will be educated on the importance of comprehensively assessing resident falls for causative factors as well as completing an evaluation of the resident's current fall interventions to assess for effectiveness prior to		
	(H64, H88) who had	repeated falls. This failure			5/2/17.	}	

resulted in actual harm for R64.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		245397	B. WING	i		03.	/23/2017
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE SEMIDJI, MN 56601	1 00,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	ge 54	F3	323	The facility's Assessment After a Fall policy was reviewed on 4/19/17.		
	Findings include:				The facility's Fall Prevention Policy was reviewed on 4/19/17.		
	diagnoses included dizziness, seizures, degeneration (poor delusional disorder and the seizures) defended and disorder and	Jum Data Set (MDS) dated by MDS dated 12/20/16, evere cognitive impairment, entiveness, required toileting and dressing, alking in room and corridor, tinent of urine, had functional		M	Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure all resident falls are assessed for causative factors, that an intervention is implemented after each fall, and that interventions are assessed for their effectiveness. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.  The Director of Nursing is responsible for this regulation.  Completion Date: 5/2/17		
	10/2/16, indicated Rediagnosis and was a balance during transfeccived daily doses diuretic medication, Fadaily and had sustain assessment period. for falls which could rinjury, soft tissue inju	a Assessment (CAA) dated 64 also had a Bi-polar fall risk due to impaired fer transitions, R64 had of an antipsychotic and a R64 had wandering behavior led nine falls since the last In addition, R64 was at risk result in fractures, head ry, muscle injury and ted by Alzheimer's dementia					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	JLTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
		245397	B. WING	à		03/23/2017
	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STAT 1633 DELTON AVENUE BEMIDJI, MN 56601		30,20,2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 323	R64's Cognitive Los 10/2/16, indicated F may be an attempt toileting needs, unc CAA also indicated with other residents communicating a neinattention that fluct confusion, and incresisolation. Complicat dementia with beha mood disorder. Staff and supervision who R64's Urinary Incon indicated R64 requitoileting and was free	ass/Dementia CAA dated R64's unexplainable behavior at communication about pain, omfortable position etc. the R64 had physical behaviors which may be a way of R64 eed of some kind. R64 had cuated, was at risk for eased behaviors, falls and e by Alzheimer's disease, vior disturbances and Bi-polar ff will proceed to provide cues	F	323		
	R64 was frequently directed staff to prove 1.5-2.5 hours and to change as needed, and directed staff to use [unidentified] parassist to position for physician informed, mobility with potential ambulate to specific in secured unit, when and reposition self, selegs into bed independent. The plan directions are selected unit.	ewed on 3/16/17, indicated incontinent of urine and vide limited assistance every ocheck with toileting and R64 had a potential for pain medicate R64 as ordered, an scale to assess pain, comfort and to keep R64 had decreased physical all for falls with inability to destinations at specific times el self, transfer self or turn sit up, lie down or get feet and endently, wanders on secured ed staff to provide limited				

		AND HUMAN SERVICES					ED: 04/10/2017 RM APPROVED
		& MEDICAID SERVICES					IO. 0938-0391
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) E	OATE SURVEY COMPLETED
		245397	B. WING		W.		00/00/004~
NAME OF	PROVIDER OR SUPPLIER		-	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		03/23/2017
	WOOD CARE CENTER			1633	DELTON AVENUE IDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTINEYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BF	(X5) COMPLETION DATE
F 323	with walker. Provide transfer and also tra safety halos, and to (physician orders) for hand written, undate in space wheelchair	ge 56  limited assist of one staff to nsfers self at times, utilize refer to nursing orders or further fall interventions. And entry indicated a manual tilt was to be utilized for comfort, ty. Restorative nursing as	F 3	23			
	10/23/16, through 2/5 fall prevention interverselavender oil behind day (initiated 11/23/1-contour mattress wit-30 minute checks (in	th cut out (initiated 11/23/15) initiated 2/19/16) secure dementia unit due to					
	between 10/23/16, ar	l and fall assessment reports nd 3/19/17, revealed R64 lowing 14 falls, one which (fall on 3/2/17):					
	corresponding Safety indicated R64 had fal hallway on 10/23/16, wandering in the hallwanother resident's roctried to stop R64 and grabbed R64 at the safety indicates the safety and the s	I which was witnessed in the at 10:00 p.m. R64 had been vay and attempted to enter by when a staff member					

laid down. No injury noted with this fall. Orthostatic blood pressures were stable.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			E SURVEY MPLETED		
		245397	B. WING	i		03/	22/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 1633 DELTON AVENUE BEMIDJI, MN 56601					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPR	BE .	(X5) COMPLETION DATE		
	p.m. indicated this year, R64 was currurinary tract infectic increased R64's rist balance. Current faplace were a conto every 30 minute character and the Evaluation Not only that a Fall Prev. R64's pain was resupdated.  Although this incide medical record lack fall prevention interest.  2. R64's Fall Assective corresponding Safe indicated R64 had a dining room on 11/2 found on the floor manother resident had R64 had not been unoted with this fall. It was stable. Plan with pressure, blood sugmonitor R64.	note dated 10/24/16, at 1:06 had been R64's 17th fall this ently being treated for a on (UTI) which could have k for falls and R64 had lost her all prevention interventions in ured mattress with cutout and	F3	323					
	a.m. indicated this v	vas R64's 18th fall this year, ipper socks, R64 ambulated							

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245397 B. WING 03/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1633 DELTON AVENUE** HAVENWOOD CARE CENTER BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 58 F 323 with a walker most often, but staff needed to remind R64 to use it. It was not noted if R64 had been using the walker at the time of the fall. R64's fall prevention interventions in place remained the same. Staff does not plan to discuss use of a wheelchair for resident as staff felt R64's risks in the wheelchair were significantly worse. Evaluation Notes indicated by a check mark only that a Fall Prevention Program was initiated, pain was resolved and care plan was updated. R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following the 11/27/16, in order to minimize further falls and/or injury. On 3/22/17, at 1:03 p.m. the director of nursing (DON) and registered nurse (RN)-B confirmed the above fall. However, stated both were on leave during this fall event. RN-B verified the family had requested R64 remain independent and walking. The DON stated the fall process included the fall would be discussed at the morning meetings- the falls committee which included unit managers, therapy, MDS nurse. If a

fall occurred the fall committee talked about it on the next day and an action plan would be made and a follow up progress note was put into place. The DON stated on the weekend, the charge nurse would put immediate interventions into place, educate staff, if needed and document. As far as determining causal factors related to this

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245397	B. WING			02	/22/2017
	PROVIDER OR SUPPLIER			16	TREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE EMIDJI, MN 56601	1 03,	/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	Continued From pa fall, the DON stated this as she was not fall.	ge 59 I was unable to comment on in the facility at the time of the	F3	23			
	corresponding Safe indicated R64 had a resident's bathroom R64 was found in ar floor in the bathroom the back of her head her and the lights in Vitals were checked bed. Staff indicated	sment dated 11/30/16, and ty Event's - Falls note in unwitnessed fall in another on 11/30/16, at 9:45 p.m. nother resident's room on the n. R64 sustained a bump on d. R64 had her walker with the bathroom had been off. and R64 was assisted to they had redirected R64 back uple of times prior to the fall.					
	a.m. (late entry) indito the end bathroom ambulated independ unit, however she of would have to bring a significant change words and follow correported an overall oconcerned R64's overwould continue and I but it depended on wR64. Staff to discuss allow resident to conindependently with haction noted and no other cognitive declir	erall decline in condition R64 would continue to fall, what the family wanted for with family their desire to tinue to ambulate er high fall risk. No further further indication related to nes.				•	
	Fall interventions ren staff to talk to R64's t	nain the same. Plan was for family about their desire for					

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY
		IDENTIFICATION NOWBER:	A. BUILDING	ā		MPLETED
		245397	B. WING		02	/00/0047
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	03/	/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE	(X5) COMPLETION DATE
F 323	Tom pag	ge 60 ambulate independently.	F 323			
	only that a Fall preve	es indicated by a check mark ention program was initiated, nd R64's care plan was				
	comprehensive anal factors which contrib fall prevention intervention implemented following	d lacked documentation of a ysis of identified causal outed to this fall and no new entions were identified or ng the fall in order to further falls and/or injury.				
	On 3/22/17, at 1:19 pfall, the DON confirm were put into place.	o.m. following review of this ned no new interventions				
	corresponding Safety indicated R64 had an TV/day room on 12/4 in the dining room an was found flat on her TV/day room. R64 a and had a bump on the addition, R64 had sor	n unwitnessed fall in the /16, at 4:40 a.m. Staff were d heard a thud noise. R64 back on the floor of the ppeared to have hit her head ne back of her head. In me bruising noted on her rer it was unclear if these is fall or the fall R64				
1	a.m. (late entry) indica	e dated 12/8/16, at 11:19 ated staff was unsure of ed to assure R64 could				

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245397	B. WING	à		ດວ	/22/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 1633 DELTON AVENUE BEMIDJI, MN 56601	ZIP CODE	03/	/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BI THE APPROPRIA	E ATE	(X5) COMPLETION DATE
	with the flooring and larger recliner chairs was resident's 20th R64 to continue to a R64's overall anxiety fall from the wheeloh remember any safet wheelchair use. It was utilizing the walker of prevention interventifamily was concerned time so staff would in symptoms of a urina.  The Evaluation Note only that a Fall prevention and injury were updated.  R64's medical record comprehensive analy factors which contributed fall prevention intervention interve	ir. The chairs were contrast I R64 frequently sat in these is. The note also indicated this fall this year, Family wanted imbulate as this helped with y. Family also felt R64 would nair since she would not y techniques related to the as not noted if R64 had been r not. The current fall ons remain unchanged. The id that R64 had a UTI at this nonitor R64 for signs and ry tract infection (UTI).  Indicated by a check mark ention program was initiated, resolved and care plan was discovered and care plan was entions were identified or ig the fall in order to further falls and/or injury.	F3	323			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245397 B. WING 03/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE HAVENWOOD CARE CENTER BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID JD PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 323 | Continued From page 62 F 323 touch. Pain medication was given for headache. A drop in orthostatic blood pressure was noted and blood sugar was elevated so staff would recheck both. R64 was unable to state what happened other than she fell. The note does not identify if R64 was utilizing the walker or not. The follow up fall note dated 12/23/16, at 10:05 a.m. indicated this was R64's 21st fall this year, current interventions remained the same. A physician order was obtained for a urinalysis and culture due to history of UTI's. R64's physician was on site and discussed R64's falls, current dementia status, UTI treatment and also overall condition. The physician indicated R64 could be at her maximum medication treatments so suggested a reduction even though R64 displayed symptoms of depression and anxiety. An order to reduce Klonopin (antianxiety with known side effects of dizziness and lowering the blood pressure) from 0.5 milligrams (mg) three times a day to 0.5 mg twice a day. No further documentation related to the increased blood sugar or change in orthostatic blood pressure was noted. Staff also talked to the family about having R64 use a wheelchair, however, the family stated the physician and rest of the family felt

care plan was updated.

fall from it.

R64 was not ready to use a wheelchair and would

The Evaluation notes indicated by a check mark that a Falls prevention program was initiated, pain was resolved, injury was resolved, and R64's

Although R64's medical record identified R64's

		AND HUMAN SERVICES					D: 04/10/2017 MAPPROVED
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	<del>,</del>	BE	MIDJI, MN 56601		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
v	antianxiety medicati factor which could he the medical record leading further falls and/or in the further falls and/or in the falls and/or in the falls and/or in the falls and/or in the falls and/or in the falls and and seen R64 had a TV/day room on 12/2 had seen R64 on the found R64 seated or the TV/day room and missed the chair who injury was noted with stated her feet hurt.  The follow up fall not p.m. (late entry) indicof falls, this was R64 always wore gripper Physical therapy wer was "stable on her falls from education due to been participating in program, a family controlled.	on (Klonopin) as a causal ave contributed to R64's fall, acked new interventions to be or to minimize the risk for	F	323	OLI IGIENOT)		
	waiting the results of sent on 12/24/16. Cuinterventions remained The Evaluations Note that a Falls Prevention pain was resolved, in plan was updated. "S	a urinalysis which had been					

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	D BE	(X5) COMPLETION DATE	
F 323	Family was aware of	ge 64 of R64's fall risk and wanted oe able to ambulate.	F3	323				
	comprehensive ana factors which contri fall prevention inter- implemented following	rd lacked documentation of a lysis of identified causal buted to this fall and no new rentions were identified or ing the fall in order to further falls and/or injury.						
	corresponding Safei indicated R64 had a 12/26/16, at 1:20 p.r bathroom on the floo off the toilet and R64	ssment dated 12/26/16, and by Event's - Falls note in unwitnessed fall on in R64 was found in R64's pants were down to the e bruising on R64's right						
	p.m. Indicated this w Staff had just assisted 1:00 p.m. prior to the R64's body was at m tolerance and that so her falls related to he quickly and was enco periods. Current fall p included remained un with walking with her the medical record in remember to take the required reminders of her. Staff were waiting urinalysis and culture	te dated 12/27/16, at 1:51 as R64's 23rd fall this year. ed R64 to the bathroom at e fall, R64's physician felt exaximum level of medication omething might be causing er medications. R64 tired ouraged to take frequent rest orevention interventions inchanged. R64 was stable walker most often. However, idicated R64 did not e walker with her and r staff to bring the walker to ing on the results of the (UA/UC) which had been the results of the UA/UC.						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245397 B. WING 03/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1633 DELTON AVENUE** HAVENWOOD CARE CENTER BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 65 F 323 R64 was not treated for a UTI) Evaluation Notes indicated family wants R64 to continue to ambulate until family conference is held. Urine culture recently obtained, orthostatic blood pressures stable. Check marks indicated a Falls Prevention Program was initiated, Pain was resolved, and care plan was updated. No mention of R64's blood sugar was noted. R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following this fall in order to minimize the risk for further falls and/or injury. R64's Event report note dated 1/1/17, indicated a conference was held with four of R64's family members to discuss R64's falls. Family was given an update on R64's activities of daily living abilities/status and activities. R64 had an eye appointment set up for the month of 1/17, however, family did not feel R64 had any visual changes at this time. Staff would be adding activities on Maple Lane in which family felt would be beneficial as R64 enjoyed activities and liked

to stay busy. The staff discussed with R64's family two overall options for R64 which was mainly to continue to ambulate as she currently was or to try a wheelchair for R64. Family's main concern was that a wheelchair be customized for R64 with a tilt mechanism. Discussion held on R64's frustration level if unable to get out of the wheelchair independently. Family feels R64 would

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION  DING	(X3) DA	ATE SURVEY OMPLETED
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	not be able to get ou are "Ok" with this as Family asked about as needed basis, ho family that R64 was she was tired and not always verbalize appropriately. The famoticeable decline for voice wants/needs a assume what R64 with talked about R64 color walker as she current falling and breaking in her past. Family are for injury and did not to pull through surge R64 did require surging her baseline status. Simedication changes psychotropic medication changes psychotropic medic	at of the wheelchair and they along as R64 might be safer using the wheelchair on an ewever, staff informed the not a good resource to say if eeded to sit down and could needs in general, amily confirmed this was a or R64 as she was unable to and family often had to as trying to say to them. Staff intinuing to ambulate with her attly was with the risk of her something as she had done greed R64 was at high risk feel R64 would ever be able ry to repair an injury and if ery, she would not return to Staff also discussed R64's like Aricept and also other tions as well as possible side one of the medications that isk. At this time, R64's continue to ambulate with her atch out for her as best they quested the facility move a customized wheelchair with ion and to utilize it only on to R64 could still move as feducated family on their and R64 would need the memory problems and also unicate accurately when she formed family they would he assistance, however, the	F3	323		

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) 141	LTID		MR M	<u>U. 0938-039</u>
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	<u> </u>	J/23/2017
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F 323	understood the risks wheelchair. R64 was wheelchair. On 12/2 wanted R64's Aricep physician was notified physician was on sit which he stated he con how to prevent fur agreed with family's however, requested physician as well. Physician as we	s of placing R64 into a s to be fitted for a customized 9/16, family reported they of stopped and R64's ed. On 12/30/16, R64's e and discussed R64's falls in did not have any suggestions or ther falls for R64. Also request to stop Aricept, staff notify R64's psych and also reported R64's did not require treatment.	F3	923			
	Indicated this was res R64 had been walkin- current fall preventior unchanged. Followin conference the family for a customized whe requested. Staff assis walker when noted R6 The plan for this fall wall because R64 had bee aggressive behaviors	r agreed to have R64 fitted elchair which had been at R64 with locating her R64 was walking without it. ras to update the provider and displaying more					

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE
	she either tripped or fall." R64 was not u unable to tell staff w was ambulatory with usually did quite wel remember to use the various places on the followed by physicial due to her use of psy well as her behaviors Klonopin, staff have aggressive behaviors residents on the unit. R64's pain was resol plan was updated.  R64's medical record comprehensive analy factors which contributed fall prevention intervestimplemented followin minimize the risk for the floor and leaning of coom area. R64 could happened. No injury bralls are occurring at	r slipped and this caused the sing the walker and was hat caused her to fall. R64 use of the walker and I but does not always walker and would leave it in e unit. Continues to be from the behavior center ychotropic medications as s. Since the decrease in noted an increase in swhich has impacted other. Falls Program initiated, led, injury resolved and care if lacked documentation of a visis of identified causal uted to this fall and no new entions were identified or g the fall in order to further falls and/or injury.  The ment dated 1/22/17, and Event's - Falls note unwitnessed fall on 1/22/17, as found kneeling down on on a chair in the TV/living do not tell staff what but did state her knee hurt. night.	F3	23			
111	ndicated R64 was una	ted 1/22/17, (untimed) able to tell staff what lained of her knee hurting					

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER  VOOD CARE CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE BEMIDJI, MN 56601	1 00	3/23/2017
(X4) ID PREFIX TAG	LEACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE
ii a fi	walker was located in same fall prevention request a scheduled knee pain which may fall. The medical reconnection complaints of this new year and did numerous falls prior indicated It had been last fall which was an same interventions condicated a Falls Preventiated, Pain was read care plan was up and care plan was up factors which contributed fall prevention interves implemented following minimize the risk for fall on R64's Fall Assessorresponding Safety indicated R64 had an at 9:20 p.m. (second found on the floor in a floorway. R64 was under the school of the same for the same fall on the floor in a floorway. R64 was under the same fall on the floor in a floorway. R64 was under the same fall on the floor in a floorway. R64 was under the same fall on the floor in a floorway. R64 was under the same fall on the floor in a floorway. R64 was under the same fall on the floor in a floorway. R64 was under the same fall on the floor in a floorway. R64 was under the same fall of the same fall of the same fall on the floor in a floorway. R64 was under the same fall of t	er walker, however, the nearby. Continue with the interventions. Plan was to Tylenol or ibuprofen for the y have contributed to R64's ord did not reveal if R64 had if knee pain.  icated this was R64's first fall if not address history of to new year however almost a month since R64's improvement for her. The ontinue. A check mark vention Program was solved, injury was resolved adated.  lacked documentation of a sis of identified causal ated to this fall and no new notions were identified or go this fall in order to urther falls and/or injury.	F3	23			
						1	1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE **HAVENWOOD CARE CENTER** 1633 DELTON AVENUE BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 323 Continued From page 70 F 323 The follow up note dated 1/22/17, (untimed) indicated since R64 had been found in the bathroom and had been toileted less than an hour before this fall, post void residual checks would be completed to ensure R64 was emptying her bladder. Orthostatic blood pressure checks would be done and current fall prevention interventions included the use of a contour mattress with cutout, reminders for R64 to use her walker, every 30 minute checks, lavender oil and gripper socks. Although post void residual was identified as possible causal factor for this fall, a comprehensive analysis was not conducted to identify causal factors of R64's repeated falls or interventions implemented in order to minimize the risk for further falls and/or injury. 11. R64's Fall Assessment dated 1/31/17, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 1/31/17, at 2:55 a.m. staff heard a loud noise and found R64 lying on the floor in the TV/living room area. R64 stated she was just trying to wake up. A fist sized bump was noted on the back of her head, right side. A hand written entry indicate read "? if

weak legs r/t [related to] increased leg swelling

The follow up note dated 1/31/17, at 2:16 p.m. indicated this was R64's 3rd fall this year. Current fall prevention interventions in place included the use of a contour mattress with cutout, every 30 minute checks, lavender oil twice a day, reminders to use the walker, and gripper

could have contributed to fall."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) DA	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  VOOD CARE CENTER			163	REET ADDRESS, CITY, STATE, ZIP CODE 33 DELTON AVENUE EMIDJI, MN 56601	03	/23/2017
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F 323	Continued From passocks.	ge 71	F3	23			
	using her walker at was noted to be nex sitting in. Vital signs blood sugar. Occup for possibility of lym significant lower extrimplemented on 2/2 was having dysuria a urine therefore a uri further analysis was remained the same. Falls Prevention Pro	tes indicated R64 was not the time of the fall rather it at to the chair she had been were stable. Had an elevated ational therapy was consulted phedema treatment due to remity edema which was 7/17. Staff had noticed R64 and cloudy, sediment filled ne culture was obtained. No identified. Fall interventions A check mark indicated a gram was initiated, Pain was resolved and care plan was					
	which may have con 1/31/17, was R64's i legs, however, a con	d indicated causal factors tributed to R64's fall on ncreased swelling in R64's nplete analysis of the interventions was not					
	corresponding Safety indicated R64 had a 9:45 a.m. R64 was wroom area without wawobbled, and was guassistant, however, it lowering to the floor. floor, unsure if the unificated R64 had a safety in the safety in t	witnessed fall on 2/9/17, at walking out of the TV/Living					

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CONTRACTOR OF STREET				<u> </u>	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	3		1	STREET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE BEMIDJI, MN 56601	_103	3/23/2017	
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F 323	Continued From pa	ge 72	F3	323				
	R64 had a UA/UC v treated for a UTI (st R64 was also having which may benefit F	dated 2/9/17, (untimed) ne R64's 4th fall this year, which was positive and was arted antibiotics 2/10/17), g lymphedema treatment R64 because of the swelling in Current fall prevention tot noted.						
	a Falls Prevention P	dicated by a check mark that rogram was initiated, pain are plan was updated.						
	lymphedema and UT including the evaluat	ors were identified as  1. A complete analysis ion of current interventions in ppropriateness was not						
For the control of th	indicated H64 was at had had three or more months, had taken method increase predisposing disease could also increase fall interventions were directed to continue we naterventions with no eather the disk as ailed to identify what isk factors placing R6	essment dated 2/23/17, high risk for falls as R64 re falls in the past three ore than three medications the risk for falls, and had s such as seizures which 164's risk for falls. No new re identified and staff were with the current fall changes at this time. sessment was completed, it could be done about the 164 at high risk or evaluate rent interventions as they						

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	()(0) 1411			OWR M	O. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION		ATE SURVEY OMPLETED
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F 323	Continued From pa related to those ide		F 3	23			
	corresponding Safe indicated R64 had a at 2:05 a.m. Staff h. bathroom by the TV, member told R64 sh R64 unattended in the brief from R64's room help and found R64 unable to state what fall. Staff felt R64 eit attempted to get upsent to the emergen have sustained a not later identified a rib fon at the time of the night time. R64's sleen at 2:05 a.m.	essment dated 3/2/17, and ty Event's - Falls note in unwitnessed fall on 3/2/17, ad assisted R64 into the /Living room area. The staff ne would be right back and left he bathroom to retrieve a new m. Staff heard R64 calling for laying on the floor. R64 was happened to cause her to her tipped off the toilet or from toilet and fell. R64 was cy room and was found that se and wrist fracture (and racture). Gripper socks were fall. Similar falls occurred at ep issues were reported to ead been discussing plans in swith her family.					
	Evaluation Notes date customized wheelchawhich had not yet arr JTI in 2/17. R64 has ast year. Staff had be related to falls and disamily related to R64' every 30 minute checutilized a contour mate nonitor for pain signs nours. R64 ambulates he assistance of a weel wheelchambulates.	ated 3/2/17, 3:31 p.m. and ed 3/2/17, indicated a air had been ordered for R64 ived. R64 was treated for a had significant falls over the een updating her physicians' scussion had been held with s falls. R64 remained on eks for quite some time and atress with cutout. Staff and symptoms every four son the secured unit with alker. R64 had been started and been placed on a short					

		AND HUMAN SERVICES					D: 04/10/201
		& MEDICAID SERVICES				OMB NO	M APPROVEI <u>0. 0938-039</u>
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NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		1/23/2017
HAVENV	VOOD CARE CENTER			16	33 DELTON AVENUE EMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	concern with the fluiplaced R64 at increareceived lympheden and orthostatic blood lungs sounds were tresults of these cheefall prevention intervimplemented include close by her at all timalone on the toilet, Rwhen moving about, R64's wheelchair, armanual tilt and spacecomfort and safety. It a correlation of the notice toileting and a toiletin noted following the forevealed R64 was towrist at all times until walking with her walk assistance close by a for falling, and orthose Evaluation Notes india Fall Prevention Proinjury was resolved and No further information fractures and pain concerns and pain concerns and pain concerns and pain concerns and selection of the comprehensive root of the concerns and pain concerns and pain concerns and selection was spincrease in swelling in comprehensive root of the concerns and pain concerns	diuretics because of the d in R64's feet and legs which ased risk for falls. R64 had na treatment. R64's vital signs d pressure, blood sugar and to be checked however the cks were not indicated. New tentions identified and ed R64 should have someone thes, R64 was not to be left and ed R64 should have a wheelchair anti-rollback's should be on the ed wheelchair for positioning, R64's medical record lacked number of falls surrounding the plan assessment was not alls. R64's physician orders wear an Ace wrap to left a further notice. If R64 was ker, she should have at all times due her high risk static blood pressures daily.  I ficated by a check mark that the gram was initiated, pain and and care plan was updated. In noted related to new ontrol.  The R64's legs, however, a cause analysis was not entions leading up to the fall and control to the fall of the related to the related to the fall of the related to the re	F3	323			

PRINTED: 04/10/2017

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 04/10/201
STATEMEN	ERS FOR MEDICARE IT OF DEFICIENCIES	& MEDICAID SERVICES				FOF OMB N	M APPROVED 0. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245397	B. WING	à			
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	_   _ 0;	3/23/2017
HAVEN	WOOD CARE CENTER				3 DELTON AVENUE		
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES		BE	MIDJI, MN 56601		
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T ir s re	14. R64's Fall Assess corresponding Safet indicated R64 had an at 2:20 a.m. R64 was another resident's rothe fall, R64 was sea station. Staff had ass 2:15 a.m. R64 was u was trying to do at the staff were unable to covitals signs were stationary this fall. R64's customized whand staff were working noted to have troubled but staff were continuated to have been attemphelp keep R64 safe at falls, however, R64 cophysician started new of crying and laughing night. Even though R6 andicated she was supplied to the follow up note data andicated R64 received taff have encouraged eviewed R64's medicated eviewed R64's medicated eviewed R64's medicated received and received  ssment dated 3/19/17, and y Event's - Falls note in unwitnessed fall on 3/19/17, as found sitting on the floor in om. A few minutes prior to ated on a chair by the nurse's sisted R64 to the bathroom at nable to tell staff what she is time of the fall and facility determine cause of fall. One. No injury was noted with seelchair had been received by with R64 on use. R64 was a adjusting to the wheelchair ing to encourage use. Staff very 30 minute visual checks of ontinued to fall. Psych medication due to periods a similar falls occurred at the system of the s	F3	323	DEFICIENCY)			

someone close by her at all times, R64 was not to be left alone on the toilet, R64 was to use a wheelchair when moving about, anti-rollback's

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE **HAVENWOOD CARE CENTER 1633 DELTON AVENUE** BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLÉTION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 76 F 323 should be on R64's wheelchair, and R64 should use the manual tilt and space wheelchair for positioning, comfort and safety and every 30 minute checks. The Evaluation Notes indicated by a check mark a Fall Prevention Program was initiated, pain was resolved and care plan was updated. On 3/21/17, at 1:50 p.m. R64 was observed seated in the TV/living room area, seated in a hard back chair. R64's walker was in front of her and R64 had non-skid slippers on. R64 had black/blue bruises noted under each eye, on the bridge of R64's nose, and upward onto R64's forehead. R64 had an ace bandaged on her left wrist. On 3/22/17, continuous observations were made from 7:05 a.m. until 9:20 a.m. -At 7:05 a.m. R64 was observed dressed and seated in a dining room hard back chair. The restorative aide was performing exercises with R64. R64 was very engaged with staff. R64's daughter was also visiting. The black and blue marks remain under her eyes and forehead. R64's legs are very edematous. No ace wrap

wrist.

noted on her legs. R64 had gripper socks on her feet and does not have an ace wrap on either

-At 7:15 a.m. R64 remained at dining room table, visiting with daughter. Restorative nursing had

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER 1633 DELTON AVENUE BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX תו (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 77 F 323 been finished. R64 had remained in her chair throughout the exercises. Daughter mentioned R64 did not have her wrap on her wrist. Licensed Practical Nurse (LPN)-B stated R64 had taken it off during the night and would not let the night nurse put it back on. R64 remained seated in the chair visiting with her daughter until 7:48 a.m. at which time her daughter had left. -At 7:56 a.m. R64 remained seated at the dining room table. NA-F approached R64 and placed a clothing protector on her. -At 8:03 a.m. NA-G served R64 her breakfast of pancakes. R64 had been dozing in the chair however was awoken by NA-G. R64 proceeded to start eating her pancakes. R64 remained at the table, eating her breakfast until 8:39 a.m. -At 8:39 a.m. NA-F approached R64, removed her clothing protector and asked R64 if she needed anything else. R64 stated she did not know what to do. NA-F informed R64 she was okay sitting right where she was and directed R64 to "sit back and let her food settle." -At 8:43 a.m. R64 was restless and fidgety. NA-F approached R64, provided her the walker and offered R64 to go to the bathroom in which R64 stated she did not have to go to the bathroom. NA-F guided R64 into the living room area. R64 became tearful, NA-F tried to reassure R64 and assisted R64 into a recliner, elevated the feet of the recliner and placed a light blanket over R64. R64 does not have ace wraps on her wrist or

-At 8:55 a.m. R64 remained seated in the recliner in the living room area. R64 told NA-F that her

leas.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER 1633 DELTON AVENUE BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 | Continued From page 78 F 323 legs were cold. NA-F asked R64 if she wanted to have her legs wrapped up. R64 replied "yes." NA-F informed LPN-B R64 wanted her legs wrapped. -At 9:00 a.m. LPN-B applied Ace wraps to lower extremities. R64 stated she had to go to the bathroom. -At 9:17 a.m. LPN-B lowered recliner foot rest, placed the walker in front of R64 and assisted R64 into an upright position. LPN-B assisted R64 into the bathroom and remained with R64 until they both exited it at 9:20 a.m. On 3/22/17, at 12:26 p.m. R64 was observed walking independently without the walker into the dining room area. NA-F scurried to R64's side and assisted R64 into R64's wheelchair.

On 3/22/17, at 1:03 p.m. the DON and RN-B both

corresponding notes. On 3/23/17, at 2:15 p.m. the DON verified R64 was at a high risk for falls and recognized the majority of R64's falls had occurred in the bathroom or TV/living room area and at night. The DON stated R64 had nights that she did not sleep well therefore staff were using lavender oil and allowing her to sleep in the recliner. She also stated a float NA could sit with residents on the unit if needed, and the facility would be changing lighting levels as the day went on. The DON stated staff should have identified the root cause of the falls and developed

individualized fall prevention interventions for R64

confirmed the aforementioned falls and

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
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	in order to prevent confirmed part of the process should have current fall preventing evaluation of those they were appropriated in fragment of the DON verified purished in the prevention intervention intervention intervention intervention intervention orders or lavender oil behind day (initiated 11/23/out (initiated 12/19/16). In when R64's potentiated out, the facility to determine the root on 3/23/17, at 8:31 new wheelchair whice	reoccurring falls. The DON re post fall follow up evaluation re included a review of R64's on interventions and an interventions to determine if ate, effective and sustainable. rior to R64's fall on 3/2/17, actures, the only fall tions documented on R64's R64's care plan were the ears for relaxation twice a 15), contour mattress with cut 15), and 30 minute checks a addition, the DON confirmed al causal factors for falls were re failed to reevaluate R64's fall of cause for R64's falls.  a.m. NA-E stated R64 had a ch tilted and R64 seemed to	F3	123			
	like. If R64 went to t supposed to stay wir started walking, staf make sure R64 had were to keep a frequestless, it usually mbathroom.  R88's undated Face dementia without being of left clavicle and semyelodysplastic synches.	he bathroom, staff were th her. If she got up and f were to walk with her and her walker with her. Staff lent eye on R64. If R64 was eant she had to use the  Sheet included diagnoses of havioral disturbance, fracture					

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY	
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HAVEN	WOOD CARE CENTER	1		1633 DELTON AVENUE BEMIDJI, MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETION DATE	
	extensive assistance mobility and toileting from one staff for transportation in range of extremity. The MDS frequently incontines admission with fract and had two falls at the staff assistance for a prior to admission, of fracture, dementia, visince admission to the R88 was at risk for munitary of falling prior also had two falls sin risk for more falls, so head injury, fracture aby history of falling.  R88's Fall Risk assessindicated R88 requires used the wheelchair for transportation and or were not able to be conveakness. The assessingh risk for falls. A corequested and not recorded.	g, required extensive assist ansferring and personal ed balance and functional of motion in one upper a further indicated R69 was not of urine, had a fall prior to ure within the last six months, the facility since admission.  d 12/15/16, indicated R88 se, was unsteady, required ambulation, history of falling ervical spine and clavicle weakness, and had two falls ne facility. The CAA indicated nore falls with injury. Being ion and while ambulating and to steady him. Resident has a to his admission and he ce his admission. Was at off tissue or muscle injury, and discomfort. Complicated sesment dated 12/15/16, and two assist for ambulation, for main mode of thostatic blood pressures completed related to esment indicated R88 was at ppy of this assessment was beived.	F 32	23			
i	nad a potential for fall	f 12/28/16 indicated R88 s related to decreased					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	mobility, history of fa and clavicle fracture from staff for activiti listed indicated R88 ambulate per ambulinterventions included provide extensive a reposition every two assist to sit up/lie dinto bed extensive assist of with walker staff wheel to all derefer to nurses ordermonitor for persister egistered nurse Physical therapy five R88's monthly ADL (Flowsheet reflected included:  Low, Low bed, start Mat at bedside, start Check resident even neck collar is in place Mattress at bedside can't be in room unstart date 12/20/16	alling, had a cervical spine e, and required assistance es of daily living. The fall goal would maintain ability to lation program. The ed the following: assist of 1 to turn and hours own and get feet and legs one to transfer and ambulate stinations. ers for fall interventions nt red areas and notify the oft collar as ordered. e times a week.  activities of daily living) interventions for falls that  date of 2/2/17 t date of 2/2/17 ty 30 minutes to ensure soft e, start date of 2/3/17 supervised unless lying down, and assistant care guide sheet was a fall risk, could not be his room unless in bed, turn	F3	123				
	R88's undated nursir informed staff, R88 v left unsupervised in h and reposition every	vas a fall risk, could not be						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			16	REET ADDRESS, CITY, STATE, ZIP CODE 633 DELTON AVENUE EMIDJI, MN 56601	1 03	/23/2017	
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F 323	The state of the po	e and mat, and every	F3	23				
	corresponding Safe 12/18/16, R88 sustance occurred at 9:25 p.r. crawling on his hand was unsure where hindicated he rolled confusion. The second when the R88 was finight gown or brief of been trying to go the resulted in injuries.	sment dated 12/18/16, and ty Events, indicated on ained two falls. The first fall m. when resident was found d and knees in his room and he was going, however out of bed and had increased and fall occurred at 10:00 p.m. ound on the floor without in and R88 indicated he had be bathroom. Neither incident The Fall Assessment ing interventions were in place lis:						
	-low, low bed -mats at bed side -contour mattress wi -every ½ hour check The fall assessment or reduce the risk of -check for urinary tra -moved bed against -sleep study	s. indicated the plan to prevent falling included act infection						
	following interventior	ow sheets indicated the is were not added until he wall, low bed, and fall						
	R88 sustained one wurkenstellen	itnessed and two ween 2/17 and 2/18/17.						

DE	PARTMENT OF HEALT	H AND HUMAN SERVICES				D: 04/10/201 MAPPROVE
STATE	MENT OF DEFICIENCIES LAN OF CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	OMB NO	D. 0938-039 TE SURVEY MPLETED
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	OF PROVIDER OR SUPPLIER ENWOOD CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	I03	723/2017
(X4) PRE TAI	FIX   (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE
F3	Continued From pa	age 83	F 32	23		
	Safety Events date 2/17/17, at 6:15 p.m wheelchair and land on the floor, wanted witnessed, and no in Documentation refliewas not completed and indicated the planti-rollback device 3. R88's Fall Assess Safety Events dated 2/18/17, at 7:30 a.m resident was found wheelchair. The assess were unwitnessed a	ected the Fall Assessment until three days after the fall an would be to add for the wheelchair.  sment and Corresponding 1 2/20/17, indicated on and at 9:00 a.m. the sitting on the floor in front of essment indicated the falls and no injuries sustained. The				
	The record indicated comprehensively as:	ed the plan was to add wedge the wheelchair.  I these falls were not sessed for causal factors and the not put into place until		,		
	On 3/20/17, at 7:25 prin bed. The bed was mattress on the bed at midpoint of the mattwo regular bed matt duct tape, the fall matthe wall, not down ne	the mattress was noted to				

PRINTED: 04/10/2017

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER 1633 DELTON AVENUE BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLÉTION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 323 Continued From page 84 F 323 On 3/22/17, at 7:06 a.m. R88 observed lying in bed. The bed was in low position and the doubled mattresses were next to the bed with the fall mat next to the mattresses. -At 3:28 p.m. NA-K was unable to articulate R88's fall interventions but stated R88 had a low bed and required a mattress next to his bed. On 3/23/17, at 10:33 a.m. The DON explained after a fall occurred staff were to complete the in house worksheet for falls and try to figure out why the fall occurred. After they finished the worksheet they would enter the information from the worksheet onto the Event tracking and write a progress note. The DON indicated the information reviewed by the falls committee and the committee attempted to determine the root cause of the fall, reviewed the care plan for effectiveness of the interventions and changed as necessary. The DON stated if the falls occur over the weekend, the falls committee would not review until Monday, however in the meantime the RNs that worked during the weekend would look at the fall to ascertain if any immediate interventions could be put into place. -At 1:17 p.m. RN-C stated the falls that occurred on 2/17, and 2/18, were not assessed until

Monday, 2/20/17. The intervention that was immediately put into place according to the progress note indicated R88 received one to one services for the shift on 2/18, and on 2/19, as staff had R88 up by the nurse's station. RN-C indicated the RNs assessed his needs for fall interventions shift by shift. RN-C indicated

STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	Tania da i Tom pa	be on the care plan or	F3	323				
	Indicated all falls wo The staff were direct determine the root of for solutions. All fall determine trends. E fall monitoring log co each fall. Intervention	Fall policy dated 4/2015, uld carefully be assessed. ted to review each fall to ause of the fall and to plans would be tracked to each resident would have a completed and reviewed after ons would be added to the at staff could track what had east falls, what had worked, orked.						
SS=D	was the policy of the who were at high risk individual fall precaut post fall assessment each fall and any chabe noted on the form orders, alarms would staff assignment she nurses' notes. The fappropriate interventi 483.45(d)(e)(1)-(2) DFROM UNNECESSA 483.45(d) Unnecessa Each resident's drug unnecessary drugs. Adrug when used		F 32	9	F329  Resident 88's care plan was reviewed and revised on 3/22/17 to reflect the concern of insomnia and the non-pharmacological interventions for this problem.  Resident 88's care plan was revised to include individualized non-			

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V0) MI	II TIDI	LE CONCERNICATION OF THE CONCERNICATION OF T	OMB NO. 0938-039	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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r c c	(2) For excessive du (3) Without adequate (4) Without adequate (5) In the presence of which indicate the do discontinued; or (6) Any combinations paragraphs (d)(1) thr 483.45(e) Psychotrop Based on a compreh resident, the facility m (1) Residents who had drugs are not given the medication is necessic condition as diagnose clinical record; (2) Residents who use gradual dose reduction interventions, unless can effort to discontinuations. This REQUIREMENT by: Based on observation eview the facility faile orders for the administile predication, faile lifferentiate target being PRN mood stabilizer as	e monitoring; or e indications for its use; or of adverse consequences ose should be reduced or of the reasons stated in ough (5) of this section.  Dic Drugs. ensive assessment of a must ensure that  ve not used psychotropic nese drugs unless the ary to treat a specific ed and documented in the expectation of a specific ed and documented in the expectation of a specific ed and documented in the expectation of as needed (PRN) and to identify and mayiors for administration of	F3	329	pharmacological interventions for pain as well. Resident 88's behaviors were reviewed and staff identified his target behaviors as well as individualized non-pharmacological interventions.  All resident's care plans will be reviewed and revised prior to 5/2/17 to ensure non-pharmacologic interventions are listed on all resident's care plans for insomnia as well as pain.  The pharmacy consultant will complete a review of all of the resident's current medication orders for unnecessary medications on 5/1/17. This included resident 88's medication orders. All psychotropic medications will be reviewed prior to 5/2/17 for nonpharmacological interventions and will be added if indicated.  Education will be provided to all charge nurses prior to 5/2/17 regarding adding nonpharmacological interventions to care plans and medication orders for pain and behavior management. All nurses will also be educated on the importance of documenting behaviors and the non-pharmacological interventions attempted prior to administering a prn medication prior to 5/2/17.		

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	IDI E CONSTRUCTION	OMB NO. 0938-039	
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NAME OF	PPO//IDED OF OURS	245397	B. WING _		03	3/23/2017
	PROVIDER OR SUPPLIER  VOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601		720/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OLILD RE	(X5) COMPLETION DATE
	medications. In add ensure a nurse, (or assessed the need nurse (or other qual the effectiveness of medications. Furthe develop a plan of ca and revise the plan of individualized non-pl for 1 of 5 residents (unnecessary medications). Findings include:  R88's undated Face dementia without belof left clavicle and sebladder, myelodysplated anxiety disorder.  R88's 14 day Medication anxiety disorder.  R88's 14 day Medication and anxiety disorder.  R88's 14 day Medication and anxiety disorder.  R88's 14 day Medication and anxiety disorder.  R88's 14 day Medication and anxiety disorder.	gical interventions attempted the administration of PRN ition, the facility failed to other qualified professional) for PRN administration and a ified professional) evaluated all administered PRN rmore, the facility failed to the for impaired sleep integrity of care for pain to include the harmacological interventions R88) reviewed for attions.  Sheet included diagnoses of the havioral disturbance, fracture eventh vertebra, overactive existic syndrome, diverticulitis, atted R88 had severe in mild depression, had staying asleep, or sleeping sion MDS dated 12/18/16, in depressive symptoms sion with a score of 4 and dinot have trouble with atted R88 displayed rected towards others and	F 329	Immediate education was provided to all TMAs, LPNs, and RNs on 3/23/17 regarding the completion of an assessment by a nurse prior administering a prn medication. Education was also completed of the evaluation of the effectivene of a prn medication needing to be completed by a nurse.  Education will be provided to all TMAs, LPNs, and RNs regarding following MD orders prior to 5/2/17.  Education will be provided to all Registered Nurses regarding care plan development prior to 5/2/17.  The facility's policy on nursing care plans was revised on 4/17/17. The facility's policy on psychotropic medication monitoring was reviewed on 4/25/17.  IDT meetings will be completed every month with the director of nursing (or designee) and pharm consultant. The purpose of these meetings is to eliminate unnecessary medications, identification individualized interventions for each resident.  Random audits will be completed	n or to n ss see I g I e 7. 7.	
F	188's care plan dated	12/28/16, indicated R88		by the Director of Nursing or designee weekly x 4 weeks to		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE **HAVENWOOD CARE CENTER** 1633 DELTON AVENUE BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 Continued From page 88 ensure care plans are updated when F 329 had an alteration in thought process with potential changes occur. The results of these for anxiety related to dementia/impaired cognition audits will be reported to the QAPI and nursing home placement. R88 displayed Committee. The QAPI Committee behaviors such as yelling out, swearing, will determine further auditing attempting self-transfers, disrobing, resistive to needs. treatment/cares, hitting out at staff, removing neck brace and arm sling. Interventions directed The Director of Nursing is staff to assist R88 to activities, medicate as responsible for this regulation. ordered, assess pain, offer snack, offer to use toilet, provide movie and music (country western Completion Date: 5/2/17 Willie Nelson and Patsy Kline), allow time to express concerns and offer to talk with his daughter, reorient and validate as needed. anticipate needs, provide cues and supervision when making poor decisions. R88's current physician orders included: -Neurontin 100 mg (milligrams) three times a day for low back pain at 8:00 a.m., 2:00 p.m., 8:00 p.m. -Neurontin solution 250mg/5ml (milliliters) give 50 mg every 2 hours PRN for pain, anxiety, restlessness. Max of 6 as needed doses in 24 hours. - Oxycodone 2.5 mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. for low back pain

-Tylenol 1000mg three times a day at 8:00 a.m.,

-Seroquel 12.5 mg three times a day at 12:00 p.m., 5:00 p.m., 8:00 p.m. and 12.5 mg PRN for paranoia/agitation not to exceed two as needed

2:00 p.m., and 8:00 p.m. for low back pain
-Trazodone 50 mg at 8:00 p.m. every night for
trouble sleeping, may give one additional tablet
PRN after scheduled dose prior to 3:00 a.m.
-Effexor extended release 3 capsules every

evening at 5 p.m. for anxiety disorder

doses in 24 hours. Use only when

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING \_ COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER **1633 DELTON AVENUE** BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 329 Continued From page 89 F 329 non-pharmacological measures such as offer of snack or drink, toileting, repositioning, massage, distraction with conversation or activity have failed (This order was revised on 3/17/17, to include use of non-pharmacological interventions). Trazadone for sleep: R88's Medication Administration Record (MAR) from 2/20-3/21/17, revealed the following PRN doses of Trazodone were administered (documentation reflected all scheduled doses given per order): -2/21 PRN dose administered at 2:53 a.m. for restlessness, result was semi effective. The record lacked documentation of non-pharmacological interventions attempted or offered prior to administration.

effective.

-2/23 dose administered at 7:04 p.m. for restlessness and was effective however, dose was not given according to physician orders and

non-pharmacological interventions attempted or

-2/28 PRN dose administered at 4:43 p.m. for yelling and unable to redirect however, dose was not given according to physician orders and lacked evidence of non-pharmacological interventions attempted or offered prior to administration. The TMA (trained medication assistant) documented the medication was

-3/5 PRN dose administered at 4:36 p.m. for yelling and hollering out, not able to redirect, dose

the record lacked documentation of

offered prior to administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
NAME OF	DDOL NO.	245397	B. WING	B. WING			03/23/2017		
NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601		03/23/2017			
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	according to physical documentation of manifer ventions attern administration.  -3/7 PRN dose administration of the documented as effective administration of the amedication.  -3/10 PRN dose administration of the amedication.  -3/10 PRN dose administration of the amedication.  -3/10 PRN dose administration of the amedication.  -3/11 PRN dose administration of the amedication.  -3/11 PRN dose administration of the amedication.  -3/11 PRN dose administration of the amedication of the amedication.  -3/11 PRN dose administration of the amedication of the amedica	however, dose was not given sian orders and lacked con-pharmacological pted or offered prior to the ministered at 9:19 p.m. given collering, not able to redirect, ective. The medical record con that a nurse assessment or to and after the expedication and the medical mentation of all interventions attempted or administration of the ministered at 1:59 a.m. and expensive, however, the MAR lacked expensive the ministered at 1:50 a.m. for out and was noted as seminated and medical record on of non-pharmacological ted or offered prior to the medication.  Ininistered at 1:35 a.m. for ted as seminated at 1:35 a.m. for	F3	329					

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nistered for yelling and dimedication record on-pharmacological offered prior to the ation.  Physician orders for done and lacked macological vided prior to ensure a nurse I prior to and after ninistered by trained. In addition, the are plan for impaired on-pharmacological and restlessness a treflect a the behaviors for the or pain and for the antipsychotic) or res were associated directlessness a and agitation in the medication to identified and	F 32	29					
	DICAID SERVICES ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:  245397  OF DEFICIENCIES E PRECEDED BY SULL	COLOR SERVICES ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:  245397  B. WING  OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION)  Cation. Inistered for yelling and dimedication record on-pharmacological offered prior to the ration.  Ohysician orders for done and lacked macological vided prior to ensure a nurse diprior to and after ininistered by trained. In addition, the lare plan for impaired ion-pharmacological vided prior to and after ininistered by trained and restlessness at reflect a left behaviors for the ion-pharmacological vided prior to and after ininistered by trained and restlessness and agitation in the medication to identified and ut. attempting to	DICAID SERVICES  ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:  245397  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 1633 DELTON AVENUE BEMIDJI, MN 56601  OF DEFICIENCIES E PRECEDED BY FULL ITEYING INFORMATION)  PREFIX TAG  TAG  PROVIDER'S PLAN OF CORRE EXTREMENCED TO THE API DEFICIENCY)  PROVIDER'S PLAN OF CORRE EXTREMENCED TO THE API DEFICIENCY)  F 329  cation. Inistered for yelling and do medication record on-pharmacological offered prior to the action.  Physician orders for done and lacked macological vided prior to ensure a nurse el prior to and after ninistered by trained  In addition, the are plan for impaired on-pharmacological and restlessness  t reflect a el the behaviors for the for pain and for the antipsychotic) or ris were associated do restlessness a and agitation in the medication to identified and tt. attempting to	DICAID SERVICES  ADVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:  245397    A BUILDING	DICAID SERVICES  OWND INC  245397  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE  BEMIDJI, MN 56601  OF DEFICIENCIES  E PRECODED BY FULL  IFFYING INFORMATION)  PREFIX  TAG  TAG  TO DEFICIENCY  F 329  Cation.  Inistered for yelling and do medication record on-pharmacological offered prior to the lation.  Obysician orders for done and lacked macological offered prior to an after ninistered by trained. In addition, the are plan for impaired on-pharmacological on-pha	DICAID SERVICES OMB NO. 0939.  (X2) MULTIPLE CONSTRUCTION A. BUILDING  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X5) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE  (X4) DATE  (X5) DATE  (X5) DATE  (X6) DATE  (X7) DATE  (X	

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	-2/27 PRN dose adribehavioral issue and Medical record lacked documentation and non-pharmacological offered prior to the amedication3/3 PRN dose admifor bottom hurting areffective. Medical rea nurse assessment order to assess need evaluation of the effective and applying barrier measures were indicated non-participated prior to the bottom pain was repand applying barrier measures were indicated non-pain, anxious semi-effective. The rephavior and pain dodocumentation of no interventions attempted administration of the radministration of the ra	revealed the following as surrontin were administered:  ministered at 4:20 p.m. for d pain, was semi effective. The ded behavior and pain lacked documentation of all interventions attempted or administration of the surror to the administration of a prior to the administration in d and also lacked nurse ectiveness of the medication. The prior to the administration for the cositioning every two hours cream, however no eated for the headache. The medical record lacked coumentation and lacked nurse and agitation, and was medical record lacked coumentation and lacked nurse and agitation, and was medical record lacked nurse and agitation, and was medical record lacked nurse and agitation. The medical record in of behavior and of a interventions attempted or nistration.  mistered at 9:47 a.m. for pain pain scale and was not sident spit out the	F3	329			
	medication. The med	lical record lacked pain					

documentation and lacked documentation of non-pharmacological interventions attempted or

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	_0!	MB NO	. 0938-039 TE SURVEY
NAME OF	PROVIDER OR SUPPLIER	245397	B. WING	_			03/	23/2017
	VOOD CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE			
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F	effective. The medic documentation of no interventions attemp administration of the -3/15 PRN dose adm hollering and hitting a medical record lacker non-pharmacological attempted prior to the The facility failed to induce the dependent of the English of the TMA, and failed to ensure a deministration of all Fithe TMA, and failed to enon-pharmacological administration of the Enon-pharmacological administration	administration of the ministered at 1:22 p.m. for d butt pain. The med was all record lacked on-pharmacological ated or offered prior to the medication.  Ininistered at 10:26 p.m. for and was effective. The ed documentation of I intervention offered or e administration.  I intervention offered or e administration.  I intervention offered or e administration.  I intervention offered or e administration.  I intervention offered or e administration of n, the facility failed to ensure the prior to and after PRN doses administered by o document interventions prior to PRN doses. In addition, the a care plan for pain to ological interventions.	F3	29				

target behaviors and non-drug

(non-pharmacological) interventions to be attempted prior to administration of the

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 245397 B. WING 03/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1633 DELTON AVENUE** HAVENWOOD CARE CENTER BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 Continued From page 94 F 329 medication. The report also indicated the physician need not be contacted, but nursing staff should address as soon as possible (a copy of the pharmacists' recommendation was requested and not received). The physician's orders reflected the direction to use non-pharm interventions prior to administration of medication was not added until 3/17/17. R88's record did not reflect a differentiation between target behaviors for the administration of Seroquel and for the administration of Neurontin or identify which target behaviors were associated with symptoms of anxiety and restlessness versus symptoms of paranoia and agitation in order to determine appropriate medication. Target behaviors identified and monitored included: crying out, attempting to stand without help, and potential for combative with cares. R88's nursing progress notes, daily documentation of behavior monitoring, and the MAR were reviewed from 2/20-3/21/17, and revealed the following documentation on administration of the as needed Seroquel: -2/21 at 2:53 a.m. dose administered for behavioral issues and was semi effective. The medical record lacked documentation of behavior displayed and non-pharmacological interventions

attempted prior to the administration.
-2/21 progress note entered at 1:06 p.m.
indicated R88 received as needed Seroquel for behaviors this shift. Medication appears to be

effective. However, the record lacked

documentation of the time administered, behavior

PRINTED: 04/10/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION IING	(X3) DA	TE SURVEY
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	displayed and non-pattempted or offered -2/26 at 9:58 p.m. do behavioral issues an medical record lacked displayed and non-pattempted or offered the medication2/27 at 4:20 p.m. for semi effective. The nodocumentation of be non-pharmacological offered prior to the admedication3/1 progress note ended a dose was given at the causing disruptions. It causing disruptions. It evident in the record. evidence non pharmacoffered or attempted the medications and a effectiveness of administration and lace the behavior prior to a medication. In additional documentation of the nodocumentation of the nodocumentation of the nodocumentation of medication. The progress note ended a dose was administed administration of the nodocumentation of medication. The progress note ended a dose was administed but help me and was repocumentation lacked and the progress note ended the progress note ended and the progress note ended the progress note end	charmacological interventions of prior to administration. One administration of the acological interventions were prior to the administration of an evaluation of an evaluation of an evaluation of an evaluation of the administration and lacked an on effectiveness. The administration and administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and asment of behavior prior to the administration and	F 32			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER **1633 DELTON AVENUE** BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 Continued From page 96 F 329 addition, the medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication and lacked evaluation of medication effectiveness. -3/11 progress note entered at 6:47 p.m. and progress noted 3/12 at 4:40 a.m. indicated a dose was administered for yelling and hollering. The medical record lacked time of dose, non-pharmacological interventions attempted or offered prior to the administration of the medication and an evaluation of effectiveness. -3/13 progress not entered at 5:47 p.m., 3/14 progress note entered at 5:39 p.m., and 3/15 progress note entered at 6:30 p.m. all indicated a dose was given for behaviors. The medical lacked documentation of target behaviors, times of medication administration, evaluations for effectiveness and non-pharmacological interventions attempted or offered prior to the administration of the medication. The facility failed to identify specific (target) behaviors associated with symptoms of paranoia and agitation after the consultant pharmacist recommended the need for identification of target behaviors and failed to immediately identify non-pharmacological interventions in order to justify the administration of as needed doses. In addition, the facility failed to ensure complete documentation of behaviors, failed to ensure a nurse assessed R88's behaviors prior to and after administration of as needed doses administered by TMA, and failed to document non-pharmacological interventions attempted prior to the administration of as needed doses.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

PRINTED: 04/10/2017 FORM APPROVED OMB NO. 0938-0391

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	245397	B. WING		0.	2/22/2017
	WOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZI 1633 DELTON AVENUE BEMIDJI, MN 56601	IP CODE	3/23/2017
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	On 3/21/17, at 8:32 seated at the dining not tearful) intermitt NA-L explained R88 he thought his wife NA-L asked R88 if responded by stating woods to pray. R88 prayer was and stop was Christian and his Lord Jesus.  -at 9:16 a.m. R88 wa area in his wheelchadoctor, help me doct member walked by a in today and walked out for his doctor.  -At 9:19 a.m. unident repositioned R88 in it the resident he was ghim to therapy R88's medical record	a.m. R88 was observed room table sobbing (but was ently. NA-L sat next to him. It was not doing well because was dead which she was not he wanted to talk about it, R88 g he wanted to go out to the was asked what his favorite ped sobbing and stated he has favorite prayer was Come has seated in the TV viewing hir crying repeatedly help me had stated the doctor was not away. R88 resumed calling hifled staff member his wheelchair and informed going to therapy and assisted help assed behaviors the facility.	F 32	29		
e s a e le h w	medications. R88 states and the interest the interest and the states are the interest and the exclaimed ouch a coupair me alone. LPN-is pain pills and he now as seated on the edutempted to administration by bottom hurts. R88	.m. licensed practical nurse room with R88's ted leave me alone, LPN-D edications and he needed to and LPN-D attempted to e side of the bed, R88 sple of times and cried just D explained to R88 she had eeded to sit up. When R88 ge of the bed as LPN-D er medications, R88 stated continued to be verbally sperative. LPN-D indicated				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER **1633 DELTON AVENUE** BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION DATE TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 98 F 329 she would administer the rest of the medication after he was up and dressed and directed TMA-B to complete cares. LPN-D exited the room. As TMA-B washed and dressed R88, R88 stated leave me alone just leave me alone, get out of here. After each time R88 made the statements, TMA-B gave encouragement quietly and calmly, explained what she was doing, used distraction with other topics, and tried to engage R88 in conversation. Although R88 was verbally resistive, he was cooperative. R88's Behavior/Mood flow sheet for 3/22, written following the above observations indicated merely read "behaviors during cares" and did not specify what the behavior was. The flow sheet indicated the behaviors occurred at 7 a.m. and all interventions were attempted. The documentation indicated the response to the interventions was resistive at first, but after 2-3 attempts behavior/mood stopped. On 3/23/17, at 8:39 a.m. R88 was observed seated in his wheelchair in the lobby area. R88 cried out repeatedly, "oh God please help me, God please help me I have to go potty, I have to poop!" Surveyor immediately communicated to facility staff R88 had to use the restroom. R88 continued to yell out and became increasingly agitated and fidgety until he was assisted to the bathroom at 8:44 a.m. by NA-H. R88's medical record on 3/23/17 did not reflect documentation of the observed behaviors the facility had identified as target behaviors.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED

		DEATH IORTION NUMBER:	A. BUILD	DING		OMPLETED
NAME OF BROWN		245397	B. WING			
HAVENWOOD C	ARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601	(	3/23/2017
(X4) ID PREFIX (E. TAG RE	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	UDBE	(X5) COMPLETION DATE
On 3/23, resident needed see whe administ was give effective narcotic give it. W R88's Se yelling, so indicated hard time out of because the the question of t	e, doesn't knowe le, doesn't knowe le, doesn't knowe led out every as much bette or unit. Staff used behaviors redirectable.  5 p.m. NA-J response led rectable.  5 p.m. NA-J response led rectable.  6 p.m. NA-K staff unit.  7 p.m. NA-K staff unit.  8 p.m. NA-K staff unit.  9 p.m. NA-K staff unit.  1 p.m. NA-K staff unit.  1 p.m. NA-K staff unit.  1 p.m. NA-K staff unit.  1 p.m. NA-B staff unit.  2 p.m. NA-B staff unit.  3 p.m. NA-B staff unit.  4 p.m. NA-B staff unit.  5 p.m. NA-B staff unit.  6 p.m. NA-B staff unit.  7 p.m. NA-B staff unit.  8 p.m. NA-B staff unit.  9 p.m. NA-B staff unit.  9 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  2 p.m. NA-B staff unit.  3 p.m. NA-B staff unit.  4 p.m. NA-B staff unit.  5 p.m. NA-B staff unit.  5 p.m. NA-B staff unit.  6 p.m. NA-B staff unit.  6 p.m. NA-B staff unit.  7 p.m. NA-B staff unit.  8 p.m. NA-B staff unit.  9 p.m. NA-B staff unit.  9 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B staff unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  1 p.m. NA-B unit.  2 p.m. NA-B unit.  2 p.m. NA-B unit.  2 p.m. NA-B unit.  3 p.m. NA-B unit.  4 p.m. NA-B unit.  5 p.m. NA-B unit.  5 p.m. NA-B unit.  5 p.m. NA-B unit.  5 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.  6 p.m. NA-B unit.	ge 99 p.m. NA-I stated R88 was ed out "help me, help me" all ow what he needed or wants, day all day. NA-I reported er since return from the atilized redirection when he and most of the time was eported R88 yelled out all day rould attempt as many rould. NA-J stated R88's er since he returned from the eated R88 got anxious and rated R88 got anxious anxious anxious anxious anxious anxious anxious anxious anxious anxious anxious anx	F 32			

DEPA	RTMENT OF HEALT	H AND HUMAN SERVICES			PRINTE	D: 04/10/2
SIALEME	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 100  Neurontin?" TMA-B stated it depended on how anxious he R88 was and if he was really anxious she would administer the Seroquel. TMA-B state it was hard to tell exactly what's going on with R88 but if she had any questions on what to administer, she would ask a nurse.  -At 9:24 a.m. the director of nursing (DON) indicated she was not aware the TMA's work.	(X2) MUI	LTIPLE CONSTRUCTION	OMB NO	M APPROVO. 0938-0: ATE SURVEY DMPLETED	
		245397	B. WING			WILLELED
NAME OF	245397  E OF PROVIDER OR SUPPLIER  ENWOOD CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  29 Continued From page 100  Neurontin?" TMA-B stated it depended on ho anxious he R88 was and if he was really anxi she would administer the Seroquel. TMA-B s' it was hard to tell exactly what's going on with R88 but if she had any questions on what to administer, she would ask a nurse.  -At 9:24 a.m. the director of nursing (DON) indicated she was not aware the TMA's were administering as needed medications without nurse assessment and stated the TMA's were allowed to determine if as needed medications should be given. The DON confirmed as need medications required a nurse assessment in order to determine if the medication was appropriate for use, and if the medication was administered, the nurse was to go back and assess the effectiveness of the medication. The DON immediately provided educations to the provided education to the provided educa		D. WING		03	3/23/2017
U 41/Ekii	WOOD OAD			STREET ADDRESS, CITY, STATE, ZI	P CODE	7-0/2011
IMA EM	WOOD CARE CENTER	₹	- 1	1633 DELTON AVENUE		
(X4) ID	SUMMARY ST	ATCMENT OF STREET		BEMIDJI, MN 56601		
PREFIX TAG	1 (EACH DEFICIENT)	Y MUST BE DOCCOCD DV CVV.	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
F 329	Continued From no	go 100			,	-
	, and a rom pa	ge 100	F 32	29		
	Anxious be Doo	stated it depended on how				
	She would administ	s and it he was really anxious				
	it was hard to tell av	ractly what's going				
	R88 but if she had a	any questions on what to				1
	administer, she wou	in questions on what to				
	, , , , , ,	and dark a hurse.				
	-At 9:24 a.m. the dire	ector of nursing (DON)			I	
	inulcated she was no	of aware the TMA's word				'
l	auministering as nee	eded medications without a				
- 1	nuise assessment a	nd stated the TMA's word not				
- 1	anowed to determine	If as needed medications				
	medications requires	e DON confirmed as needed				
	Order to determine if	a nurse assessment in				
1	appropriate for use	and if the madication was				
	administered, the nu	Se was to go back and				
1	assess the effectiven	ess of the modication. The				
1.8	DON INTINEGIATED Dro	Vided education to the				
	i with a pertaining to th	De administration of as				
1 1	reded medications.	The DON stated she would				
۱ د	administer Mentolitin	IT H88's hehaviors of				
C	gitation and anxiety	manifested by pain and ab-				
¥	round administer Ser	OGUEL for when Boo				
10	iispiayeu aditation an	d anxiety manifected by				
tl	he tarnet behaviore :-	tions. The DON indicated				
n	1edications were not	which to administer the clear. The DON stated	,			
b	ehavior documentation	on should include what the				
اد	pecific defiation was.	DOD-pharmacological				
1 111	itel velitions aπempte	d and what the recognes to				
	iose ilitervetition Mer	e. and effectiveness of the				
1 111	iculcation, if it had to	De administered The DON	1			
	simed frazodone was	S DOI administered				
a	phropriately and state	d R88's physician's orders				
0,	Tould have been follo	Wed and documentation				
1.51	IUIUU USVA BAan aam	ploted and a line				

should have been completed related to

DEP.	ARTMENT OF HEALTH	AND HUMAN SERVICES			DOINTE	D 0.11.010-	
CEN	TERS FOR MEDICARE	& MEDICAID SERVICES			FOR'	D: 04/10/20 M APPROVE	17 =D
STATEN	IENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO	D. 0938-039	91
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) ML	LTIPLE CONSTRUCTION		TE SURVEY	
			A. BUIL	DING	CO	MPLETED	ļ
		245397	B MUNIC				
NAME	OF PROVIDER OR SUPPLIER	240037	B. WING		03	3/23/2017	
l				STREET ADDRESS, CITY, STATE, ZIP CODE		,,,	⊣
HAVE	NWOOD CARE CENTER			1633 DELTON AVENUE			
(X4) I	D SUMMARY STA	TEMENT OF DEFICIENCIES		BEMIDJI, MN 56601			
PREF	A I CAUM DEFICIENCY	MUST BE DECEDED BY FULL	ID PREF	PROVIDER'S PLAN OF CORRECT	ION	(X5)	$\dashv$
TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	TAG	( SHOT	LD BE	(X5) COMPLETION DATE	1
				DEFICIENCY)	/FRIATE	DAIL	
F 32	Ontinued Francis					-	$\dashv$
. 02	- This pay	ge 101	F3	329			
	response to those in	terventions as well as the					
	enectiveness of the	Medication if administered					
	The DON indicated t	nere have been					
	plan for sleep and to	I interventions in the care					
	pain should include I	r pain. The documentation o ocation of pain, intensity,	f				
	non-pharmacologica	l interventions and response					
	TO MENT AND EMECTIVE	Piess of the as needed pain.					
	medication if adminis	stered.					
	Fooility Day 1						
	racility Psychotropic	Medication Monitoring policy	,				
	reviewed April 2015,	INDICAted was to assure					
	psychopharmacologic effective and necessa	cal drug therapy was	1				
	condition that quality	of life was enhanced for					
	those residents on the	ese medication. The policy					
	directed staff to fill ou	t a monthly behavior					
	Inionitoring sheet each	I time the identified behavior			1		
	I occurred so the docto	r could review the					
	trequency of the beha	viors and what approaches					
	were beneficial. The n	Olicy indicated orders for as					
	Theeded medication Mo	Ould be given for specific					
	I clearly documented ci	rcumstances and enocitie					
	needed psychotropic	ntions would be listed for as medications. The policy				- 1	
	directed nursing to mo	neulcations. The policy				1	
	presence of target beh	naviors on a daily basis				İ	
	charting by exception i	(when behaviors are					
	present) and nursing v	VOUID care plan the					
	resident's specific tard	et behaviors and effective				1	
	Tron-phannacological II	nterventions as well as					
F 425	allach them to the med	Clication on the MAR		F 405		ĺ	
SS=D	483.45(a)(b)(1) PHARI ACCURATE PROCED	MACEUTICAL SVC -	F 425	F 425		[	
טבטט	A SOUTH E PROCED	UHES, HPH		Resident 15's medication order was			
	(a) Procedures. A facil	ity must provide		revised to include direction to have			
1	pharmaceutical service	s (including procedures		the resident rinse his/her mouth			
		~ (ordanig procedures		are resident imac mo/net mouli			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE **HAVENWOOD CARE CENTER** 1633 DELTON AVENUE BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 425 Continued From page 102 after administration of the Advair F 425 that assure the accurate acquiring, receiving, discus. dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. All residents receiving Advair discus and other steroid inhalers (b) Service Consultation. The facility must will have their medication orders employ or obtain the services of a licensed reviewed and revised prior to pharmacist who--5/2/17 to include the direction to rinse their mouth after (1) Provides consultation on all aspects of the administration of this medication. provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced Education will be provided to all TMAs, LPNs, and RNs prior to Based on observation, interview and document 5/2/17 regarding the importance of review, the facility failed to ensure a mouth rinse offering a mouth rinse after the was provided after the administration of a administration of these steroidal metered dose inhaler medication in medications. order to prevent oral thrush, as directed by the medication's manufacturer recommendations for Random audits will be completed 1 of 1 resident (R15) observed to receive the by the Director of Nursing or medication without the provision of an oral rinse designee weekly x 4 weeks to following the medication administration. ensure mouth rinses are being offered after the administration of these medications. The results of Findings include: these audits will be reported to the QAPI Committee. The QAPI Committee will determine further R15's Physician Order report dated auditing needs. 2/22/17-3/22/17, included an order for Advair Diskus (combination steroid/bronchodilator) The Director of Nursing is 250-50 micrograms (mcg)/dose: 1 puff inhalation responsible for this regulation. twice a day for chronic obstructive pulmonary disease. Completion Date: 5/2/17 On 3/22/17, at 9:05 a.m. licensed practical nurse

(LPN)-A was observed to hand an unlabeled Advair Diskus inhaler to R15. R15 administered a puff and inhaled the medication. LPN-A handed

PRINTED: 04/10/2017 FORM APPROVED OMB NO. 0938-0391

AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
		245397	B. WING				o 22,25
	F PROVIDER OR SUPPLIER			STI 163	REET ADDRESS, CITY, STATE, ZIP CODE 33 DELTON AVENUE EMIDJI, MN 56601	0;	3/23/2017
(X4) ID PREFI) TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DRE	(X5) COMPLETION DATE
F 429	urinary tract health) and directed R15 to observed to take two LPN-A did not offer othe mouth.  On 3/22/17, at 9:11 a	30 milliliters (ml) and water take a drink. R15 was o sips and swallow the fluid. or suggest R15 swish/rinse	F 4	25			
	Medication Guide an Advair Diskus packa LPN-A. The Medicati Use directed the use without swallowing/si to help reduce the ch fungal infection). LPN	d Instructions for use in the ging was reviewed with on Guide and Instructions for r to rinse mouth with water bit after using Advair Diskus ance of getting oral thrush (a I-A confirmed she had not a feet the					
	been offered as recor	m. the director of nursing touth rinse should have mmended by the e use of the Advair Diskus					
F 431 SS=D	accordance with good practices. 483.45(b)(2)(3)(g)(h) LABEL/STORE DRUG	sed April 2014, indicated nistered as prescribed in nursing principles and DRUG RECORDS, as & BIOLOGICALS	F 43 <sup>-</sup>		F 431 Resident 15's Advair discus is		
	drugs and biologicals them under an agreem	de routine and emergency to its residents, or obtain the described in the facility may permit			labeled appropriately.		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER 1633 DELTON AVENUE BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 431 Continued From page 104 The medications in the zip lock bag F 431 unlicensed personnel to administer drugs if State were labeled and disposed of law permits, but only under the general according to facility policy. supervision of a licensed nurse. All medication rooms and (a) Procedures. A facility must provide medication carts will be audited pharmaceutical services (including procedures prior to 5/2/17 to ensure all that assure the accurate acquiring, receiving, medications are labeled dispensing, and administering of all drugs and appropriately. biologicals) to meet the needs of each resident. Education will be provided to all (b) Service Consultation. The facility must TMAs. LPNs, and RNs to ensure employ or obtain the services of a licensed all medications are labeled pharmacist who-according to facility policy. (2) Establishes a system of records of receipt and Random audits will be completed disposition of all controlled drugs in sufficient by the Director of Nursing or detail to enable an accurate reconciliation; and designee weekly x 4 weeks to ensure medications are properly (3) Determines that drug records are in order and labeled in the medication carts and that an account of all controlled drugs is medication rooms. The results of maintained and periodically reconciled. these audits will be reported to the QAPI Committee. The QAPI (g) Labeling of Drugs and Biologicals. Committee will determine further Drugs and biologicals used in the facility must be auditing needs. labeled in accordance with currently accepted professional principles, and include the The Director of Nursing is appropriate accessory and cautionary responsible for this regulation. instructions, and the expiration date when applicable. Completion Date: 5/2/17 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in

have access to the keys.

locked compartments under proper temperature controls, and permit only authorized personnel to

(2) The facility must provide separately locked,

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/10/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER 1633 DELTON AVENUE BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 431 Continued From page 105 F 431 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure the appropriate prescription labels with directions for use were on an inhalant medication for 1 of 1 resident (R15) whose inhalant medication was observed during medication administration. In addition, the facility failed to ensure 1 of 3 medication rooms medications stored for destruction were properly labeled.

urinary tract health) 30 milliliters (ml) and water FORM CMS-2567(02-99) Previous Versions Obsolete

disease.

Findings include

R15's Physician Order report dated

2/22/17-3/22/17, included an order for Advair Diskus (combination steroid/bronchodilator) 250-50 micrograms (mcg)/dose: 1 puff inhalation twice a day for chronic obstructive pulmonary

On 3/22/17, at 9:05 a.m. licensed practical nurse (LPN)-A was observed to hand an unlabeled Advair Diskus inhaler to R15. R15 administered a puff and inhaled the medication. LPN-A handed R15 a plastic cup containing UTI Stat (nutrient for

Event ID: 813H11

Facility ID: 00017

If continuation sheet Page 106 of 112

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 04/10/2017 STATEMENT OF DEFICIENCIES FORM APPROVED AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 NAME OF PROVIDER OR SUPPLIER B. WING 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER **1633 DELTON AVENUE** BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE DEFICIENCY) F 431 Continued From page 106 and directed R15 to take a drink. R15 was F 431 observed to take two sips and swallow the fluid. LPN-A did not offer or suggest R15 swish/rinse the mouth. On 3/22/17, at 9:11 a.m. the manufacturer's Medication Guide and Instructions for use in the Advair Diskus packaging was reviewed with LPN-A. The Medication Guide and Instructions for Use directed the user to rinse mouth with water without swallowing/spit after using Advair Diskus to help reduce the chance of getting oral thrush (a fungal infection). LPN-A confirmed she had not offered or provided R15 a mouth rinse/spit after the use of the medication. LPN-A confirmed the Advair Diskus lacked a prescription label and directions for use. LPN-A stated the Advair Diskus came in a manufacturer's package, which was in a Ziploc bag containing the prescription label. The Ziploc bag was in the manufacturer's boxed package which also contained the prescription label and the directions for use. LPN-A stated staff threw the packaging away and just keep the inhaler. LPN-A stated if the packaging was available the directions for use would have prevented me from providing a drink versus rinse/spit. -at 9:27 a.m. registered nurse (RN)-A confirmed the Advair Diskus prescription label with instruction for use should have been on the inhaler or the Advair Diskus should have been stored in the prescription labeled packaging. RN-A confirmed she revised the medication

directions.

administration record directing staff to provide rinse and spit according to manufactures

STATEME!	NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	1		FOR	D: 04/10/2 M APPRO' O. 0938-0
IND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	245397	B. WING			-: <b>-</b> -
	WOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI	03	3/23/2017
(X4) ID				BEMIDJI, MN 56601		
PREFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDED'S DI AN OF CORD	N. II	(X5) COMPLETI DATE
F 431	Continued From pag	e 107	F 43			
C (I ir m	observed in the medic confirmed the Ziploc I 100 round pink tablets tablets following count were no identifiable in medications and state the medications were, they were in the destruted in the medications were left in the medications were left in the medications were left in the medications were left in the nurse destruction completed on 3/23/17, at 2:05 p.m. DON) confirmed a prendications for use should be in appropriate estruction. The DON constitution.	who they were for, or why uction bin. RN-B confirmed in containers or cards they e responsible for medication the task.  In the director of nursing scription label with all ations for destruction				
lat		ith tooility room in .				
des nar via win	e Med (medication) Deviewed 4/2015, indicate stroy medications (other cotic) that could not be our incinerating prograg in the medication roce container for pills and	ed the LPN'S would er than scheduled e returned to pharmacy am. Located on each				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 04/10/2017 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING \_ COMPLETED 245397 B. WING NAME OF PROVIDER OR SUPPLIER 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE HAVENWOOD CARE CENTER 1633 DELTON AVENUE BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 108 F 431 The nurses would log these medications on the med destruction sheet and would place the meds in the containers. Once these containers were full, pharmacy would remove them and they would be incinerated per their protocol. F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS F 441 SS=D F 441 (a) Infection prevention and control program. NA-D and NA-E were educated The facility must establish an infection prevention regarding proper hand hygiene. and control program (IPCP) that must include, at a minimum, the following elements: The facility's perineal care policy was reviewed and revised on (1) A system for preventing, identifying, reporting, 4/21/17. investigating, and controlling infections and communicable diseases for all residents, staff, The facilities infection control volunteers, visitors, and other individuals manual was reviewed on 4/25/17. providing services under a contractual arrangement based upon the facility assessment All nursing staff members will be conducted according to §483.70(e) and following educated prior to 5/2/17 regarding accepted national standards (facility assessment the peri-care policy update. implementation is Phase 2); Random audits will be completed (2) Written standards, policies, and procedures by the Director of Nursing or for the program, which must include, but are not designee weekly x 4 weeks to limited to: ensure hand washing is being completed appropriately during (i) A system of surveillance designed to identify peri-care. The results of these possible communicable diseases or infections audits will be reported to the OAPI before they can spread to other persons in the Committee. The QAPI Committee facility: will determine further auditing needs. (ii) When and to whom possible incidents of

reported:

communicable disease or infections should be

(iii) Standard and transmission-based precautions

The Director of Nursing is

Completion Date: 5/2/17

responsible for this regulation.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 04/10/2017 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 03/23/2017 HAVENWOOD CARE CENTER 1633 DELTON AVENUE BEMIDJI, MN 56601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 109 to be followed to prevent spread of infections; F 441 (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 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

by:

cares

This REQUIREMENT is not met as evidenced

Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use was provided for 1 of 1 resident (R15) observed during the provision of

		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	1		FOR	D: 04/10/20 M APPROV
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DA	O. 0938-03 ATE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	245397	B. WING			
	WOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	/23/2017
(X4) ID				1633 DELTON AVENUE BEMIDJI, MN 56601		
PRÉFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETIC DATE
F 441	Continued From pag	e 110	F 441	DEPICIENCY)		
	Findings include:					
i i v v	a clean brief, perineal of lanoseptic barrier chands and applied glofom R15's brief and kwas observed saturate used both gloved hand wet brief from under Rwas wet with urine and	ved to transfer R15 to her nence cares. NA-E obtained cleansing wipes and a tube ream. Both NA's washed wes. NA-E removed tape owered the brief. The brief ed with yellow urine. NA-E as to turn and removing the 15. R15's perineal skin also had red scratch dressing on the right				
se th ap ha ar to: Sc ob R1 ba bar ren froi her	everal times to wipe the barrier cream with he polied the barrier cream and and applied the crea. NA-E removed he ssed it in the trash. NA-15 onto her back. R15 tratched her periarea a stained cleansing wipe 15's periarea. NA-E pictrier cream with her le rrier cream to R15's fronto right soiled global.	A-E and NA-D positioned was noted to have at this time. NA-E s and proceeded to wipe cked up the lanoseptic ft hand and applied the ont periarea. NA-E s clean brief, adjusted the lanoseptic s clean brief, adjusted				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 04/10/2017 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245397 NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 03/23/2017 HAVENWOOD CARE CENTER **1633 DELTON AVENUE** BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 111 creams using soiled gloves. NA-D was not F 441 observed to provide assistance with cleansing or application of barrier cream. R15 was not observed to be offered or provided hand washing following scratching her periarea. On 3/21/17, at 2:38 p.m. NA-E verified R15 was incontinent of urine, frequently scratched her skin including the periarea. NA-E stated R15 scratched her skin frequently resulting in open areas. NA-E confirmed the red areas on R15's peri area was from scratching and the tegaderm on the right buttock covered an open area from scratching. On 03/21/2017, at 2:42 p.m. registered nurse (RN)-A verifed soiled gloves should have been removed and hands washed and clean gloves reapplied prior to applying barrier cream. The facility undated, Application of Ointment, direct staff to wash hands, open the jar or tube, apply gloves, apply ointment, remove gloves and wash hands.

The facility Perineal Care Procedure policy, review date 4/2015, lacked direction for applying a perineal/barrier cream during perineal cares.

#### **Havenwood Care Center**

#### Addendum to PoC

#### F 282

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure residents are receiving turning and repositioning per their care plan. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

#### F 309

Resident 69's pacemaker transmission was completed on 3/22/17 and was successful. His next check will be completed at the clinic in Bemidji on July 3<sup>rd</sup>, 2017. Resident 69 will be discharging from the facility 4/30/17 but this information will be included on his discharge paperwork.

An audit will be developed and implemented prior to 5/2/17 to ensure resident pacemaker checks are completed timely. These audits will be completed 3 times weekly x 4 weeks by the DON or designee to ensure pacemaker checks are being completed timely. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

#### F 312

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure residents are receiving incontinent care per their care plan. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

#### F 314

Random turning and repositioning audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure residents are receiving incontinent care and turning and repositioning per their care plan. Random audits will be completed by the DON or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are revised appropriately. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

#### F 323

After reviewing resident 88's falls, the facility identified his/her anxiety, restlessness, and difficulty sleeping as causative factors. This resident's anxiety, restlessness, and difficulty sleeping have improved with medication adjustments. His interventions were reviewed for effectiveness and were found to be appropriate.

After reviewing resident 64's falls, the facility identified his/her difficulty sleeping and a correlation that he/she seems to be falling after he/she is being assisted to the bathroom as causative factors related to his/her falls. A sleep study and three day bowel and bladder tracking were initiated on 4/27/17 to assess for sleeping patterns as well as anxiety and restlessness after toileting needs have been met.

The new interventions implemented for resident 64 include an alarming lap belt on her w/c to alert us when she is attempting to get up. A large recliner was placed in the TV area with dycem underneath to prevent sliding. The recliner was added to make her more comfortable when she is sleeping since she prefers to sleep in a recliner. We also felt it would reduce anxiety and restlessness. A video monitor was also added in the TV area to help monitor the resident if she is sitting in the recliner.

A meeting is scheduled to be held on 4/28/17 with her primary care physician for further discussion regarding her fall history.

Occupation and physical therapy will evaluate the resident on 4/28/17.

Prosthetic laboratory will be here on 5/2/17 to measure this resident for a protective helmet.

Audits will be completed by the DON or designee after every fall x 4 weeks to ensure all resident falls are assessed for causative factors, that an intervention is implemented after each fall, and that interventions are assessed for their effectiveness. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

#### F329

Random audits will be completed by the DON or designee 3 times weekly x 4 weeks to ensure care plans are updated when changes occur. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

### F 425

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure mouth rinses are being offered after the administration of these medications. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

#### F 441

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure hand washing is being completed appropriately during peri-care. The results of these audits will be reported to the OAPI Committee. The QAPI Committee will determine further auditing needs.

Branca Breke. Admirtstrator 4/27/17

#### **Havenwood Care Center**

#### Addendum to PoC

#### F309

A Pacemaker Care policy was created on 4/24/2017.

#### F323

A restraint assessment was completed for the use of an alarming lap belt for resident 64. The resident cannot release the lap belt on command.

A video monitoring policy was created on 4/26/2017. Notification of use of this video monitoring device has been provided to residents and/or responsible parties. The use of this device has been evaluated and it has been determined that the purpose of this device is to assist in identifying resident safety concerns due to limited visibility of this public lounge area. This device is not recording activity it is only providing staff with real time video monitoring of a public lounge area in our facility.

R64s MD feels the use of a protective helmet is medically necessary.

### F329

Random audits will be completed by the DON or designee three times weekly x 4 weeks to ensure MD orders are followed, to identify and differentiate target behaviors for administration of prn medications, to ensure resident specific target behaviors and non-pharmacological interventions are identified for each resident, to ensure documentation is completed of non-pharmacological interventions attempted prior to administering a prn medication, and to ensure a nurse is assessing both the need/effectiveness of a prn medication. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

Brandon Bjeke, Administratu 4-28-17

## **Havenwood Care Center**

### Addendum to PoC

F323

The facility will be removing all language relating to the use of a video monitoring device from this PoC.

Brandon Bjerke, Administrator 5-1-17

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - NURSING HOME 245397 B. WING 03/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1633 DELTON AVENUE HAVENWOOD CARE CENTER BEMIDJI, MN 56601** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 APPROVED The & Su FIRE SAFETY By Tom Linhoff at 3:18 pm, Apr 26/2017 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Havenwood Care Center 01 Main Building 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY 2017 **DEFICIENCIES (K-TAGS) TO:** APR 26 Health Care Fire Inspections State Fire Marshal Division MN DEPT. OF PUBLIC SAFETY 445 Minnesota Street, Suite 145 STATE FIRE MARSHAL DIVISION St. Paul, MN 55101 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 813H21

Facility ID: 00017

If continuation sheet Page 1 of 4

PRINTED: 04/12/2017

PRINTED: 04/12/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .		LE CONSTRUCTION 01 - NURSING HOME		E SURVEY IPLETED
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K 000	Or by e-mail to: Marian.Whitney@s and Angela.kappenmail  THE PLAN OF COL DEFICIENCY MUS FOLLOWING INFO  1. A description of vito correct the deficit 2. The actual, or proceeding to the correct of the deficit of the correct of the second of the 1968 original by the origi	RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency Center was built in 4 stages. ruilding is 1- story, without a determined to be Type II (111) 71 an addition to the south of I was built, is 1-story with a and was determined to be of a ruction. The 1974 addition was the 1971 addition, is 1-story t and was determined to be of uction. In 1992 additions were the 1968 building and east of They are separated with and determined to be Type	K	000			

PRINTED: 04/12/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - NURSING HOME	(X3) DATE SURVEY COMPLETED	
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K 000	a fire alarm system detection, with add areas, installed in a National Fire Alarm alarm system has local fire departme. The facility has a densus of 74 at the Because the origin meet the construct buildings, this facilibuildings, this facilibuilding.  The requirement a NOT MET as evident NOT MET as evident NFPA 101 Corridor. Corridor - Doors 2012 EXISTING Doors protecting or required enclosure hazardous areas as as those construct core wood, or capazardous areas as those construct core wood, or capazardous areas suitable for There is no imped doors. Clearance of loor covering is not latches are prohibic corridor doors and or combustible macomplying with 7.2	n that includes corridor smoke litional detection in all common accordance with NFPA 72 "The n Code" 1999 edition. The fire automatic notification of the int.  Tapacity of 90 beds and had a etime of the survey.  Tall building and its additions allowed for existing ity was surveyed as a single of the survey.  Tall 42 CR, Subpart 483.70(a) is enced by:		K363  Gaps identified between the doors and the door frames on resident room doors 29,49, an 69 were filled with Poron Flar Retardant Cellular Urethane Foam Gasket Tape on 4/26/17  New doors for resident rooms 49, and 69 have been ordered. They have not yet been delive The Director of Environments Services has audited all reside room doors to check for appropriate fit of door and doframe.	d me 29, red.	

PRINTED: 04/12/2017 FORM APPROVED OMB NO. 0938-0391

	THE PERSON NAMED IN COLUMN	& MEDICAID SERVICES			IVID NO. C		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245397				(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME		(X3) DATE SURVEY COMPLETED	
		B. WING	03/22/2017				
NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE BEMIDJI, MN 56601				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
K 363	of unlimited height meeting 19.3.6.3.6 Door frames shall to or other materials ithe smoke compar window assemblies sprinklered compairestrictions in area frames in window a 19.3.6.3, 42 CFR Fand 485 Show in REMARKS protection ratings, etc.  This STANDARD is Based on observa facility failed to promeans suitable to raccordance with the (NFPA 101) section deficient practice of the corridor making fire, affecting 39 of undetermined amount of the facility tour pm on 03/22/2017 interview revealed doors did not fit tigs.	d. Nonrated protective plates are permitted. Dutch doors are permitted. Dutch doors on the labeled and made of steel on compliance with 8.3, unless the timent is sprinklered. Fixed fire are allowed per 8.3. In the interments there are no or fire resistance of glass or	K 363	This audit will be completed monthly for three months and results of this audit will be reported at our QAPI Committe meetings. The QAPI Committe will determine further auditing needs.  The Director of Environmental Services is responsible for compliance with this regulation Completion Date 4/26/17.	e		



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5842

April 10, 2017

Mr. Brandon Bjerke, Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, Minnesota 56601

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5397027

Dear Mr. Bjerke:

The above facility was surveyed on March 20, 2017 through March 23, 2017 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the correction orders cited herein are not corrected, a civil fine for each correction order not corrected shall be assessed in accordance with a schedule of fines promulgated by rule 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 <u>only a suggestion</u> 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Havenwood Care Center April 10, 2017 Page 2

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.

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

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 Lyla Burkman at the phone number or email mentioned above.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00017 B. WING 03/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1633 DELTON AVENUE HAVENWOOD CARE CENTER** BEMIDJI, MN 56601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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 lb 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. 4/27/17 **INITIAL COMMENTS:** Minnesota Department of Health is documenting Minnesota Department of Health is the State Licensing Correction Orders using the documenting the State Licensing federal software. Tag numbers You have agreed Correction Orders using federal software. to participate in the electronic receipt of State Tag numbers have been assigned to licensure orders consistent with the Minnesota Minnesota state statutes/rules for Nursing Department of Health Informational Bulletin Homes. 14-01, available at Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATE FORM

4-26-17

If continuation sheet 1 of 89

PRINTED: 04/10/2017 FORM APPROVED

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
00017		B. WING		03/23/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Corrected requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance.	nether a violation has been compliance with all rule provided at the tagule number indicated below. It is several items, failure to the items will be considered 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.					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	the State Licensing federal software. Ta to participate in the licensure orders co	rs: nent of Health is documenting Correction Orders using the ag numbers You have agreed electronic receipt of State nsistent with the Minnesota lth Informational Bulletin		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/23	3/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE		
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2 000	<http: www.health.fobul.htm=""> The St delineated on the a Department of Hea you electronically, is necessary for State enter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department's staff, the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department evidence statement, evidence by." Follow evidence by."</http:>	state.mn.us/divs/fpc/profinfo/in ate licensing orders are ttached Minnesota and alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  2, 23, 2017, surveyors of this visited the above provider and ation orders are issued. Four electronic plan of have reviewed these orders, when they will be completed.  The order and the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis column also includ	2 000	The assigned tag number appear far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statut of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the finding are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Methodorrection and the Time Period Forrection.  PLEASE DISREGARD THE HEATHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OCORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA SETATUTES/RULES.	Tag." If the atute/rule cies" Inply" his swhich after the as veyors ad of or  DING OF FOO THIS	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
HAVENV	HAVENWOOD CARE CENTER 1633 DELTON AVENUE								
		BEMIDJI,	MN 56601						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
2 000	Continued From pa	ge 2	2 000						
2 560	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA  THERE IS NO REC PLAN OF CORREC MINNESOTA STAT  MN Rule 4658.0405 Plan of Care; Conte	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.  QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.  5 Subp. 2 Comprehensive ents	2 560						
	comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The comust include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).							
	by: Based on observati review, the facility for related to the identi- ulcers in order to prodevelopment for prodevelop a care plan non-pharmacologic implemented for 1 of for pressure ulcers In addition, based of	on, interview and document ailed to develop a care plan fied risk/goals for pressure event the risk for the essure ulcers and failed to a which included a goal and al interventions to be of 4 residents (R88) reviewed and hypnotic medication use. In observation, interview, and the facility failed develop a care							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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			DRESS, CITY, S	STATE, ZIP CODE	<u>,                                    </u>	<u>-, -, -, -, -, -, -, -, -, -, -, -, -, -</u>
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
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2 560	Continued From pa	ge 3	2 560			
	goals and medical i	nacemaker which included management interventions for 9) reviewed who had a				
	Finding included:					
	R88 was at risk for pressure related ulcers and received medication to induce sleep for a diagnosed sleep disorder and a care plan was not developed to identify these areas.  R88's undated Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, obstructive sleep apnea, myelodysplastic syndrome (a blood cancer), and anxiety disorder.					
	12/18/16, indicated impairment, require one to two staff for balance impairment in range of motion i MDS further indicat incontinent of urine upon admission, wa and had a turning a 14 day Medicare M	inimum Data Set (MDS) dated R88 had severe cognitive ed extensive assistance from activities of daily living, had t and had functional limitations in one upper extremity. The ted R69 was frequently, did not have a pressure ulcer as at risk for pressure ulcers, and repositioning program. The DS dated 12/25/16, indicated ling asleep, staying asleep, or				
	Physician's orders included, Trazodone 50 milligrams by mouth at bedtime, and may give one additional dose as needed after the					

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2 560	scheduled bedtime R88's pressure ulce	dose prior to 3:00 a.m. er CAA dated 12/18/16	2 560			
	related to urinary in mobility that require staff, cognitive loss of motion, diagnosi weakness, fracture The CAA indicated schedule of turning reposition every two indicated a care pla	at risk for pressure ulcers continence, and impaired ed extensive assistance from functional limitation in range s of dementia, pain, of clavicle, and poor nutrition. R69 required a regular and staff would turn and be hours while in bed. The CAA and would be developed and act skin and continue to luled.				
	identify R88 was at lacked a goal for prisk of obtaining a prindicated R88 had a was incontinent morand directed staff to two staff to transfer hours, staff check wheeded, and provide elimination. The candecreased physical and directed staff to one to turn and reported to turn and reported dehydration, redness, plan lacked a care include goals, mediatrazodone (medicanon-pharmacologic	plan dated 12/28/16, did not risk for pressure ulcers and eventing or decreasing the pressure ulcer. The care plan alteration in elimination and re than seven times per week to provide extensive assist of on and off toilet every two with toileting and change as e peri rectal care after re plan also indicated R88 had mobility with potential for falls to provide extensive assist of osition every two hours. The R88 was at risk for ected staff to monitor skin for and breakdown. The care plan for sleep which would cation management of tion to induce sleep) and al interventions to be the administration of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF I				STATE, ZIP CODE	03/2	.3/2017
	PROVIDER OR SUPPLIER	1633 DFI	TON AVENU	<i>'</i>		
HAVENW	OOD CARE CENTER	8	MN 56601	_		
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2 560	Continued From pa	age 5	2 560			
	Trazadone.					
	confirmed a specification or was an assessive ulcers, however, stareduce the risk for the problem statem RN-E stated a speculcers would be depressure ulcer or head of the confirmed there should be depressure ulcer or head of the confirmed there should be depressure ulcer or head of the confirmed there should be depressure ulcer or head of the confirmed there should be depressed by the confirmed the confir	s p.m. registered nurse (RN)-E c care plan was not developed ed goal identified for pressure ated the interventions to pressure ulcers were added to nent that was causing the risk. cific care plan for pressure veloped if there was an actual istory of pressure ulcers. rector of nursing (DON) ould have been a care plan sure ulcers and for sleep.				
	R69 had a pacema the care plan.	ker which was not identified on				
	diagnoses of atrial hypertension, and I indicated R69 had and required exten complete activities Face Sheet indicate myocardial infarction	DS dated 1/20/17 included fibrillation, heart failure, nistory of stroke. The MDS moderate cognitive impairment sive assistance from staff to of daily living. R69's undated ed R69 had a diagnosis of old on (heart attack). R69's Summary dated 1/20/17, a pacemaker.				
	of atrial fibrillation a	ted 2/8/17 identified diagnosis and stroke, however did not ce of R69's pacemaker.				
		P.m. a pacemaker monitor 169's nightstand. R69				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
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(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 560	explained the purpo pacemaker clinic co functionality of the p abnormal heart rhy	ge 6 ose of the monitor was so the buld continuously monitor the bacemaker and monitor for thms. R69 stated he was his pacemaker checked every	2 560			
	(LPN)-D stated was information pertaini not sure what arrhy to correct, and did r parameters. LPN-D (RN) obtained infor	a.m. licensed practical nurse is not sure where to find ing to R69's pacemaker, was thin the pacemaker was set not know R69's pulse is stated the registered nurses mation pertaining to ould develop the care plan.				
	(RN)-F indicated Robradycardia (slow half defibrillator, the low minute, RN-F explaunder 70 beats for and the staff at the pacemaker clinic to appropriately. RN-F expected facility stapacemaker settings	emaker clinic registered nurse 69's pacemaker was for leart rate), was not a rend setting was 70 beats per lined if R69's pulse should go a full minute, it was a concern, facility would need to call the rensure pacer was functioning stated the pacemaker clinic lift to have knowledge of s, when to contact the clinic, ed pacemaker checks.				
		DON indicated there should lan developed for the				
	why R69 had a pac plan included the pa	E stated she did not know emaker and thought the care acemaker, and was not aware nould have been on the care				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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2 560	Continued From pa	ge 7	2 560			
	reviewed 4/2015 ind and Rationale 1. to independence and directing staff effort appropriate utilization services and avoid 7. To meet accounts intermediaries. The	dent Care Planning last cluded: Planning Objectives promote optimal resident quality of care by focusing and s to individuals, 2. To promote on and coordination of duplication and wasted efforts, ability requirements for fiscal e policy lacked direction and/or e care plan content.				
	The director of nurs revise policies and plan development a to address the impocomprehensive carneeds. Resident ca revised for complian and assurance com	HOD OF CORRECTION: sing or designee could review/ procedures related to care and provide education to staff ortance of developing a e plan to meet each resident's re plans could be reviewed/ nce. The quality assessment mittee could establish a e plans to ensure compliance.				
	TIME PERIOD FOF Twenty-one (21) da					
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				
	This MN Requireme	ent is not met as evidenced				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE BEMIDJI, MN 56601   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG WITH APPROPRIATE DATE OF CROSS REFERENCE) TO THE APPROPRIATE DATE  2 565  Continued From page 8 by: Based on observation, interview and document review, the facility failed to provide turning and repositioning assistance and/or incontinence cares as directed by the care plan 2 of 2 residents (R15, R89) who required assist with repositioning parts and incontinence cares. In addition, the facility failed to ensure the placement of Prevalon pressure reduction boots as directed by the care plan for 1 of 2 (R89) residents at risk for heel breakdown.  Findings include:  R15 was at risk for pressure ulcers and was incontinent and did not receive timely turning and repositioning and incontinence care as directed by the care plan.		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER  1633 DELTON AVENUE BEMIDJI, MN 56601  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  2 565  Continued From page 8 by: Based on observation, interview and document review, the facility failed to provide turning and repositioning assistance and/or incontinence cares as directed by the care plan 2 of 2 residents (R15, R89) who required assist with repositioning and incontinence cares. In addition, the facility failed to ensure the placement of Prevalon pressure reduction boots as directed by the care plan for 1 of 2 (R89) residents at risk for heel breakdown.  R15 was at risk for pressure ulcers and was incontinent and did not receive timely turning and repositioning and incontinence care as directed by turning and repositioning and incontinence care as directed by the care plan for 1 of 2 (R89) residents at risk for heel breakdown.		00017		B. WING		03/2	3/2017
RAVENWOOD CARE CENTER   BEMIDJI, MN 56601	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  2 565  Continued From page 8  by: Based on observation, interview and document review, the facility failed to provide turning and repositioning assistance and/or incontinence cares as directed by the care plan 2 of 2 residents (R15, R89) who required assist with repositioning and incontinence cares. In addition, the facility failed to ensure the placement of Prevalon pressure reduction boots as directed by the care plan for 1 of 2 (R89) residents at risk for heel breakdown.  R15 was at risk for pressure ulcers and was incontinent and did not receive timely turning and repositioning and incontinence care as directed	HAVENV	VOOD CARE CENTER			E		
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R15's Care Plan dated 1/18/17, indicated R15 had decreased physical mobility, bilateral lower extremity amputation with inability to transfer, turn/reposition or site up/lie down per self. R15 required two staff extensive assist for turning and repositioning every hour. R15 was unable to complete personal hygiene independently and had bowel and bladder incontinence. The plan indicated R15 required extensive assistance of two staff to check and change R15's incontinent product and provide cleansing after elimination every two hours.  The untitled and undated nursing assistant worksheets indicated R15 required turning and repositioning assistance every hour and	2 565	by: Based on observation review, the facility for repositioning assist cares as directed by residents (R15, R85 repositioning and in the facility failed to Prevalon pressure of the care plan for 1 of heel breakdown.  Findings include:  R15 was at risk for incontinent and did repositioning and in by the care plan.  R15's Care Plan day had decreased phy extremity amputation turn/reposition or significant turn/repositioning every complete personal had bowel and blad indicated R15 requitive staff to check a product and provide every two hours.  The untitled and unworksheets indicated R15 required the repositioning every two hours.	on, interview and document ailed to provide turning and ance and/or incontinence by the care plan 2 of 2 of 2 of 2 of 2 of 2 of 2 of 2 o	2 565			

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2 565	Continued From pa	ge 9	2 565			
	7:15 a.m. to 11:00 a remain seated in he assistance.  -At 7:45 a.m. R15 w wheelchair to the di returned to her roor -At 9:04 a.m. licens entered R15's room LPN-A did not offer or toileting assistan -At 9:53 a.m. R15's -At 9:58 a.m. nursine entered R15's room immediately exited -At 10:00 a.m. R15 she needed her incithe NA stated she was bounded assist -At 10:18 a.m. NA-C proceeded to assist -At 10:18 a.m. NA-C proceeded to assist -At 10:35 a.m. NA-C asked her what she informed R15 she with stated she did not with stopped assisting R10t. When asked by down so staff could product, R15 stated light on in the first product was observed with urine. NA-C consaturated. NA-C product was observed with wipes. R1 doing, NA-C stated	ed practical nurse (LPN)-A n to administer medication. nor provide R15 repositioning ce. call light was observed on. ng assistant (NA)-C was n, turned the call light off and the room. stated she had told the NA ontinent product changed and would be back to help her usy with another resident. C returned to R15's room and at R15's roommate. C began to assist R15. R15 was doing and NA-C was going lay her down. R15 want to lie down. NA-C at 15 and stated R15 refused a the surveyor if she would lay change her incontinent I that was why I turned the call				

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2 565	completing the peri needed to get the n NA-C returned to the applied a tegaderm buttock covering and R15 she had a sma from scratching. LP measured approxim by 0.50 cm. LPN-A scratched her body resulting in open and stated she applied to infections. LPN-A funcontinence and we frequently falls off. At 10:58 a.m. R15' NA-C confirmed R1 with urine and her shad not provided R1 repositioning and in now.  At 10:59 a.m. NA-E stated she had assippointed to a white mand stated staff door were provided on the a.m. was noted on the shad not provided repositioning assist (three hours and 30 referred to the nurs she removed from I was to be reposition product checked and NA-B stated even the needed help, it was	care, NA-C stated she urse and would be right back. The room with LPN-A who dressing to R15's right open area. LPN-A informed all open area on her bottom on the N-A stated the open area nately 0.25 centimeters (CM) stated R15 frequently including her peri area area and scratch marks. LPN-A of the dressing to help prevent of the stated, due to R15's et skin, the dressing secares were completed. 5's brief was very saturated skin was wet. NA-C stated she	2 565			

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On 3/22/17, at 11:10 a.m. the director of nursing

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2 565	(DON) confirmed R repositioned every land change incontinuity directed by the care her expectation for R15's care plan, as  R89 was not provide repositioning during Prevalon boots (here were not provided from 3/22/17, as directed as a directed repotential for alterating pressure sore on le registered nurse (R registered nurs	15 should have been nour and provided with check nence care every two hours as a plan. The DON stated it was staff to follow and implement written.  ed every one hour two observations and el offloading device/boots) or 1 hour 30 minutes on the by the Care Plan  e Plan indicated R89 had on in skin integrity related to fit heel and directed staff to:  n every one hour and as care after each incontinent tent red areas and report to N) en utrition and hydration by ecub [decubitus] program ing change as ordered.  nd dry.  pressure pad] mattress on bed. ots on both feet as ordered.	2 565			

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		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	sleeping bed, lying shoulders positioned was not repositioned during this time.  -From 9:16 a.m. to continuously obserwithout staff enteriring and no on the day yet. at 10:47 a.m. R89 watching television her back. R89 statmorning and no on the day yet. at 10:52 a.m. licelentered R89's room administered R89's room administered R89's remained positione offer or provide reperat 11:26 a.m. (2 h NA-C stated she has 9:15 a.m. at which incontinence brief at to get up for the day had been dry and F NA-C entered R89' water and proceed when, NA-C uncowearing blue Prevaremoved the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing on the left intact and without removed the boots dressing of the left intact and without removed the boots dressing of the left intact and without removed the boots dressing of the left intact and without removed the boots dressing of the left intact and without removed the boots dressing of the left intact and without removed the boots dressing of the left intact and without removed the left intact and without removed the left intact and without removed the left intact and without removed the left intact and without removed the left intact and without removed the left intact and without removed the left intact and without remov	ge 12 as continuously observed on her back with her ed slightly to the right. R89 ed or offered repositioning 10:47 a.m. R89 was ved in bed, lying on her back in bed, lying on her back in her own for repositioning. It was observed awake and while in bed, positioned on ed she liked to sleep in in the en had come in to get her up for insulin in the abdomen. R89 do nher back. LPN-A did not ositioning assistance.  Ours and 10 minutes later) and last been in R89's room at time she checked R89's and asked R89 if she wanted by NA-C indicated R89's brief R89 was not ready to get up. It is room, gathered a basin of ed to provide morning cares. It is revealed gauze heel. R89's right heel was edness. Following the onal cares, NA-C stated R89 to and placed a mechanical lift A-A entered the room with a both NAs transferred R89 to 9's wheelchair was observed	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00017	B. WING	<del></del>	03/2	3/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S FON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	positioned across the wheelchair foot/leg raised slightly less the wheeled R89 out of room at approximate Prevalon boots were.  On 3/22/2017, at 1: her room, seated in stated she had just Prevalon boots. Let them on and confirmate all times due to it asked LPN-A, "Areathem once in a whill should be on at all the once of the day NA-C verified the beapproximately one on a should have been to one hour and should boots at all times expected by the care plan.  A Resident Care Plan	ne calf support area of the rests. The foot/leg rests were than parallel to the floor. NA-C her room and to the dining tely 12:00 p.m. R89's e not reapplied.  37 p.m. R89 was observed in her wheelchair. LPN-A assisted R89 to put on her PN-A verified R89 had not had med she should have them on sues with her heels. NA-C n't we supposed to release e?" LPN-A stated the boots times.  p.m. NA-C confirmed she had alon boots on when she got and should have done so.	2 565			
	promote optimal requality of care by for efforts to individual	sident independence and cusing and directing staff needs and to promote tion and coordination of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00017 B. WIN		B. WING		03/23/2017		
NAME OF E	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/2	
	OOD CARE CENTER	1633 DEL	TON AVENU			
HAVENV	OOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 14	2 565			
	services.					
	The director of nurs could review or revied education for staff r implementation. The Assurance (QAA) caudits to ensure con	ne Quality Assessment and ommittee could do random mpliance.				
	TIME PERIOD FOF Twenty-one (21) da					
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			
	care must be review interdisciplinary teal physician, a register for the resident, and disciplines as determined and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on interview facility failed to revis	and document review, the se the care plan to include ntion interventions following				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	•		STATE, ZIP CODE	03/2	3/2017
		1633 DF	LTON AVENU			
HAVENV	OOD CARE CENTER	₹	, MN 56601	<del>-</del>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 570	Continued From pa	age 15	2 570			
	for accidents. In ac revise the care plan non-pharmacologic	of 4 residents (R64) reviewed ddition, the facility failed to n for pain to include cal interventions for 1 of 5 riewed for unnecessary				
	Findings include:					
		as not revised to include ention interventions following				
	R64's Face Sheet [undated], indicated R64's diagnoses included Alzheimer's disease, anxiety, dizziness, seizures, depression, obesity, macular degeneration (poor vision), cataracts, psychosis, delusional disorder and dementia.					
	indicated R64 was prevention interven	sessment dated 2/23/17, at risk for falls. No new fall tions were identified and staff intinue with the current fall				
	2/9/17. R64's care a problem area for integrity. Fall preve included: - provide assist of coff the unit - provide limited as also transfers self a	alls between 10/23/16, through plan dated 3/16/17, identified potential risk for falls and skin ention interventions listed one staff to ambulate on and sist of one staff to transfer, at times pace wheelchair for comfort,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 570	positioning and safe-refer to nursing or interventions  R64's physician ord through 2/9/17, the interventions were i identified on the car-Lavender oil behind a day (initiated 11/2-Contour mattress 12/28/15) - 30 minute checks  On 3/23/17, at 2:15 (DON) confirmed ponly fall prevention R64's physician ord lavender oil behind day (initiated 11/23/out (initiated 12/28/(initiated 2/19/16).  Fall Prevention polifacility would identified risk for falls and deprecautions for those assessment would and any changes in on the form, in the interventions.	ders for further fall  ders indicated from 10/23/16, following fall prevention in place which were not re plan: nd the ears for relaxation twice (3/15) with cut out (initiated (initiated 2/19/16)  p.m. the director of nursing rior to R64's fall on 3/2/17, the interventions documented on ders or R64's care plan were the ears for relaxation twice a (15); contour mattress with cut 15); and 30 minute checks  cy dated 4/2015, indicated the ry residents who were at high	2 570	DEFIGIENCY)		
	non-pharmacologic	s not revised to include al interventions for pain be attempted prior to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	23/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENV	VOOD CARE CENTER		TON AVENUI MN 56601	<b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 570	Continued From page 17		2 570			
	administration of ar	n as needed pain medication.				
	dementia without be of left clavicle and s	ncluded diagnoses of ehavioral disturbance, fracture seventh vertebra, ndrome, diverticulitis, and				
	R88's admission Minimum Data Set (MDS) dated 12/18/16, indicated R88 had severe cognitive impairment, had occasional pain which did not interfere with activities or sleep, had scheduled pain medications, rated pain at a 5 on a 0-10 scale, used as needed pain medications, and non-pharmacological interventions were not used. A Care Area Assessment for pain was not triggered or completed.					
	R88 had a potential related to a cervical fracture and low bath directed staff to mescale to assess pail comfort and to keep plan lacked non photostatic plans and to seep plans lacked and potential relationships and to seep plans lacked and potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are second potential relationships and the second potential relationships are	pain dated 12/28/16, indicated for alteration in comfort I spine fracture, left clavicle ck pain. The care plan dicate as ordered, use a pain n, assist to positron for physician updated. The care armacological interventions to the use of pain medication.				
	Neurontin solution 2 mg every two hours	ders revealed an order for 250mg/5ml (milliliters) give 50 as needed for pain, anxiety, of six as needed doses in 24				
	On 03/23/2017, at 4	4:27 p.m. director of nursing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00017 B. WING			03/23/2017		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	(DON) indicated the non-pharmacologic attempted prior to a pain medication.  Facility policy Resid Procedure last revie plans were to be re RN. If changes in a occurred between scharge nurse and descriptions.	ge 18 e care plan should include al interventions that could administration of an as needed dent Care Planning Policy and ewed 4/2015, indicated care viewed every 30 days by an a problem, goal, or approach scheduled review times the lepartment member involved a meet informally and revise	2 570			
	The director of nurs revise policies and plan revision and praddress the importation when there has been resident care plans for compliance. The assurance committee	THOD OF CORRECTION: sing or designee could review/ procedures related to care rovide education to staff to ance of revising care plans en a change in services. It could be reviewed/ revised e quality assessment and ee could establish a system to ensure compliance.				
	TIME PERIOD FOF Twenty-one (21) da					
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			
	receive nursing care custodial care, and	general. A resident must e and treatment, personal and supervision based on d preferences as identified in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	23/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		ΓΟΝ AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must remain in This MN Requirements:  Based on observation of care as des des as des des as des des des des des des des des des de	resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.  ent is not met as evidenced on, interview and document	2 830			
	Based on observation, interview and document review, the facility failed to provide ongoing monitoring and coordination of care with a pacemaker clinic to ensure routine pacemaker checks were completed for 1 of 1 resident (R69) reviewed who a had pacemaker without routine checks had conducted.  Findings included:					
	1/20/17, indicated F fibrillation (irregular rapid heart rate), he history of stroke. The had moderate cognextensive assistant activities of daily living Face Sheet also indicated R69 had a second control of the history of the hist	inimum Data Set (MDS) dated R69 had diagnoses of atrial heart rhythm, often time's eart failure, hypertension, and ne MDS also indicated R69 itive impairment and required the from staff to complete ing. R69's undated facility cluded diagnosis of old in (heart attack). R69's Summary dated 1/20/17, a pacemaker.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING	·····	03/2	23/2017
	NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER  1633 DE BEMIDJI			STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	1/21/17, indicated F due for a pacer che [January 2017] and performed these ch assessment did not indication for pacer rate settings, pulse pacemaker check s  R69's care plan dat diagnoses of atrial f the plan did not ider pacemaker.  R69's Vitals Report admission and reve on taken on 1/20, 1, 3/8, and on 3/15/17 1/20/17, R69's pulse medical record lack clinic was notified o end setting of 70 be by the pacemaker of the purpose of the reclinic could continue of the pacemaker a heart rhythms. How had not worked sind was not sure when stated he was supp	R69 had a pacemaker and was ck sometime this month while at home, R69 ecks wirelessly. The include or identify the naker and/or type, pacemaker parameters, location, or inchedule.  Red 2/8/17, indicated R69 had fibrillation and stroke, however ntify the presence of R69's  Was reviewed since raled R69's pulse was taken record reflected on ewas 68. However, R69's ed evidence the pacemaker of R69's pulse below the low eats per minutes as indicated elinic registered nurse (RN)-F.  p.m. a pacemaker monitor fo's nightstand. R69 stated monitor was so the pacemaker pusly monitor the functionality and to monitor for abnormal ever, R69 stated the monitor ce admission to the facility and it was going to get fixed. R69 osed to have his pacemaker emonths and thought he had	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	23/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	On 3/22/17, at 7:09 (LPN)-D stated was information pertaini was not sure what a set to correct, and oparameters. LPN-D (RN) obtained information pacemakers and work of the set to correct, and oparameters. LPN-D (RN) obtained information pacemakers and work of the set to correct and if there parameters. RN-C was supposed to be January, however the suppo	a.m. licensed practical nurse is not sure where to find ing to R69's pacemaker and arrhythmia the pacemaker was did not know R69's pulse is stated the registered nurses mation pertaining to bould develop the care plan.  It stated she was aware R69 is pacemaker was supposed to were recommended pulse confirmed R69's pacemaker in the facility could not get the due to the lack of correct could be confirmed R69's pacemaker in the equipment was easier clinic was called to and to ensure functionality. It is a compared to the lack of correct count to ensure functionality. It is a compared to the equipment was easier clinic was called to and to ensure functionality. It is a compared to the lack of correct count aware of when the next inducted, however stated it is emonths.  First stated R69's pacemaker is a low end setting was 70 beats on firmed R69's last was 10/17/16, and had missed RN-First stated it would be a less should go under 70 beats of facility staff would need to clinic to ensure the	2 830			
	if the pacemaker m pacemaker itself wo	nctioning properly. RN-F stated onitor was off line, the buld continue to store ular rhythms until the next				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/23/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 22	2 830			
	clinic expected the pacemaker settings and of recommend  -At 11:00 a.m. the c stated there should developed for R69's  -At 12:27 p.m., RN-why R69 had a pacincluded the pacempacemaker should  Facility policy/proces	RN-F stated the pacemaker staff to have knowledge of s, when to contact the clinic, ed pacemaker checks.  director of nursing (DON) I have been a care plan s pacemaker.  E stated she did not know emaker, thought the care plan haker but was not aware if the be on the care plan or not.  edure was requested related to and monitoring and was not				
	director of nursing of and/or revise policion assessment and imfollowing a fall and pacemakers. Educa staff. The quality and develop a system to the plan.	THOD OF CORRECTION: The or designee could review es and procedures related to aplementation of interventions the care and monitoring of ation could be provided to the ssurance committee could or monitor the effectiveness of CORRECTION: Twenty-one				
	(21) Days.					
2 840	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 B Adequate and re; Clean skin	2 840			
	Subp. 2. Criteria fo	or determining adequate and				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	proper care. The cadequate and proper B. Clean skin a odors. A bathing plane resident's plan of cacondition requires the must be given a condition requires the must be given a condition resident every two hours, and following each episor [144A.04 Subd. 11 Notwithstanding Mid 4658.0520, an incondecked according written in the reside attending physician interval longer than if competent, or a fact appointed conservation agent of a resident in writing to waive prodetermining this interval documented in the Clean linens or clot promptly each time Perineal care including the perineal area. It is keep the bed dry comfort. Special at skin to prevent irritat types of protectors completely covered contact with the resident in the resident in the perineal area. It is to prevent irritation to	criteria for determining er care include:  and freedom from offensive an must be part of each are. A resident whose nat the resident remain in bed implete bath at least every often as indicated. An a must be checked at least indicated are ode of incontinence.  Incontinent residents. Incontinent residents. Incontinent residents interval interva	2 840			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/23/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
HAVENV	OOD CARE CENTER		TON AVENU	E		
0(0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	MN 56601	PROVIDER'S PLAN OF CORRECTI	ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 24	2 840			
	This MN Requirements by: Based on observation review, the facility for incontinence care at 1 of 1 resident (R15)	ent is not met as evidenced on, interview and document ailed to provide timely bladder is directed by the care plan for who was incontinent of urine ed timely assistance.				
	1/16/17, indicated F required extensive a toileting. The MDS always incontinent, development of pre	ssure ulcers, had moisture nage and required application				
	had stress incontine coughing and sneed due to blocked urette and functional incort to the toilet in time of R15's CAA further in incontinent of urine, toileting and was at rashes/breakdown, R15's Care Plan da	dated 10/23/15, indicated R15 ence which occurred with zing, overflow incontinence has or weak bladder muscles attinence due to inability to get due to physical disability. Indicated R15 was always arequired extensive assist with risk for infection, skin and offensive body odor.  ted 1/18/17, indicated R15 blete personal hygiene				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
		1633 DEL	TON AVENU			
HAVENV	VOOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 25	2 840			
	incontinence and re assist for toileting n staff to check and c	equired two staff extensive eeds. The plan directed two change R15's incontinent covide peri-rectal care every				
	R15's Physician Or 2/22/17-3/22/17, dir change brief as soo	ected staff to attempt to				
	The untitled and undated nursing assistant worksheets, indicated R15 required toileting checks every two hours.					
	7:15 a.m. to 11:00 a R15 was observed wheelchair without -At 7:45 a.m. R15 w wheelchair to the di returned to her roor -At 9:04 a.m. licens entered R15's room exited the room. LI repositioning or toile -At 9:53 a.m. R15's -At 9:58 a.m. nursir entered R15's room immediately exited -At 10:00 a.m. R15 needed her incontir stated NA-C told he because she was b -At 10:18 a.m. NA-C proceeded to assist -At 10:35 a.m. NA-C	ed practical nurse (LPN)-A n to administer medication and PN-A did not offer eting assistance to R15. call light was observed on. ng assistant (NA)-C was n, turned off the call light and the room. stated, she had told NA-C she nent product changed. R15 er she would be back to help usy with another resident. C returned to R15's room and				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/23/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE		
TO THE OT	THOUBER ON OUT LIER		ΓΟΝ AVENU			
HAVENV	OOD CARE CENTER		MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	Continued From page 26		2 840		ļ	
	her down. R15 stated down so NA-C stop stated R15 refused surveyor if she wou product could be chewhy she had turned -At 10:45 a.m. NA-C incontinent brief. The heavily saturated whise was saturated R15's peri area with cleansing, R15 ask and NA-C responded clean her well becan her bottom. Upon of cares, NA-C retriev Tegaderm dressing informed R15 she hottom from scratch area measured app (CM) by 0.50 cm. a scratched her body open areas and scra	med R15 she was going to lay red she did not want to lay ped assisting R15. NA-C cares a lot. When asked by ld lay down so her incontinent ranged, R15 stated that was the light on in the first place. O proceeded to remove R15's re brief was noted to be with urine. NA-C confirmed the rand proceeded to cleanse or cleansing wipes. When red NA-C what she was doing red by stating she needed to use of R15's scratch marks on completing the peri-rectal red LPN-A. LPN-A applied a round to R15's right buttock and red a small open area on her rang. LPN-A stated the open round trought and perineal area resulting in atch marks. LPN-A stated she rem to help prevent infection. In the did not be resing frequently fell off. In the firmed R15's incontinent resing frequently fell off. In the firmed R15's incontinent resing frequently fell off. In the round ro				

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nursing assistant work sheet and confirmed R15

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/	23/2017
_	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 840	was to have her inc changed every two though R15 could to staff's responsibility R15 having to ask to On 3/22/17, at 11:1 (DON) confirmed R with incontinence condirected by the care	continent product checked and hours. NA-B also stated even cell us she needed help, it was to provide the cares without us.  O a.m. the director of nursing also should have been provided are every two hours, as a plan. The DON stated it was	2 840			
	A Resident Care Planereviewed 4/2015, in promote optimal requality of care by forefforts to individual	staff to follow and implement directed.  anning Policy and Procedure, dicated the care plan was to sident independence and cusing and directing staff needs and to promote tion and coordination of				
	Although requested incontinence care v	l, no policy related to vas provided.				
	The director of nurs review policies and needed, train staff, evaluate to assure of urine, receive the following each epise	THOD OF CORRECTION: sing and/or designee could procedures, revise as assess the system, monitor, residents who are incontinent e necessary services and care ode of incontinence.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00017		B. WING	<del></del>	03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	Continued From page 28		2 840			
	(21) days.					
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			
	comprehensive resident of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	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.					
	by: Based on observati review, the facility for development of two of 4 residents (R88) ulcers following adr addition, the facility repositioning in orde pressure ulcer deve (R89, R15) identifie	ent is not met as evidenced on, interview and document ailed to prevent the stage 2 pressure ulcers for 1 ) who developed two pressure mission to the facility. In failed to provide timely er to minimize the risk of elopment for 2 of 4 residents d at risk for pressure ulcers ssistance for repositioning.				
	Findings included:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENUI MN 56601	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	R88's undated Factore dementia, fracture overtebra, myelodys disorder.  R88's admission M 12/18/16, indicated impairment, required two staff for bed morequired extensive transferring. The M frequently incontine	ge 29 e Sheet included diagnoses of of left clavicle and seventh plastic syndrome, and anxiety inimum Data Set (MDS) dated R88 had severe cognitive ed extensive assistance from obility and toileting, and assist from one staff for DS further indicated R88 was ent of urine, did not have a nadmission, was at risk for	2 900			
	R88's Pressure Ulco (CAA) dated 12/18/ for pressure ulcers incontinence, impair functional limitation diagnoses of deme of clavicle, and poor R69 required a turn turn and reposition bed. The CAA indications, however, antidepressant, and medications that copressure ulcers. The would be developed pressure related ulco R88's Braden scale the risk for develop	d was on a turning and am.  er Care Area Assessment (16, indicated R88 was at risk related to urinary red mobility, cognitive loss, in range of motion and ntia, pain, weakness, fracture r nutrition. The CAA indicated sing schedule and staff would R88 every two hours while in ated R88 received no at risk ver failed to identify the use of ipsychotics, and narcotic pain ould increase the risk for se CAA indicated a care pland related to the risk for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED		
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	ulcers. R88's Tissue Tolera	ge 30 unce Assessment (a tool to of time skin can tolerate	2 900			
	indicated R88 shou hours while in the w bed.	ange) dated 3/20/17, ld be repositioned every two /heelchair, reclining chair, and				
	had decreased physic to provide extensive reposition every two down and get feet a one to ambulate an destinations. Monito notify the registered indicate R88 was at ulcers. R88 had alto incontinent and directly assist of two to toilet toileting and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and change rectal care after elir indicated R88 was at the continent and cha	ed 12/28/16, indicated R88 sical mobility and directed staff e assistance to turn and hours, assist to sit up/lie and legs into bed. Assist of d transfer. Staff to wheel to all or for persistent red areas and a nurse. The care plan did not trisk for pressure related eration in elimination, was exted staff to provide extensive et every two hours, check with e as needed, and provide perimination. The care plan also at risk for dehydration and nitor R88's skin for hydration, down.				
		tant (NA) care guide directed osition R88 every two hours.				
	3/13/17, indicated F loss of 9% in 30 da approximately 30 da clinic stay and retur	ary assessment dated R88 had a significant weight ys, and R88 had an ay inpatient behavioral health ned to the facility on 2/2/17. dicated R88 was able to feed				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 900	himself and on 2/3/supplement was initrecorded weights result of 124 lbs. (pounds and on 3/21/17, R8  R88's physician ord medication) three times are times are times. Trazodone an antid sleeping. Effexor, a release every event Seroquel three times paranoia/agitation.  R88's progress note Administration Recusince admission and a recliner in the 1 his bed. Progress mindicated R88 had bottom hurt, medicatransferred to anoth Documentation does	17, four ounces of dietary tiated four times a day. R88's evealed an admission weight), weight on 2/6/17, 121 lbs. 8 weighed 116 lbs.  Hers included Neurontin (pain mes a day and as needed for estlessness. Oxycodone, a es a day for low back pain. a day for low back pain. a day for low back pain. The pressant, 50 mg for trouble in antidepressant, extended ing for anxiety disorder and es a day and as needed for	2 900	DEFICIENCY)		
	-Progress note date indicated R88 was was more restless needed Seroquel a administered. Docu	mentation does not reflect assessment which would have				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENW	OOD CARE CENTER	1633 DEL <sup>-</sup> BEMIDJI,	FON AVENU	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From page 32		2 900			
	p.m. as needed dos administered for bu Documentation indi effective. Corresponsation applied barrier crea evidence that a skir - MAR dated 3/5/17 needed dose of Nebuttocks pain, anxious Documentation indi however, the medic skin inspection to ru-Progress note date indicated R88 had befor the first portion on needed dose of Neto R88 "screaming Documentation indi However, the medic loss of the medicated R88 had befor the first portion of the R88 "screaming Documentation indi However, the medicated R88 had before the R88 "screaming Documentation indi However, the medicated R88 had before the R88 "screaming Documentation indi However, the medicated R88 had before the R88 "screaming Documentation indi However, the medicated R88 had before the R88 "screaming Documentation indi However, the medicated R88 had before the R88 "screaming Documentation indi However, the medicated R88 had before the R88 ha	ttocks pain and headache. cated the dose was not inding progress note indicated ed R88 every two hours and im, however, the note lacked in inspection was conducted.  If, indicated at 4:51 p.m. as urontin was administered for ety, and agitation. cated the dose was effective, cal record lacked evidence of a calle out impaired skin integrity.  If the night. At 1:22 p.m. as urontin was administered due about butt pain."  Cated dose was effective. cal record lacked evidence nent was completed which				
	skin inspections, me for impaired skin in	rd lacked evidence of routine onitoring, and/or assessment tegrity or changes to skin cal record revealed no history e skin.				
	seated in his wheel in a slumped position cushion was noted	a.m. R88 was observed chair at the dining room table on. A pressure reducing seat in the wheelchair. e of the seat cushion could				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	OOD CARE CENTER		TON AVENU	E		
			MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
2 900	Continued From page 33		2 900			
	-At 8:36 a.m. R88 planted his feet on the floor and adjusted himself in the chair to a more upright position.					
	-At 9:19 a.m. R88 was again in a slumped position while seated in the wheelchair. An unidentified staff member assisted R88 to sit upright by moving behind the wheelchair, wrapping her arms underneath R88's arms and lifted/slid R88 to an upright position.					
	-At 2:03 p.m. physical therapist (PT)-D and registered nurse (RN)-C were observed to stand and ambulate R88. R88 took small shuffling steps and required continuous verbal cues from PT-D.					
	On 3/22/17, at 7:50 a.m. trained medication assistant (TMA)-B stated it was time to administer R88's medications which included pain pills. R88 was lying in bed when TMA-B entered the room. TMA-B asked R88 if he had any pain in which R88 had denied.					
	-At 7:52 a.m. licensed practical nurse (LPN)-D entered the room with R88's medications. R88 stated "leave me alone", LPN-D explained she had medications and he needed to sit up. When TMA-B and LPN-D attempted to assist R88 to sit on the side of the bed, R88 stated "ouch" a couple of times and cried "just leave me alone." LPN-D informed R88 she had his pain pills and he needed to sit up. When R88 was sitting on the edge of the bed, and as LPN-D attempted to administer medications, R88 stated his bottom hurt. R88 continued to be verbally resistive, however cooperative, and LPN-D stated she would administer the rest of the medications after R88 was up and dressed. LPN-D proceeded to					

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		00017	B. WING		03/23/2017	
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S	ETATE, ZIP CODE		
BEMIDJI,		BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 900	assisted R88 to roll TMA-B pulled R88's underneath R88, R4 hurting me, leave m started to wash R88' "ouch." TMA-B state and continued to wathen requested to ir bottom. Inspection ulcer approximately the inside right butter aised with an open was not aware of the said anything about and R88 did not have put on it either. TM R88's morning care -At 8:21 a.m. LPN-LLPN-D and TMA-B assisted him to his R88 the rest of his put the open area and of the open area and of the pressure ulcer.  -At 12:02 p.m. RN-C been previously rep staff and had not be assessed and deter (partial thickness lo shallow open ulcer without slough or proposed to the pressure of continued blister) precedent of the pressure ulcer without slough or proposed to the pressure ulcer without slough or pressure ulcer without slough or proposed to the pressure ulcer without slough or proposed to the p	B donned gloves, directed and over onto his right side. As incontinent brief from 88 yelled "ouch, you are ne alone." When TMA-B B's bottom, R88 again yelled ed R88 said ouch quite a bit ash R88's bottom. Surveyor respect R88's skin on his revealed a stage two pressure of the size of a pencil eraser on bock. The area was slightly center. TMA-B indicated she are open area and nobody had a R88 having an open area, we any cream in his room to A-B proceeded to complete	2 900			

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Minneso	<u>ita Department of He</u>	ealth earth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00017	B. WING		03/23/2017	
		00017			03/2	3/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		1633 DEL	TON AVENU	E		
HAVENW	OOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEFICIEINO I )		
2 900	Continued From pa	ige 35	2 900			
	R88's family was co	ontacted, the doctor would be				
		sult would be requested from				
		stated nurses did not look at				
		e or assess except on				
		change of condition, however,				
		each residents' skin daily with				
		port areas of concern to the				
		ed NAs also looked at skin on				
		ld document any noted areas				
		the bath worksheets, give the				
		urse and the nurse would				
		condition concern onto a				
		en asked if staff kept records				
		or evidence that a skin				
		ducted following the				
		kin concern, RN-C stated no,				
		re thrown away once				
		he progress note. RN-C stated				
		note was only written when				
		of concern identified. RN-C				
	confirmed R88's me	edical record lacked evidence				
	of routine skin mon	itoring and evaluations. RN-C				
		nd was found, nurses were to				
	complete a wound	assessment worksheet and				
	the resident would	also be added to the facility's				
	weekly wound roun	ds.				
	1					
		D stated R88's scheduled bath				
		enings and confirmed the NAs				
		v about any resident skin				
		stated the RNs usually				
		rehensive skin assessment on				
		es did not perform whole body				
		d did not know how often, if				
	-	spections by a nurse was				
	conducted.					
	. A. 4 50 . NA 1					
		stated residents' skin was				
		cares and on bath days and if				
	sne saw sometning	g, she would report it to the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. Bolebina.			
		00017	B. WING		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	seated in his wheelectied out, "oh God phelp me I have to go Surveyor immediate staff R88 had to use to yell out and becafidgety until he was 8:44 a.m. by NA-H. cried out, "Jesus more grab bar to independent of the physical assistance sit down on the toiled dated 3/22/17, was and not covering the inside buttock. NA-I revealed another stoccyx which was son the right buttock pink wound bed. Now worked on Monday was not there at the the other wound has stated the area wou applied and the next and in a couple of cagain. NA-H confirm when she found skill documentation she any impaired skin in	a.m. R88 was observed chair in the lobby area. R88 blease help me, God please o potty, I have to poop!" ely communicated to facility ethe restroom. R88 continued ame increasingly agitated and assisted to the bathroom at Once in the bathroom R88 y butt hurts." R88 utilized the identity stand up with minimal and verbal cues to turn and et. The Mepilex foam dressing located over the coccyx area e pressure ulcer on the right H removed the dressing which age two pressure ulcer on the slightly smaller than the wound. It was oval shaped with a A-H stated she had last and the wound on the coccyx at time. However, NA-H stated d always been there. NA-H uld get red, cream would be to day the area would be gone thays the areas would be back med she reported to the nurse in problems and bath ets were used to write down integrity. NA-H applied barrier is wound without obtaining	2 900	DEFICIENC!)		
	cream was remove	entered the room. The barrier d from the coccyx by NA-H. e wound had not been				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	previously reported and had not been to wound and stated it wanted another nur assess the coccyx obtained for better in the bathroom and flashlight, RN-C cor and assessed the wanted and large cover and protect but the pressure ulcer which a depth of less cleansed and large cover and protect but the pressure ulcer which are depth of less cleansed and large cover and protect but the pressure ulcer which are depth of less cleansed and large cover and protect but the pressure ulcer which are depth of less cleansed and large cover and protect but the pressure ulcer which are the pressure ulcer	ge 37 or identified by facility staff reated. RN-E looked at the was not open, however, se that had better eyes to wound. A flash light was viewing related to poor lighting donce viewed under the offirmed the wound was open wound to be a stage two homeasured 0.5 cm by 0.2 cm than 0.1 cm. The area was foam dressing was applied to oth pressure ulcers.	2 900			
	discomfort and comskin each time the whowever had not do stated the skin show were reports of bott nursing (DON) state Tuesday 3/21/17, a skin integrity. The Experience of the nurses would in something was broud DON verified the nurses would in something was broud the nurses would in something was broud the nurses would in something was broud the nurses would in something was broud the nurses would in something was broud the nurses would in something was broud the nurses would in something was broud the nurse of the nurse would be not something was broud to the nurse would be not something was broud to the nurse would be not something was broud to the nurse would be not something was broud to the nurse would be not something was broud to the nurse would be not something to th	firmed she had observed the wheelchair was changed, ocumented any findings. RN-C all be inspected when there om discomfort. The director of ed she had toileted R88 on and had not noted any impaired DON stated the NAs looked at daily basis and also on bath any concerns to the nurse and formally look at the skin when aght to their attention. The urses looked at residents' skin Braden Scale assessment on weekly for three weeks and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	nurse if the dressing Would also recomm look into changing s cream to be applied and wounds to be e and weekly skin che	g was not staying in place. nend labs to the physician, seat cushion, lanispetic barrier d, request a dietary consult evaluated by the RN weekly ecks by the LPN.	2 900			
	failed to provide ever repositioning and fa	pressure ulcers and the staff ery one hour turning and illed to ensure pressure e applied at all times, as e plan.				
	R89 had diagnoses chronic kidney dises pulmonary disease, MDS also indicated was non-ambulator two persons for bed extensive assist of hygiene and was to persons for transfer further indicated R8	S dated 1/15/17, indicated which included stage 3 ase, chronic obstructive anemia and diabetes. The R89 was cognitively intact, y, required extensive assist of mobility and dressing, one person for personal tally dependent on two as and toilet use. The MDS as had one unhealed, stage 2 ent on admission to the				
	indicated R89 requi and was always inc The CAA indicated sores, worsening ur gangrene, discomfo complicated by curr dependence on star	er CAA dated 10/27/16, red total assist with bathing ontinent of bowel and bladder. R89 was at risk for pressure rinary tract infections/sepsis, ort and weight loss which was rent cellulitis, severe pain, ff for bed mobility and toileting d chronic kidney disease.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/23/2017	
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	ETATE, ZIP CODE E		
(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) COMPLETE DATE
2 900	Continued From page 39		2 900			
	potential for alterati pressure sore on le implement the follor turn and reposition needed provide perirectal episode. monitor for persis registered nurse (R maintain adequate providing dietary de wound care/dress keep skin clean a APP [alternating p	care after each incontinent tent red areas and report to N) e nutrition and hydration by cub [decubitus] program ing change as ordered.				
	R89's undated Nursing Assistant Care Worksheet directed staff to turn and reposition R89 every one hour and indicated R89 needed to have Prevalon boots (heel offloading device to help prevent the development of heel pressure injuries) on at all times except when bathing.					
	Prevalon (blue) hee	der Report dated cluded an order to wear el lift boots at all times except heel is in proper position.				
	R89's Braden Scale dated 2/21/17, indicated R89 was at moderate risk for skin breakdown.					
		ance Assessment dated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	23/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
HAVENV	VOOD CARE CENTER		TON AVENUI	E		
11747 2144	TOOD OANE OENTEN	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 40	2 900			
	the wheelchair, cha	ir or recliner every one hour osition every one hour when in				
	25 minutes) R89 was sleeping in bed, lyin covers, with her shot the right. R89 was repositioning during determine if R89's I directed. R89 was again con lying on her back frow without staff assistated 10:47 a.m. R89 positioned on her back television. R89 star morning and no one the day yetat 10:52 a.m. LPN administered R89's immediately exited positioned on her back provide repositioning and no one that the state of the provide repositioning and no one that the state of the provide repositioning and no one that the state of the provide repositioning and no one that the state of the state of the provide repositioning and no one that the state of the state o	was observed in bed ack, awake and watching ted she liked to sleep in in the e had come in to get her up for I-A entered R89's room and insulin in the abdomen and the room. R89 remained ack. LPN-A did not offer nor				

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	ITA Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI	E CONSTRUCTION	(V3) DATE	QLID\/EV
	OF CORRECTION	IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. DOILDING.			
		00017	B. WING		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
11A\/=\I\A	OOD CARE CENTER	1633 DEL	TON AVENU	E		
HAVENW	OOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 41	2 900			
	However, NA-C was pulling a sheet under hips to lift them off to intact with a small put to her right buttock. be repositioned every turned every hour wher heel. NA-A entermechanical lift and transfer R89 to the wheelchair was equal padded board was of the wheelchair for were raised. NA-C morning cares and room and to the dimensional lift and transfer R89 to the wheelchair was equal to the wheelchair for were raised. NA-C morning cares and room and to the dimensional lift and transfer R89 to the wheelchair was equal to the wheelchair for were raised.	the use of a grab bar. It is required to assist the turn by the R89's hips and pushing her the bed. R89's buttocks were be a sized light red area noted NA-C indicated R89 was to the ry two hours but used to be when R89 had an open sore to be red the room with a NA-A and NA-C proceeded to wheelchair via the lift. R89's hipped with a seat cushion and is across the calf support area not/leg rests. The leg rests assisted R89 to complete her then wheeled R89 out of her ing room at approximately be revalon boots were not				
	had come to her aft day and indicated s and repositioning so	27 p.m. RN-A stated NA-C ser assisting R89 up for the he had thought R89's turning chedule was for every two ed R89's current repositioning very one hour.				
	her room, seated in she had just assiste boots. LPN-A verifi and confirmed she times due to issues LPN-A, "Aren't we s	37 p.m. R89 was observed in the wheelchair. LPN-A stated ed R89 to put on her Prevalon ed R89 did not have them on should have them on at all with her heels. NA-C asked supposed to release them PN-A informed NA-C the at all times.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	On 3/22/17 at 1:40 not put R89's Preva assisted R89 up for done so. NA-C ve approximately one of the second	p.m. NA-C confirmed she had alon boots on when she the day and should have rified the boots were off for hour and 30 minutes.  51 a.m. RN-A verified R89 a facility with a left heel ulcer healed and also had a history on her bottom. RN-A uld have been turned and one hour and should have had on at all times except for don the care plan.  Pressure related sores and ally turning and repositioning ted by the care plan.  S dated 1/16/17, indicated antion and required extensive taff for transfers, required two for bed mobility and had solved in the care plan.  Illy Living Functional Status, solved in the care plan in the care plan in the care plan.  The CAA indicated R15 was better neuropathy, chronic ary disease and bilateral lower ons. The CAA indicated R15 assist with repositioning and action, skin rashes/breakdown, so.	2 900			
	n ibs care plan dat	ed 1/18/17, indicated R15 had				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DFI	DRESS, CITY, S	*		
HAVEINV	VOOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ae 43	2 900			
	decreased physical lower extremity am transfer, turn, repos Staff were directed two to turn and repo	mobility related to bilateral putation with the inability to sition self, to sit up or lie down. to provide extensive assist of osition R15 every hour. The ected staff to turn and				
	R15 was at risk for	e dated 3/20//17, indicated pressure ulcers due to inability ight and make frequent or in position.				
	7:15 a.m. to 11:00 a remain seated in he assistanceAt 7:45 a.m. R15 wheelchair to the direturned to her roor-At 9:04 a.m. LPN-administer medicat LPN-A did not offer assistanceAt 9:53 a.m. R15's -At 9:58 a.m. NA-C the call light off and -At 10:00 a.m. R15 she needed her inc NA stated she would she was busy with a-At 10:18 a.m. NA-C proceeded to assistanceAt 10:35 a.m. NA-C asked her what she informed R15 she was tated she did not we stated she did not we she was believed to assist the stated she did not we stated she did not we she was believed to assist the stated she did not we stated she did not we she was believed to assist the stated she did not we stated she did not we she was believed to assist the stated she did not we shall she did not we shall she was believed to assist the stated she did not we shall she did not we shall she was believed to assist the she did not we shall she was believed to assist the she did not we shall she was believed to assist the she did not we shall she was believed to assist the she did not we shall she was believed to assist the she was believed to assist the she did not we shall she was believed to assist the she	A entered R15's room to ion and exited the room. nor provide R15 repositioning call light was observed on. entered R15's room, turned immediately exited the room. stated she had told the NA-C ontinent brief changed and the d be back to help her because another resident.				

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PRINTED: 04/10/2017 FORM APPROVED

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00017 B. WING 03/23/20 <sup>-</sup>	
	17
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE	17
1633 DELTON AVENUE	
HAVENWOOD CARE CENTER  BEMIDJI, MN 56601	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) MPLETE DATE
2 900  Iot. When asked by the surveyor if she would lay down so staff could change her incontinent brief, R15 stated that was why she had turned the call light on in the first place.  -At 10:45 a.m. NA-C proceeded to provide R15 incontinent cares. When removed, the incontinent brief was observed heavily saturated with urine. NA-C confirmed the brief was saturated. NA-C proceeded to cleanse R15's peri area with wipes. R15 asked NA-C what are you doing, NA-C stated she needed to cleanse R15's well due to R15's peri area scratches. Upon completing the peri care, NA-C stated she needed to get the nurse and would be right back. NA-C returned to the room with LPN-A who applied a Tegaderm dressing to R15's right buttock covering an open area. LPN-A informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 CM by 0.50 cm. LPN-A stated fls frequently scratched her body including her peri area resulting in open areas and scratch marks. LPN-A stated she applied the dressing to help prevent infection. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently fell off.  -At 10:58 a.m. R15's cares were completed. NA-C confirmed R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had not provided R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had not provided R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had not provided R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had not provided R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had assisted R15 up at 7:00 a.m. and pointed to a white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B confirmed	

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assistance for R15 since 7:00 a.m. (three hours

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	23/2017	
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENUI MN 56601	STATE, ZIP CODE <b>E</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 900	and 30 minutes ear worksheet which shand verified R15 wa hour. NA-B stated ear she needed help, it provide the cares where the cares where the care where the care where the care where the care of th	clier). NA-B referred to the NA ne removed from her pocket as to be repositioned every even though R15 could tell us was staff's responsibility to without R15 having to ask us.  O a.m. the DON confirmed een repositioned every hour as	2 900				
	4/2015, indicated the prevention protocol to development of the schedules of at least often if condition incomplete fracility protocol Skillindicated on admissionable assessment would develop a comprehation components of the included a Braden's	in Care last reviewed 1/2015, sion a comprehensive skin be completed and used to ensive care plan. The comprehensive assessment is scale weekly times four					
	admission assessm relieving devices ar	ment-completed with the initial nent, assessment for pressure nd a tissue tolerance test scheduled assessments					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00017	B. WING	<del></del>	03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		FON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	included the Brader significant change is significant change is bath days, Tissue T significant change is indicated staff would to perirectal area days.  SUGGESTED MET The director of nurs review/revise policies ulcer prevention and	n's scale quarterly and with n status, skin assessment with status, weekly body audit on olerance Test with a n condition. The protocol also d apply moisture barrier cream aily, as needed.  THOD OF CORRECTION: sing (DON) or designee could es/procedures for pressure d care, educate staff and	2 900			
2 905	(21) days.  MN Rule 4658.0525	R CORRECTION: Twenty One S Subp. 4 Rehab - Positioning g. Residents must be	2 905			
	positioned in good to fresidents unable must be changed a including periods of been put to bed for has documented the hours during this time.	g. Residents must be body alignment. The position to change their own position t least every two hours, time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.				
	by: Based on observati review, the facility for repositioning in order	ent is not met as evidenced on, interview and document ailed to provide timely er to prevent the development ulcers as directed by the care				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			D. WING	<del>.</del>			
		00017	B. WING		03/2	3/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
L HAVENWOOD CARE CENTER		FON AVENU MN 56601	E				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 905	Continued From pa	ge 47	2 905				
	plan for 2 of 4 residence pressure ulcers.	dents (R89, R15) reviewed for					
	Finding include:						
	failed to provide ever repositioning and fa	pressure ulcers and the staff ery one hour turning and alled to ensure pressure e applied at all times, as e plan.					
	R89 had diagnoses chronic kidney dise pulmonary disease MDS also indicated was non-ambulator two persons for bed extensive assist of hygiene and was to persons for transfel further indicated R8	S dated 1/15/17, indicated which included stage 3 ase, chronic obstructive, anemia and diabetes. The R89 was cognitively intact, y, required extensive assist of a mobility and dressing, one person for personal tally dependent on two and toilet use. The MDS and one unhealed, stage 2 ent on admission to the					
	(CAA) dated 10/27/ total assist with bat incontinent of bowe indicated R89 was worsening urinary to gangrene, discomfor complicated by curr dependence on sta	er Care Area Assessment 16, indicated R89 required hing and was always I and bladder. The CAA at risk for pressure sores, ract infections/sepsis, ort and weight loss which was rent cellulitis, severe pain, ff for bed mobility and toileting d chronic kidney disease.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE APPR	ULD BE	(X5) COMPLETE DATE
2 905	R89's undated Care potential for alteratipressure sore on le implement the followater and reposition neededprovide perirectal episodemonitor for persist registered nurse (Rumaintain adequate providing dietary deuround care/dressure skin clean auround care/dressure relief book R89's undated Nurse directed staff to turn one hour and indica Prevalon boots (heep prevent the developinjuries) on at all times R89's Physician Ora 2/23/17-3/23/17, incepted staff to turn one hour and indica Prevalon (blue) heef or bathing. Ensure R89's Braden Scale was at moderate rise R89's Tissue Tolera 10/15/16, directed staff to turn one hour and indica Prevalon (blue) heef or bathing. Ensure R89's Braden Scale was at moderate rise R89's Tissue Tolera 10/15/16, directed staff to turn one hour and indica Prevalon (blue) heef or bathing. Ensure R89's Tissue Tolera 10/15/16, directed staff to turn one hour and indica Prevalon (blue) heef or bathing. Ensure R89's Tissue Tolera 10/15/16, directed staff to turn one hour and indica Prevalon (blue) heef or bathing. Ensure R89's Tissue Tolera 10/15/16, directed staff to turn one hour and indica Prevalon (blue) heef or bathing.	e Plan indicated R89 had on in skin integrity related to ft heel and directed staff to wing interventions: In every one hour and as care after each incontinent tent red areas and report to N) e nutrition and hydration by ecub [decubitus] program ing change as ordered. Indicate of the program of the progra	2 905			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
HAVENV	VOOD CARE CENTER	•	TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ige 49	2 905			
		osition every one hour when in				
	25 minutes) R89 wisleeping in bed, lyir covers, with her she the right. R89 was repositioning during determine if R89's directed. R89 was again con lying on her back fr without staff assista-at 10:47 a.m. R89 positioned on her betelevision. R89 stamorning and no one the day yet. at 10:52 a.m. LPN administered R89's immediately exited positioned on her betelevisioned on	was observed in bed ack, awake and watching ted she liked to sleep in in the e had come in to get her up for I-A entered R89's room and insulin in the abdomen and the room. R89 remained ack. LPN-A did not offer nor				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 905	However, NA-C wa pulling a sheet under hips to lift them off intact with a small put to her right buttock, be repositioned ever turned every hour wher heel. NA-A ent mechanical lift and transfer R89 to the wheelchair was equal padded board was of the wheelchair for were raised. NA-C morning cares and room and to the din 12:00 p.m. R89's Freapplied.  On 3/22/2017, at 1: had come to her affiday and indicated sand repositioning schours. RN-A verifies and repositioning schours. RN-A verifies schedule was for expending the had just assisted boots. LPN-A verificand confirmed she times due to issues LPN-A, "Aren't we sonce in a while?" L boots should be on	s required to assist the turn by er R89's hips and pushing her the bed. R89's buttocks were be a sized light red area noted NA-C indicated R89 was to ery two hours but used to be when R89 had an open sore to ered the room with a NA-A and NA-C proceeded to wheelchair via the lift. R89's uipped with a seat cushion and a across the calf support area pot/leg rests. The leg rests assisted R89 to complete her then wheeled R89 out of her hing room at approximately prevalon boots were not as a core as a current repositioning of R89's current repositioning of R89's current repositioning of R89's current repositioning of R89's current repositioning of R89 to put on her Prevalon and R89 did not have them on should have them on at all a with her heels. NA-C asked supposed to release them LPN-A informed NA-C the at all times.	2 905			
	On 3/22/17 at 1:40	p.m. NA-C confirmed she had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00017	B. WING		03/2	3/2017
	DDRESS, CITY, S	*		
HAVENWOOD CARE CENTER	LTON AVENUE I, MN 56601	<b>E</b>		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 905 Continued From page 51 not put R89's Prevalon boots on when she assisted R89 up for the day and should have done so. NA-C verified the boots were off for approximately one hour and 30 minutes.  On 3/23/2017, at 9:51 a.m. RN-A verified R89 was admitted to the facility with a left heel ulcer which had recently healed and also had a history of pressure ulcers to her bottom. RN-A confirmed R89 should have been turned and repositioned every one hour and should have had the Prevalon boots on at all times except for bathing, as directed on the care plan.  R15 was at risk for pressure related sores and did not receive timely turning and repositioning assistance as directed by the care plan.  R15's quarterly MDS dated 1/16/17, indicated R15 had intact cognition and required extensive assistance of two staff for transfers, required extensive assist of two for bed mobility and had no rejection of cares.  R15's Activity of Daily Living Functional Status, CAA dated 10/23/16, indicated R15 was diagnosed with diabetic neuropathy, chronic obstructive pulmonary disease and bilateral lowe	d	DEFICIENCY)		
extremity amputations. The CAA indicated R15 required extensive assist with repositioning and was at risk for infection, skin rashes/breakdown, and pressure ulcers.  R15's care plan dated 1/18/17, indicated R15 had decreased physical mobility related to bilateral	b			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	00017	B. WING		03/	23/2017	
UPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PENTER	1633 DEL	TON AVENU	E			
JENTER	BEMIDJI,	MN 56601				
FICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE	
rom pa	ge 52	2 905				
mity ample n, repos lirected and reposets, dire	putation with the inability to sition self, to sit up or lie down. to provide extensive assist of osition R15 every hour. The ected staff to turn and					
risk for own we	pressure ulcers due to inability ight and make frequent or					
11:00 a red in he red in he room LPN-/medicat offer m. R15's n. NA-C off and m. R15 her inche would sy with a m. NA-C off assistent off and the would sy with a m. NA-C off and the would sy with a m. NA-C off and the would sy with a m. NA-C off assistent not what she would a she would be a solution of the would so assistent not would she would be a solution of the world of the wor	a.m. R15 was observed to er wheelchair without receiving was observed to propel her ining room for breakfast and m. A entered R15's room to ion and exited the room. nor provide R15 repositioning call light was observed on. entered R15's room, turned I immediately exited the room. stated she had told the NA-C ontinent brief changed and the d be back to help her because another resident. C returned to R15's room and to R15's roommate. C began to assist R15. R15 was doing and NA-C was going lay her down. R15 vant to lie down. NA-C					
	UPPLIER  CENTER  MARY STA  EFICIENCY OR L  From pa  mity ampliant reposed and	ODDITA  UPPLIER  STREET AE  1633 DEL  BEMIDJI,  WARY STATEMENT OF DEFICIENCIES  EFICIENCY MUST BE PRECEDED BY FULL  ORY OR LSC IDENTIFYING INFORMATION)  From page 52  mity amputation with the inability to n, reposition self, to sit up or lie down. directed to provide extensive assist of and reposition R15 every hour. The ets, directed staff to turn and R15 every hour.  en Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  during continuous observations from a 11:00 a.m. R15 was observed to ted in her wheelchair without receiving the dining room for breakfast and her room.  The LPN-A entered R15's room to medication and exited the room. The continuous observed on the continuous observed on the dining room for breakfast and her room.  The LPN-A entered R15's room to medication and exited the room. The continuous observed on the continuous observed on the dining room for breakfast and her room.  The LPN-A entered R15's room to medication and exited the room. The continuous observed on the continuous observed on the dining room for breakfast and her room.  The LPN-A entered R15's room to medication and exited the room. The continuous observed on the continuous observed on the continuous observed on the continuous observed to propel her to the dining room for breakfast and her room.  The LPN-A entered R15's room to medication and exited the room.  The continuous observed to propel her to the dining room for breakfast and her room.  The LPN-A entered R15's room to medication and exited the room.  The continuous observed to propel her to the dining room for breakfast and her room.  The continuous observed to propel her to the dining room for breakfast and her room.  The continuous observed to propel her to the dining room for breakfast and her room.  The continuous observed to propel her to the dining room for breakfast and her room.  The continuous observed to propel her to inability to mean to propel her to inability to mean to propel her t	DENTIFICATION NUMBER:  00017  DUPPLIER  STREET ADDRESS, CITY, S  1633 DELTON AVENU BEMIDJI, MN 56601  MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)  From page 52  mity amputation with the inability to n, reposition self, to sit up or lie down. directed to provide extensive assist of and reposition R15 every hour. The bets, directed staff to turn and R15 every hour.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated risk for pressure ulcers due to inability own weight and make frequent or changes in position.  Den Scale dated 3/20//17, indicated r	DODOTY    STREET ADDRESS, CITY, STATE, ZIP CODE	DENTIFICATION NUMBER:    DODG	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	R15 stated that was light on in the first produced to cares. White incontinent cares. White incontinent cares. White incontinent cares. White incontinent cares. White incontinent cares. White incontinent cares are stated she needed R15's peri area scriperi care, NA-C stanurse and would be the room with LPN-dressing to R15's riarea. LPN-A informarea on her bottom the open area mea by 0.50 cm. LPN-A scratched her body resulting in open ar stated she applied infection. LPN-A fur incontinence and we frequently fell off.  At 10:58 a.m. R15 NA-C confirmed R1 with urine and her shad not provided R repositioning and ir now.  At 10:59 a.m. NA-stated she had assipointed to a white rand stated staff doc were provided on the a.m. was noted on she had not provided in the provided in the provided on t	I change her incontinent brief, is why she had turned the call place.  C proceeded to provide R15 When removed, the incontinent heavily saturated with urine. It brief was saturated. NA-C se R15's peri area with wipes. That are you doing, NA-C to cleanse R15 well due to atches. Upon completing the ted she needed to get the eright back. NA-C returned to A who applied a Tegaderm ght buttock covering an open ed R15 she had a small open from scratching. LPN-A stated sured approximately 0.25 CM stated R15 frequently including her peri area eas and scratch marks. LPN-A the dressing to help prevent ther stated, due to R15's ret skin, the dressing	2 905			

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and 30 minutes earlier). NA-B referred to the NA

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	and verified R15 wa hour. NA-B stated a she needed help, it provide the cares w On 3/22/17, at 11:1	ge 54 ne removed from her pocket as to be repositioned every even though R15 could tell us was staff's responsibility to vithout R15 having to ask us.  0 a.m. the DON confirmed een repositioned every hour as	2 905			
	A Resident Care Plreviewed 4/2015, in promote optimal requality of care by forefforts to individual					
	4/2015, indicated the prevention protocol to development of the state	r Prevention Policy dated ne facility pressure ulcer included but was not limited urning and positioning at every two hours or more dicates.				
	indicated on admiss assessment would develop a compreh components of the included a Braden's weeks, skin assess admission assessmelieving devices ar assessment. Other	in Care last reviewed 1/2015, sion a comprehensive skin be completed and used to ensive care plan. The comprehensive assessment is scale weekly times four ment-completed with the initial nent, assessment for pressure and a tissue tolerance test scheduled assessments of scale quarterly and with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING	·····	03/2	3/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S	STATE, ZIP CODE <b>E</b>		
HAVENW	OOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	significant change is significant change is bath days, Tissue T significant change is indicated staff would to perirectal area days.  SUGGESTED MET The director of nurse review/revise policies ulcer prevention and perform audits to en	n status, skin assessment with status, weekly body audit on olerance Test with a n condition. The protocol also d apply moisture barrier cream aily, as needed.  THOD OF CORRECTION: sing (DON) or designee could es/procedures for pressure d care, educate staff and	2 905			
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and	and procedures. The infection ast include policies and provide for the following: based on systematic data rosocomial infections in detection, investigation, and sof infectious diseases; deprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of	21390			

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	TON AVENU	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21390	employee health poractices, including defined in part 4658. G. a system for H. a system for products which affed disinfectants, antise incontinence products. In methods for recurrent standards of the current standards of	olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of act infection control, such as eptics, gloves, and	21390			

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	ita Department of He IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00017	B. WING		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU	E		
		BEMIDJI,	MN 56601		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 57	21390			
	wiped R15's buttool several times to wip the barrier cream wapplied the barrier chand and applied the area. NA-E remove tossed it in the trask R15 onto her back. scratched her peria obtained cleansing R15's periarea. NA-barrier cream with harrier cream to R1 removed right soiled from NA-D, applied her clothing and trawheelchair. NA-E wher gloves during the creams using soiled observed to provide application of barrier observed to be offe following scratching.	ks area, turning the wipe over be the area. NA-E picked up ith her right gloved hand and cream to her soiled left gloved he cream to R15's buttock dher soiled left glove and h. NA-E and NA-D positioned R15 was noted to have rea at this time. NA-E wipes and proceeded to wipe E picked up the lanoseptic her left hand and applied the 5's front periarea. NA-E diglove and with assistance R15's clean brief, adjusted insferred R15 back into her ras not observed to change he pericare and application of digloves. NA-D was not e assistance with cleansing or er cream. R15 was not red or provided hand washing ther periarea.				
	including the periard scratched her skind areas. NA-E confirm peri area was from	, frequently scratched her skin ea. NA-E stated R15 frequently resulting in open ned the red areas on R15's scratching and the tegaderm covered an open area from				
	(RN)-A verfied soile	2:42 p.m. registered nurse ed gloves should have been swashed and clean gloves				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	3/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21390	Continued From page 58		21390			
	reapplied prior to ap	oplying barrier cream.				
	direct staff to wash	l, Application of Ointment, hands, open the jar or tube, ointment, remove gloves and				
	review date 4/2015	I Care Procedure policy, , lacked direction for applying ream during perineal cares.				
	The director of nurs review policies and needed, train staff, evaluate to assure	THOD OF CORRECTION: sing and/or designee could procedures, revise as assess the system, monitor, proper hand hygiene was ne provision of cares.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	23/2017
	PROVIDER OR SUPPLIER	1633 DEL	DRESS, CITY, S TON AVENU MN 56601	STATE, ZIP CODE <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	residents, and volui Health shall provide regarding implemen	nteers. The Department of e technical assistance ntation of the guidelines.	21426			
	by: Based on interview facility failed to ension of the two step tube would include the ir the test was comple R110, R89, R46, R4	and document review, the ure consistent documentation erculin skin test (TST) which aduration and interpretation of eted for 5 of 5 residents (R69, 4) and 4 of 5 employees ed the required documentation.				
	R69 was admitted the Resident Tuberculing form indicated R69 step TST on 1/21/1 documentation of a second step TST wand read on 2/7/17.	o the facility on 1/20/17. The Skin Test Documentation was administered the first 7, and read on 1/23/17, with 0 mm induration. The as administered on 2/5/17, with documentation of a 0 ereadings lacked an eresults.				
	Resident Tuberculir	to the facility on 1/18/17. The skin Test Documentation administered the first step				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED	
17	B. WING		03/2	3/2017	
1633 DEL	TON AVENU				
RECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE	
duration. The stered on 1/29/17, ocumentation of a 0 s lacked an lity on 10/14/16. The st Documentation red the first step TST 16/16, with duration. The stered on 10/24/16, ocumentation of a 0	21426				
st Documentation red the first step TST 30/16, with duration. The istered on 1/22/17, ocumentation of a 0 is lacked an set Documentation ed the first step TST 1/17, with duration. The istered on 2/25/17, cumentation of a 0					
	STREET AD  1633 DELI BEMIDJI,  T DEFICIENCIES PRECEDED BY FULL YING INFORMATION)  1 1/21/17, with duration. The istered on 1/29/17, ocumentation of a 0 s lacked an  lity on 10/14/16. The st Documentation	STREET ADDRESS, CITY, S  1633 DELTON AVENU BEMIDJI, MN 56601  DEFICIENCIES PRECEDED BY FULL VING INFORMATION)  10 PREFIX TAG  21426  1/21/17, with duration. The istered on 1/29/17, ocumentation of a 0 s lacked an  lity on 10/14/16. The st Documentation ared the first step TST /16/16, with duration. The istered on 10/24/16, ocumentation of a 0 s lacked an  lity on 12/27/16. The st Documentation ared the first step TST /30/16, with duration. The istered on 1/22/17, ocumentation of a 0 s lacked an  at y on 2/15/17. The st Documentation ed the first step TST /3/17, with duration. The istered on 2/25/17, cumentation of a 0 s lacked an	STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE BEMIDJI, MN 56601  DEFICIENCIES PRECEDED BY FULL VING INFORMATION)  21426  11/21/17, with duration. The istered on 1/29/17, ocumentation of a 0 s lacked an  lity on 12/27/16. The st Documentation red the first step TST /30/16, with duration. The istered on 1/22/17, ocumentation of a 0 s lacked an  lity on 12/27/16. The st Documentation red the first step TST /30/16, with duration. The istered on 1/22/17, ocumentation of a 0 s lacked an  lity on 2/15/17. The st Documentation ed the first step TST /17, with duration. The istered on 1/22/17, ocumentation of a 0 s lacked an	STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE BEMIDJI, MN 56601  DEFICIENCIES RECEDED BY FULL TAG  11/21/17, with duration. The istered on 1/29/17, coumentation of a 0 s lacked an  lity on 12/27/16. The st Documentation red the first step TST '30/16, with duration. The istered on 1/29/17, coumentation of a 0 s lacked an  lity on 12/27/16. The st Documentation red the first step TST '30/16, with duration. The istered on 1/29/17, coumentation of a 0 s lacked an  lity on 12/27/16. The st Documentation red the first step TST '30/16, with duration. The istered on 1/29/17, coumentation of a 0 s lacked an  lity on 2/15/17. The st Documentation and the first step TST '30/16, with duration. The istered on 1/22/17, coumentation of a 0 s lacked an  ly on 2/15/17. The st Documentation and the first step TST '30/16, with duration. The istered on 2/25/17, cumentation of a 0 s lacked an	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
	PROVIDER OR SUPPLIER	1633 DEL	TON AVENU	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 61	21426			
	Employee TST					
	New Employee Tub Documentation For administered the fir on 3/1/17, with doc	start date was 3/2/17. The perculin Skin Test m indicated EE-1 was st TST on 2/27/17, and read umentation of 0 mm dings lacked an interpretation				
	Employee Tubercul Form indicated EE- TST on 1/12/17, an documentation of 0 step TST was admi on 1/23/17, with do	as 1/27/17. The New in Skin Test Documentation 2 was administered the first d read on 1/14/17, with mm induration. The second nistered on 1/21/17, and read cumentation of 0 mm dings lacked an interpretation				
	Employee Tubercul Form indicated EE- TST on 2/6/17, and documentation of 0 step TST was admit due to be read at the	as 2/10/17. The New in Skin Test Documentation 3 was administered the first read on 2/8/17, with mm induration. The second nistered on 3/21/17, and not the time of survey. The reading ted an interpretation of the				
	Employee Tubercul Form indicated EE- TST on 2/21/17, an	as 2/27/17. The New in skin Test Documentation 4 was administered the first d read on 2/23/17, with mm induration. The second				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 11 2012211101			
		00017	B. WING		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ige 62	21426			
	due to be read at th	inistered on 3/21/17, and not ne time of survey. The reading ked an interpretation of the				
	confirmed the facilit	p.m. the director of nursing ty only documented the TST not document an interpretation ired.				
	Facility policy was r	requested and not received.				
	The director of nurs review/revise policion the Tuberculin Skin	THOD OF CORRECTION: sing (DON) or designee could es/procedures for interpreting a Tests and documenting the aff and perform audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21540	MN Rule 4658.1319 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the physician. If the attending concur with the nursing dation, or does not provide				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S <b>TON AVENU</b>	STATE, ZIP CODE		
HAVENV	VOOD CARE CENTER		MN 56601	<b>=</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	adequate justification believes the resider adversely affected, matter to the medical director is the medical director physician does not the order and if the change the order, to review to the Qualit (QAA) committee rether attending physical the consulting phare directly to the QAA.  This MN Requirements by:  Based on observation review the facility for orders for the admissive with the admissive medications, and factor or offered prior to the medications. In additional medications. In additional medications. Further the effectiveness of medications. Further develop a plan of cand revise the plan	on, and the pharmacist and additional special of the pharmacist must refer the sal director for review if the not the attending physician. If a determines that the attending have adequate justification for attending physician does not the matter must be referred for a y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter the matter and the interview and document alled to follow physician's nistration of as needed (PRN) alled to identify and behaviors for administration of the administration of the administration of PRN allition, the facility failed to other qualified professional) for PRN administration and a lified professional) evaluated a fall administered PRN the professional of the profes	21540			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00017	B. WING		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENWOOD CARE CENTER			TON AVENU MN 56601	E		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21540	Continued From pa	ge 64	21540			
	Findings include:					
	dementia without be of left clavicle and so bladder, myelodysp and anxiety disorder.  R88's 14 day Medic dated 12/25/16, indecognitive impairment trouble falling asleed too much. The admindicated an increase from minimal depresalso indicated R88 sleep. The MDS incobehaviors daily not	e Sheet included diagnoses of ehavioral disturbance, fracture seventh vertebra, overactive plastic syndrome, diverticulitis, er.  care Minimum Data Set (MDS) icated R88 had severe nt, mild depression, had ep, staying asleep, or sleeping hission MDS dated 12/18/16, see in depressive symptoms ession with a score of 4 and did not have trouble with dicated R88 displayed directed towards others and epressant medication.				
	had an alteration in for anxiety related to and nursing home pubehaviors such as attempting self-transtreatment/cares, hit neck brace and arm staff to assist R88 to ordered, assess patiollet, provide movie Willie Nelson and Fexpress concerns a daughter, reorient as	ted 12/28/16, indicated R88 thought process with potential of dementia/impaired cognition placement. R88 displayed yelling out, swearing, sfers, disrobing, resistive to ting out at staff, removing in sling. Interventions directed to activities, medicate as in, offer snack, offer to use the and music (country western platsy Kline), allow time to and offer to talk with his and validate as needed, rovide cues and supervision decisions.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/23/2017	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	.0/2017
HAVENWOOD CARE CENTER			TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 65	21540			
	-Neurontin 100 mg day for low back pa 8:00 p.mNeurontin solutio 50 mg every 2 hour restlessness. Max chours Oxycodone 2.5 r a.m., 2:00 p.m., and 3:00 p.m., and 8:00 p.m., and 8:00 p.m., and 8:00 p.m., and 5:00 p.m., and 6:00	g three times a day at 12:00 p.m. and 12.5 mg PRN for not to exceed two as needed Use only when al measures such as offer of sting, repositioning, massage, versation or activity have as revised on 3/17/17, to pharmacological				

winnesc	ota Department of He	aim				
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING	B. WING		2/2017
		00017			03/2	23/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	VOOD OADE OENTED	1633 DEL	TON AVENU	E		
HAVENV	VOOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 66	21540			
	restlessness, result record lacked docu non-pharmacologic offered prior to adm -2/23 dose adminis restlessness and w was not given according to the record lacked donon-pharmacologic offered prior to adm -2/28 PRN dose ad yelling and unable to not given according lacked evidence of interventions attem administration. The assistant) documented fective.  -3/5 PRN dose adm yelling and hollering was semi effective according to physic documentation of noterventions attem administration.  -3/7 PRN dose adm for yelling out and hold documented as effective according to physic documentation.  -3/7 PRN dose adm for yelling out and hold coumented as effective acked documentation.  -3/10 PRN dose administration of the medication.  -3/10 PRN dose administration.	al interventions attempted or ninistration. tered at 7:04 p.m. for as effective however, dose rding to physician orders and ocumentation of al interventions attempted or ninistration. ministered at 4:43 p.m. for oredirect however, dose was to physician orders and non-pharmacological pted or offered prior to TMA (trained medication nated the medication was ninistered at 4:36 p.m. for gout, not able to redirect, dose however, dose was not given ian orders and lacked on-pharmacological pted or offered prior to the ninistered at 9:19 p.m. given in inistered at 9:19 p.m. given collering, not able to redirect, ective. The medical record ion that a nurse assessment or to and after the emedication and the medical				

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documentation of the reason for administration

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/23/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		TON AVENU	E		
()(1) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	MN 56601	DDOVIDED'S DI AN OF CORDECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
21540	and also lacked do non-pharmacologic offered prior to the medication.  -3/11 PRN dose ad yelling and hollering effective however, tlacked documentat interventions attem administration of th -3/13 PRN dose ad hollering and was not however, the medic documentation of ninterventions offere administration of th -3/15 PRN dose ad yelling and was not was not given accolacked documentat interventions attem administration of th -3/16 and 3/21 dose hollering out. The Nacked documentat interventions attem administration of the lacked documentat interventions attem administration of the documentation of minterventions offere administration and assessment was conditionally failed to develop the documentation of domedication assistant facility failed to develop the documentation of domedication assistant facility failed to develop the documentation of the documentation o	cumentation of al interventions attempted or administration of the ministered at 1:50 a.m. for gout and was noted as semithe MAR and medical recordion of non-pharmacological pted or offered prior to the e medication. ministered at 1:35 a.m. for oted as semi effective cal record and MAR lacked on-pharmacological d or attempted prior to the e medication. ministered at 7:00 p.m. for ed as not effective. The dose rding to physicians orders and ion of non-pharmacological pted or offered prior to the e medication. es administered for yelling and MAR and medication record ion of non-pharmacological pted or offered prior to the	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/23/2017	
	NAME OF PROVIDER OR SUPPLIER  HAVENWOOD CARE CENTER  1633 DEI BEMIDJI			STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa	ige 68	21540			
	Neurontin for pain,	anxiety, and restlessness				
	administration of N administration of Solidentify which targe with symptoms of a versus symptoms order to determine administer. Target I monitored included	erd did not reflect a een target behaviors for the eurontin for pain and for the eroquel (antipsychotic) or at behaviors were associated anxiety and restlessness of paranoia and agitation in appropriate medication to behaviors identified and crying out, attempting to and potential for combative				
	from 2/20-3/21/17,	dministration Record (MAR) revealed the following as eurontin were administered:				
	behavioral issue ar Medical record lack documentation and non-pharmacologic offered prior to the medication.  -3/3 PRN dose adm for bottom hurting a effective. Medical rea nurse assessment order to assess need evaluation of the eff TMA indicated non-attempted prior to the bottom pain was resulted to the second secon	ministered at 4:20 p.m. for ad pain, was semi effective. Red behavior and pain I lacked documentation of real interventions attempted or administration of the ministered by TMA at 3:04 p.m. and headache, was not ecord lacked documentation on the prior to the administration in red and also lacked nurse fectiveness of the medication. Pharmacological interventions he administration for the positioning every two hours r cream, however no	f			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/23/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	measures were indi-3/5 PRN dose adm bottom pain, anxious semi-effective. The behavior and pain of documentation of ninterventions attem administration of the 3/8 PRN dose was yelling out and was lacked documentation-pharmacologic offered prior to admrated a six out of 10 effective because remedication. The medication. The medication. The medication3/13 PRN dose admon-pharmacologic offered prior to the medication3/13 PRN dose adscreaming about an effective. The medication of ninterventions attem administration of the 3/15 PRN dose adhollering and hitting medical record lack non-pharmacologic attempted prior to the sand restlessness in administration of as and failed to ensure	icated for the headache.  Ininistered at 4:51 p.m. for  Isness and agitation, and was medical record lacked Iocumentation and lacked Iocumentation and lacked Iocumentation. Ininistered at 1:32 p.m. for effective. The medical record Ion of behavior and of Ininistered at 9:47 a.m. for pain I pain scale and was not resident spit out the redical record lacked pain I lacked documentation of I lacked documentation of I lacked documentation of I lacked documentation of I lacked documentation of I lacked documentation of I lacked documentation of I lacked documentation of I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked lacked I lacked I lacked lacked I lacked	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
_		00017	B. WING		03/2	23/2017
NAME OF PROVIDER OR S	UPPLIER			STATE, ZIP CODE		
HAVENWOOD CARE CENTER			TON AVENU MN 56601	E		
PREFIX (EACH DE	EFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
administrati the TMA, ar non-pharma administrati facility failed include non  Seroquel for  R88's pharm consultant p PRN dose of target beha (non-pharma attempted p medication. physician no should address the pharma and not recovereflected the intervention was not add  R88's recor between tar Seroquel ar or identify w with sympto versus sym order to det behaviors ice	essed lon of all did acologic on of the did received not ress as cists' received). The received of did not rest acologic or or of a did not ress as cists' received of the did not received of the did not received of the did not received of a ptoms of a ptoms of a ptoms of a ptoms of a dentified dentified	R88 prior to and after I PRN doses administered by d to document cal interventions prior to the PRN doses. In addition, the se a care plan for pain to acological interventions.  cord indicated on 3/1/17, the cist informed the facility the quel required identification of and non-drug cal) interventions to be administration of the port also indicated the be contacted, but nursing staff soon as possible (a copy of commendation was requested The physician's orders ion to use non-pharm to administration of medication		DEFICIENCY)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	HAVENWOOD CARE CENTER  1633 DE BEMIDJ			E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	R88's nursing prog documentation of b MAR were reviewe revealed the follow administration of the -2/21 at 2:53 a.m. obehavioral issues a medical record lack displayed and nonattempted prior to t-2/21 progress note indicated R88 recebehaviors this shift effective. However, documentation of the displayed and nonattempted or offered -2/26 at 9:58 p.m. obehavioral issues a medical record lack displayed and nonattempted or offered the medication2/27 at 4:20 p.m. semi effective. The documentation of both non-pharmacologic offered prior to the medication3/1 progress note a dose was given a causing disruptions evident in the record evidence non pharmoffered or attempted the medications an effectiveness of ad	ress notes, daily behavior monitoring, and the d from 2/20-3/21/17, and ing documentation on e as needed Seroquel:  dose administered for and was semi effective. The ked documentation of behavior pharmacological interventions he administration. The entered at 1:06 p.m. and independent of the record lacked he time administered, behavior pharmacological interventions d prior to administration. The red documentation of behavior pharmacological interventions d prior to the administration of the record lacked he time administered for and was not effective. The red documentation of behavior pharmacological interventions d prior to the administration of the record lacked he havior displayed and he ha	21540			

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Minnesc	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00017	B. WING		00/0	0/0047
		00017	B. W.K.		03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1633 DEL	TON AVENU	F		
HAVENW	OOD CARE CENTER		MN 56601	_		
			WIN 30001			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
1710		,	1710	DEFICIENCY)		
21540	Continued From pa	ge 72	21540			
	a doca was adminis	stered around 4:00 p.m. by a				
		ut and did not respond to				
		entation lacked time of				
		lacked a nurse assessment of				
		and after administration of				
		tion, the record lacked				
		•				
		on-pharmacological				
	interventions attempted or offered prior to the					
	administration of the medication and lacked an					
	evaluation of medication effectiveness3/7 progress note entered at 9:28 p.m. indicated					
		stered by a TMA for hollering				
		as not able to redirect.  Ked time of administration and				
		sessment of behavior prior to				
	addition, the medical	ation of medication. In				
		on-pharmacological				
		pted or offered prior to the emedication and lacked				
		e medication and tacked attion effectiveness.				
		entered at 6:47 p.m. and				
		2 at 4:40 a.m. indicated a dose				
	medical record lack	or yelling and hollering. The				
		al interventions attempted or				
		administration of the				
		evaluation of effectiveness.				
		entered at 5:47 p.m., 3/14			ļ	
		red at 5:39 p.m., and 3/15			ļ	
		red at 6:30 p.m. all indicated a			ļ	
		behaviors. The medical			ļ	
		ion of target behaviors, times				
		nistration, evaluations for			ļ	
		on-pharmacological			ļ	
		pted or offered prior to the			ļ	
	administration of the	e medication.				

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The facility failed to identify specific (target)

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STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/23/2017	
NAME OF PROV	/IDER OR SUPPLIER			STATE, ZIP CODE	03/2	3/2017
	D CARE CENTER	1633 DEL	TON AVENU			
HAVENWOO	D CARE CENTER	BEMIDJI,	MN 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
bel and received how provided h	d agitation after tommended their haviors and failed in-pharmacologicatify the administration, the facility cumentation of borse assessed R8 ministration of as TMA, and failed in-pharmacologic or to the administration of tearful) intermited in 3/21/17, at 8:32 ated at the dining it tearful) intermited in A-L explained R88 if his ponded by stating tooks to pray. R88 ayer was and stop as Christian and hird Jesus.  19:16 a.m. R88 we sa in his wheelch corr, help me dook to pray it in a subject to the subject of the	ed with symptoms of paranoia he consultant pharmacist need for identification of target d to immediately identify al interventions in order to ation of as needed doses. In failed to ensure complete ehaviors, failed to ensure a 8's behaviors prior to and after a needed doses administered to document al interventions attempted tration of as needed doses.  a.m. R88 was observed a room table sobbing (but was tently. NA-L sat next to him. B was not doing well because was dead which she was not ne wanted to talk about it, R88 ag he wanted to go out to the was asked what his favorite oped sobbing and stated he has favorite prayer was Come was seated in the TV viewing air crying repeatedly help me ctor! An unidentified staff and stated the doctor was not a way. R88 resumed calling intified staff member his wheelchair and informed a going to therapy and assisted ard on 3/21 did not reflect pressed behaviors the facility of the staff and stated the doctor was not a solution to the symptoms and assisted ard on 3/21 did not reflect pressed behaviors the facility of the symptoms and assisted ard on 3/21 did not reflect pressed behaviors the facility of the symptoms are searched and the facility of the symptoms and the facility of the symptoms are searched and the facility of the symptoms are searched and the symptoms are searched and the symptoms are searched and the symptoms are searched and the symptoms are searched and the symptoms are searched and the symptoms are searched and the symptoms are searched as searched and the symptoms are searched and the symptoms are searched and the symptoms are searched as symptoms are searched as searched and the symptoms are searched as symptoms are searched as symptoms and the symptoms are searched as symptoms are searched as symptoms are searched as symptoms are searched as symptoms are symptoms are symptoms and the symptoms are symptoms and the symptoms are symptoms are symptoms are symptoms are symptoms and the symptoms are symptoms are symptoms are symptoms are symptoms are sympto	21540			

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1633 DELTON AVENUE BEMIDU, MN 56601  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FILL TAG  CONTINUED FREETX TAG  CONTINUED FROM INCOME.  CROSS REFERENCE TO THE APPROPRIATE  21540  Continued From page 74  21540  Continued From page 74  21540  Continued From page 74  21540  Continued From page 74  21540  Continued From be added to sit up. When R88 medications. R88 stated leave me alone, LPN-D explained she had medications and he needed to sit up. When TMA-B and LPN-D attempted to assist R86 to sit on the side of the bed, R88 exclaimed ouch a couple of times and cried just leave me alone. LPN-D exitempted to administer medications. R88 stated my bottom hurts. R88 continued to be verbally resistive, however cooperative. LPN-D indicated she would administer medications. R88 stated my bottom hurts. R88 continued to be verbally resistive, however cooperative. LPN-D exited the room. As TMA-B washed and directed TMA-B to complete cares. LPN-D exited the room. As TMA-B washed and dressed R88, R88 stated leave me alone just leave me alone, get out of here. After each time R88 made the statements, TMA-B gave encouragement quietly and calmly, explained what she was doing, used distraction with other topics, and tried to engage R88 in conversation. Although R88 was verbally resistive, he was cooperative.  R88's Behavior/Mood flow sheet for 3/22, written following the above observations indicated merely read "behaviors douring cares" and did not specify what the behavior was. The flow sheet indicated the behaviors occurred at 7 a.m. and all	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
INVENTION OF CARE CENTER    CAN ID   SUMMARY STATEMENT OF DEFICIENCIES.   ID   PREFIX TAG   CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCE TO THE APPROPRIATE DATE			00017	B. WING		03/23/2017	
XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   ID   PROVIDER'S PLAN OF CORRECTION   XXI   XX	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
CAMIND   PRIEFIX   CAMIND FROM PROCEDED BY TILL   PROVIDER'S PLAN OF CORRECTION   CAMIND FROM PROPERTY TAG   PROVIDER'S PLAN OF CORRECTION   CAMIND FROM PROPERTY TAG   PROVIDER'S PLAN OF CORPLETE DATE	HAVENW	HAVENWOOD CARE CENTER			E		
On 3/22/17, at 7:52 a.m. licensed practical nurse (LPN)-D entered the room with R88's medications. R88 stated leave me alone, LPN-D explained she had medications and he needed to sit up. When TMA-B and LPN-D attempted to assist R88 to sit on the side of the bed, R88 exclaimed ouch a couple of times and cried just leave me alone. LPN-D explained to R88 she had his pain pills and he needed to sit up. When R88 was seated on the edge of the bed as LPN-D attempted to administer medications, R88 stated my bottom hurts. R88 continued to be verbally resistive, however cooperative. LPN-D indicated she would administer the rest of the medication after he was up and dressed and directed TMA-B to complete cares. LPN-D exited the room. As TMA-B washed and dressed R88, R88 stated leave me alone just leave me alone, get out of here. After each time R88 made the statements, TMA-B gave encouragement quietly and calmly, explained what she was doing, used distraction with other topics, and tried to engage R88 in conversation. Although R88 was verbally resistive, he was cooperative.  R88's Behavior/Mood flow sheet for 3/22, written following the above observations indicated merely read "behaviors during cares" and did not specify what the behavior was. The flow sheet	PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
interventions were attempted. The documentation indicated the response to the interventions was resistive at first, but after 2-3 attempts behavior/mood stopped.  On 3/23/17, at 8:39 a.m. R88 was observed seated in his wheelchair in the lobby area. R88	21540	On 3/22/17, at 7:52 (LPN)-D entered the medications. R88 s explained she had sit up. When TMA-lassist R88 to sit on exclaimed ouch a cleave me alone. LP his pain pills and he was seated on the cattempted to admin my bottom hurts. Resistive, however a she would administ after he was up and to complete cares. TMA-B washed and leave me alone just here. After each tim TMA-B gave encoue explained what she with other topics, are conversation. Althoresistive, he was conversation. Althoresistive, he was conversed to the behavior of the shadow of the	a.m. licensed practical nurse e room with R88's tated leave me alone, LPN-D medications and he needed to B and LPN-D attempted to the side of the bed, R88 couple of times and cried just N-D explained to R88 she had a needed to sit up. When R88 edge of the bed as LPN-D inster medications, R88 stated 88 continued to be verbally cooperative. LPN-D indicated er the rest of the medication d dressed and directed TMA-B LPN-D exited the room. As d dressed R88, R88 stated the leave me alone, get out of the R88 made the statements, ragement quietly and calmly, was doing, used distraction and tried to engage R88 in ugh R88 was verbally coperative.  Took flow sheet for 3/22, written observations indicated riors during cares" and did not havior was. The flow sheet riors occurred at 7 a.m. and all attempted. The documentation must to the interventions was after 2-3 attempts oped.	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00017	B. WING	<del></del>	03/2	3/2017
NAME OF PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
HAVENWOOD CARE CENTER		TON AVENU MN 56601	Ē		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
God please help me poop!" Surveyor imfacility staff R88 had continued to yell ou agitated and fidgety bathroom at 8:44 a.  R88's medical recordocumentation of the facility had identified.  On 3/21/17, at 2:13 very expressive, yethe time, doesn't know and yelled out every R88 was much bette behavior unit. Staff displayed behaviors easily redirectable.  -At 2:15 p.m. NA-Jevery day and staff interventions as we behaviors were bette behavioral unit.  -At 3:28 p.m. NA-Kyelled out, indicated behaviors when he something.  On 3/23/17, at 8:38 resident asked for a needed to figure outsee when the last a administered. TMA-	y, "oh God please help me, e I have to go potty, I have to mediately communicated to d to use the restroom. R88 t and became increasingly y until he was assisted to the	21540			

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		00017	B. WING		03/2	23/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	OOD CARE CENTER	8	TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	effective. TMA-B st narcotic medication give it. When asked R88's Seroquel, TM yelling, screaming, indicated she would hard time sleeping out of bed. TMA-B Neurontin based on having pain, and if to the question, "Ho administer Seroque Neurontin?" TMA-E anxious he R88 was she would administ it was hard to tell e R88 but if she had administer, she wo -At 9:24 a.m. the di indicated she was a administering as no nurse assessment allowed to determine should be given. T medications require order to determine appropriate for use administered, the no	rated she could not administer in as a nurse was required to di when she would administer MA-B stated if he was agitated, and hitting staff. TMA-B di administer Trazodone for or if agitated and trying to get stated she would administer in facial expression, if he was he was agitated. In response ow do you know when to be and when to administer B stated it depended on how as and if he was really anxious the the Seroquel. TMA-B stated exactly what's going on with any questions on what to	21540	DEFICIENCY)		
	DON immediately partial TMA's pertaining to needed medication administer Neuront agitation and anxie would administer State displayed agitation	orovided education to the or the administration of as is. The DON stated she would in if R88's behaviors of ty manifested by pain and she eroquel for when R88 and anxiety manifested by				
	delusions or halluc	inations. The DON indicated s in which to administer the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		00/00/0047	
		00017	b. Willia		03/2	23/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	VOOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	medications were rependent of the part of	not clear. The DON stated station should include what the ras, non-pharmacological pted and what the response to were, and effectiveness of the dot to be administered. The DON was not administered stated R88's physician's orders followed and documentation completed related to stall interventions attempted and enterventions as well as the emedication, if administered. If there have been stall interventions in the care for pain. The documentation of a location of pain, intensity, stall interventions and response weness of the as needed pain	21540			
	reviewed April 2015 psychopharmacolo effective and neces condition that qualit those residents on directed staff to fill monitoring sheet ea occurred so the do frequency of the be were beneficial. Th needed medication clearly documented behaviors and inter needed psychotrop directed nursing to presence of target	ic Medication Monitoring policy 5, indicated was to assure gical drug therapy was sary to treat a specific ty of life was enhanced for these medication. The policy out a monthly behavior ach time the identified behavior ctor could review the chaviors and what approaches e policy indicated orders for as a would be given for specific, dicircumstances and specific ventions would be listed for as ic medications. The policy monitor the residents for behaviors on a daily basis on (when behaviors are				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00017	B. WING		03/2	3/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENV	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	present) and nursin resident's specific to non-pharmacologic attach them to the resident suggestion of the suggestion of	ing would care plan the arget behaviors and effective al interventions as well as medication on the MAR.  THOD OF CORRECTION: sing and/or designee could procedures, revise as assess the system, monitor, physician orders were followed ere adminsitered and ately.  R CORRECTION: Twenty-one	21540			
21620	Drugs used in the r in accordance with  This MN Requirements: Based on observation review, the facility for prescription labels of an inhalant medical whose inhalant medication administically failed to ensure 1 or in accordance.	nursing home must be labeled	21620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00017	B. WING	B. WING		3/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1	
HAVENW	OOD CARE CENTER	1633 DEL <sup>-</sup> BEMIDJI,	TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From page 79		21620			
	Diskus (combinatio 250-50 micrograms	der report dated cluded an order for Advair n steroid/bronchodilator) (mcg)/dose: 1 puff inhalation inic obstructive pulmonary				
	On 3/22/17, at 9:05 a.m. licensed practical nurse (LPN)-A was observed to hand an unlabeled Advair Diskus inhaler to R15. R15 administered a puff and inhaled the medication. LPN-A handed R15 a plastic cup containing UTI Stat (nutrient for urinary tract health) 30 milliliters (ml) and water and directed R15 to take a drink. R15 was observed to take two sips and swallow the fluid. LPN-A did not offer or suggest R15 swish/rinse the mouth.					
	Medication Guide at Advair Diskus pack LPN-A. The Medicat Use directed the use without swallowing/ to help reduce the offungal infection). Lefungal infection in the use of the medicate Advair Diskus lacked directions for use. Diskus came in a massin a Ziploc bag label. The Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bag label. The Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and advair Diskus came in a massin a Ziploc bas boxed package while prescription label and a ziploc bas based on the came in a massin a Ziploc based came in a massin a ziploc based came in a massin a ziploc based came in a massin a ziploc based came in a massin a ziploc based came in a massin a zipl	a.m. the manufacturer's and Instructions for use in the aging was reviewed with ation Guide and Instructions for user to rinse mouth with water spit after using Advair Diskus chance of getting oral thrush (a PN-A confirmed she had not R15 a mouth rinse/spit after cation. LPN-A confirmed the ed a prescription label and LPN-A stated the Advair nanufacturer's package, which containing the prescription ag was in the manufacturer's ch also contained the end the directions for use.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
0001	00017 B. WING		<del></del>	03/2	3/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENWOOD CARE CENTER	1633 DELT BEMIDJI,	TON AVENU MN 56601	E		
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PF TAG REGULATORY OR LSC IDENTIFYI	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
just keep the inhaler. LPN-A s packaging was available the dwould have prevented me from versus rinse/spit.  -at 9:27 a.m. registered nurse the Advair Diskus prescription instruction for use should have inhaler or the Advair Diskus sl stored in the prescription labe RN-A confirmed she revised the administration record directing rinse and spit according to madirections.  On 3/23/2017, at 1:30 p.m. duredication storage room on the RN-B. A clear plastic specime observed in the medication deconfirmed the Ziploc bag contaton 100 round pink tablets and 87 tablets following counting. RN were no identifiable information medications and stated she did the medications were, who the they were in the destruction bis medications were left in contacame in until the nurse respondestruction completed the tas.  On 3/23/17, at 2:05 p.m. the complete complete the tas.  On 3/23/17, at 2:05 p.m. the complete complete the tas.	lirections for use in providing a drink  (RN)-A confirmed label with the been on the mould have been led packaging. The medication is staff to provide anufactures  aring tour of the interest to be a secured unit with in Ziploc bag was estruction bin. RN-B ained approximately white scored approximately white scored and there in on the interest of an approximately in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a cards they insible for medication in the interest of a card they intere	21620	DEFICIENCY		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00017	B. WING	<del></del>	03/2	3/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENW	OOD CARE CENTER	1633 DEL BEMIDJI,	ΓΟΝ AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From page 81		21620			
	The Pharmacy Services Medication Labels policy, revised 6/2015, indicated medications were labeled in accordance with facility requirements and state and federal laws.					
	The Med (medication) Destruction policy, reviewed 4/2015, indicated the LPN'S would destroy medications (other than scheduled narcotic) that could not be returned to pharmacy via our incinerating program. Located on each wing in the medication room would be a gallon size container for pills and for cream/inhalers. The nurses would log these medications on the med destruction sheet and would place the meds in the containers. Once these containers were full, pharmacy would remove them and they would be incinerated per their protocol.					
	The director of nurs develop and implement to ensure that all me stored properly. Edall staff and monitor developed to ensure	ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures edications are labeled and lucation could be provided to ring systems could be e ongoing compliance. The eported to the Quality tee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21995	MN St. Statute 626 Maltreatment of Vul	.557 Subd. 4a Reporting - Inerable Adults	21995			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENV	VOOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Subd. 4a. Interna (a) Each facility sha ongoing written pro applicable licensing of suspected maltre facility has an intern mandated reporter requirements of this internally. However responsible for com reporting requirement This MN Requirement by: Based on interview facility failed to imm abuse/mistreatmen agency (SA) for 1 o sustained fractures  Findings include:  R64's quarterly Min 12/20/16 indicated impairment and dia Alzheimer's disease anxiety disorder and MDS also indicated inattention sympton wandering behavior R64 required exten bed mobility, transfe personal hygiene air	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting as section by reporting reporting reporting the facility remains applying with the immediate	21995			

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00017	B. WING		03/23/2017	
		00017			03/2	3/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S <b>TON AVENU</b>	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER		MN 56601	<b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	R64's Fall Assessm 3/2/17, at 2:05 a.m. bathroom by the TV indicated R64 had k when the nursing as from R64's room. VTV room bathroom, the floor. R64 was for an evaluation ar fractured nose and included the questic constitute abuse or adult?" A choice of Assessment directe "Yes" response. In indicated the fall wa committee on 3/2/1 not indicated.  Review of Vulnerab October 2016, throureport for R64's fall  On 3/22/17, at 1:03 (DON) and register R64's fall on 3/2/17  On 3/23/17, at 3:08 director of nursing (with fractures was r SA, as required. Thaware a fall with se reported.	nent dated 3/2/17, indicated on R64 had a fall in the 7 room. The Assessment been left alone on the toilet sistant (NA) obtained a brief When the NA returned to the R64 was found face down on sent to the emergency room and was found to have a wrist. The Assessment on "Does this fall appear to neglect of a vulnerable "No" was circled. The end notification of the SA for a addition, the Assessment as reviewed by the fall 7, and report to the SA was with serious injury.  p.m. director of nursing end nurse (RN)-B confirmed was unwitnessed.  p.m. the administrator and DON) confirmed R64's fall not immediately reported to the ne DON stated she was not rious injury was required to be	21995			
		ter a Fall policy dated 4/2015, uld be reviewed by the Fall				

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NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	.0/2017
HAVENW	OOD CARE CENTER		TON AVENU MN 56601	E		
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21995	Continued From pa	ge 84	21995			
	Committee on a darfiled to the SA, if inc	ily basis and reports would be dicated.				
	dated 11/20/16, indicators of abuse promptly reported. injury should be cla unknown origin whe was not observed be the injury could not and the injury or the lenumber of injuries opoint in time or the The policy further dinglect, suspicious	ion/Prohibition Program policy icated fractures were possible or neglect that should be The policy also identified an ssified as an injury of en both the source of the injury by any person or the source of be explained by the resident; spicious because of the extent ocation of the injury or the observed at one particular incidence of injuries over time. irected allegations of abuse, injury of unknown origin and resident property would be sly to the SA.				
	The administrator of policies and proced	THOD OF CORRECTION: could educate all staff on lures regarding alleged reports the administrator could develop in to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
22000		5.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			
		prevention plans. (a) Each e health agencies and				

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		00017	B. WING		03/2	3/2017
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HAVENW	OOD CARE CENTER	₹	TON AVENU MN 56601	E		
(X4) ID		ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	-	(X5)
PREFIX TAG	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
22000	Continued From pa	age 85	22000			
	establish and enfor prevention plan. The assessment of the environment, and it factors which may and a statement of to minimize the risk comply with any rul promulgated by the (b) Each facility, agency and person providers, shall deversely and person providers, shall deversely and person providers, shall deversely and person providers, shall deversely and person providers, shall deversely and person providers, shall deversely and person providers, shall deversely and person providers, shall contassessment of: (1) abuse by other indivulnerable adults; (other vulnerable adustic measures risk of abuse to that	description identifying encourage or permit abuse, specific measures to be taken to of abuse. The plan shall les governing the plan elicensing agency. Including a home health care had care attendant services velop an individual abuse each vulnerable adult ceiving services from them. In an individualized had the person's susceptibility to viduals, including other (2) the person's risk of abusing dults; and (3) statements of the to be taken to minimize the lat person and other vulnerable poses of this paragraph, the				
	and personal care a knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk th reasonably be expe facility and persons	except home health agencies attendant services providers, nerable adult has committed a act of physical aggression individual abuse prevention e measures to be taken to nat the vulnerable adult might ected to pose to visitors to the soutside the facility, if				
	of a vulnerable adu misconduct or phy such information fro	der this section, a facility knows ult's history of criminal sical aggression if it receives om a law enforcement of a medical record prepared by				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00017	B. WING		03/23/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	0,2011
LI AVENIA	OOD CARE CENTER	1633 DEL	TON AVENU			
HAVENV	VOOD CARE CENTER	BEMIDJI,	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 86	22000			
		other health care provider, or g assessments of the				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse policy and procedures related to the immediate reporting of potential abuse/mistreatment or neglect to the State agency (SA) for 1 of 3 residents (R64) reviewed for abuse prohibition who had a fall with serious injury.					
	Findings include:					
	The Abuse Prevention/Prohibition Program policy dated 11/20/16, Identification section indicated a fracture as a possible indicator of abuse or neglect which should be promptly reported. The Investigation section indicated the facility would evaluate injuries of unknown origin as a possible indicator of abuse, neglect or maltreatment warranting the need for further investigation. Injuries of unknown origin would be classified as an injury of unknown origin when both the source of the injury was not observed by any person or the source of the injury could not be explained by the resident, and the injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further indicated an investigation would normally be conducted by the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00017	B. WING		03/2	23/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENV	OOD CARE CENTER		TON AVENU MN 56601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	administrator or directly designee. Staff were any incident or suspabuse or neglect incurrence unknown origin and the facility to begin	ector of nursing (DON) or e directed to promptly report pected incident of resident cluding suspicious injuries of I to report internally to allow to initiate an investigation, and nmediately to the State	22000			
	R64's quarterly Minimum Data Set (MDS) dated 12/20/16, indicated R64 had severe cognitive impairment and diagnoses which included Alzheimer's disease, depression, bipolar disorder, anxiety disorder and psychotic disorder. The MDS also indicated R64 exhibited fluctuating inattention symptoms of delirium and daily wandering behavior. The MDS further indicated R64 required extensive assistance of one person for bed mobility, transfer, dressing, toilet use, and personal hygiene and required limited assistance of one person for ambulation and locomotion on the unit.					
	R64 had a fall in the 2:05 a.m. on 3/2/17 R64 had been left a nursing assistant (N R64's room. When room bathroom, R6 floor. The assessment in the Assessment in fall appear to constitution vulnerable adult?"	nent dated 3/2/17, indicated be bathroom by the TV room at a to The Assessment indicated alone on the toilet when the NA) obtained a brief from the NA returned to the TV at was found face down on the nent also indicated the fall gency room visit where R64 a fractured nose and wrist. cluded the question "Does this itute abuse or neglect of a A choice of "No" was circled. rected notification of the SA				

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00017	B. WING		03/2	3/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
HAVENW	OOD CARE CENTER	1633 DEL <sup>-</sup> BEMIDJI,	TON AVENU MN 56601	E			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
22000	Continued From pa	ge 88	22000				
	for a "Yes" responsindicated the fall wa	e. In addition, the Assessment as reviewed by the fall 7, and report to the SA was					
		ole Adult (VA) reports from igh March 2017 lacked a with serious injury.					
	On 3/22/17, at 1:03 p.m. the DON and registered nurse (RN)-B confirmed R64's fall on 3/2/17, was unwitnessed.						
	On 3/23/17, at 3:08 p.m. the administrator and DON confirmed R64's fall with fractures was not immediately reported to the SA as required. The DON stated she was not aware a fall with serious injury was required to be reported.						
	The administrator of procedures regarding all alleged abuse/ne administrator could policies and procedures.	THOD OF CORRECTION: could develop policies and ng reporting and investigating eglect/mistreatment. The educate all staff on those lures. Theadministrator could ng system to ensure ongoing					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					

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