DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: D85Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00017

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245397**
2.STATE VENDOR OR MEDICAID NO.
(L2) **255822000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVENWOOD CARE CENTER**
(L4) **1633 DELTON AVENUE**
(L5) **BEMIDJI, MN** (L6) **56601**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 12/27/2013 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and life safety code. Effective December 10, 2013, the facility is certified for 90 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 12/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 01/15/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/23/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5397 January 16, 2014

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, Minnesota 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 December 10, 2013, 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.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 15, 2014

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

RE: Project Number S5397024

Dear Mr. Bjerke:

On November 19, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 27, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 9, 2014 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 October 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 10, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2013, effective December 10, 2013 and therefore remedies outlined in our letter to you dated November 19, 2013, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245397	A. Building B. Wing	12/27/2013

Name of Facility	Street Address, City, State, Zip Code
HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/10/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/10/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/10/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **12/10/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/10/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/10/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/kfd	01/15/2014	32601	12/27/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/31/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245397	01 - NURSING HOME	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	11/27/2013	ID Prefix Reg. # NFPA 101 LSC K0144	12/04/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/kfd	01/15/2014	32601	01/09/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/29/2013			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D85Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00017

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245397**
2.STATE VENDOR OR MEDICAID NO.
(L2) **255822000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVENWOOD CARE CENTER**
(L4) **1633 DELTON AVENUE**
(L5) **BEMIDJI, MN** (L6) **56601**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/31/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

13.Total Certified Beds 90 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the Standard survey completed October 31, 2013, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the plan of correction. PCR to follow.

17. SURVEYOR SIGNATURE Date :
Sharron Williams, HFE NEII 12/13/2013
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/19/2013
(L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7609

November 19, 2013

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

RE: Project Number S5397024

Dear Mr. Bjerke:

On October 31, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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
Minnesota Department of Health
705 - 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 10, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 10, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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

Post Certification Revisit (PCR) 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 remedies will not be imposed. 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 January 31, 2014 (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 May 1, 2014 (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
Division of Compliance Monitoring
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING _____ B. WING _____	10/31/2013

RECEIVED DEC 04 2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Approved 12/13/13 c Addendum SB	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide baths/showers at a frequency consistent with resident preferences and.or failed to provide morning cares at a time that was consistent with resident preferences for 4 of 4 residents (R13, R52, R98 and R28) reviewed for choices. Findings include: R13, R52 and R98's bathing schedules at the facility were not consistent with the preferences	F 242	F 242 The Preferences for Customary Routine and Activities assessment for R28 was completed on 12/2/2013. R28's plan of care has been updated to reflect her preferences for customary routine relating to time to wake in the morning and go to bed at night. R98, R13, and R52 have been interviewed regarding their bathing preferences relating to frequency, time of day, and whether or not they would like a shower or whirlpool bath. The plans of care for R98, R13, and R52 have been updated to reflect their preferences. All residents and/or responsible parties have been interviewed to assure that their preferences relating to bathing frequency, time of day, and whether or not they would like a shower or whirlpool bath. All residents and/or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Bjerke	Administrator	12-4-2013

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.

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	245397	A. BUILDING _____ B. WING _____	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

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F 242	Continued From page 1 they expressed in their Social History Assessment. R13's was diagnosed with Parkinson's disease. The admission Minimum Data Set (MDS) dated 10/7/13, indicated R13 was alert, orientated and required limited assistance with activities of daily living. R13's Social History Assessment completed on 10/7/13, indicated R13's personal preference was to shower twice weekly. R13's plan of care (POC) dated 10/10/13, directed staff to assist R13 with a weekly shower. On 10/28/13, at 3:15 p.m. R13 stated she preferred to shower more than once per week, but felt she would not be able to have more than one shower per week because she was the "low man on the totem pole." On 10/30/13, at 7:00 a.m. R13 stated she was only allotted one shower per week at the facility, but one shower per week was not adequate. She stated the staff were "too busy" to assist her with more than one shower per week. During this interview, R13's hair was observed to be combed, but visibly greasy. On 10/30/13, at 1:45 p.m. nursing assistant (NA)-E stated R13 received a weekly shower on Thursdays. She added, when a new resident was admitted to the facility, the clinical manger/registered nurse reviewed the shower schedule and offered the resident a day of the week and time when staff was able to assist them with bathing. NA-E reported that R13 occasionally had episodes of urinary incontinence	F 242	responsible parties have also been interviewed to assure that their preferences relating to time they wish to wake in the morning and go to bed at night are being met. Education will be provided regarding resident preferences to all nursing staff. RN's have been educated about their responsibility to gather information relating to the above mentioned resident preferences upon admission. The social worker will then review this information quarterly during resident care conferences. Random audits will be completed by the Director of Nursing or her designee weekly for four weeks to assure resident preferences are being met. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date: 12/10/2013	

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F 242	Continued From page 2 and at times would have benefited from an additional bath. On 10/30/13, at 1:50 p.m. NA-F stated she had assisted R13 with morning cares and confirmed R13's hair was in need of washing. She stated R13's weekly bath was scheduled for the following morning. On 10/31/13, at 9:00 a.m. the licensed social worker (LSW) reported that upon admission, each resident's personal history was obtained from either the resident or their family. She stated the information was documented on the facility's Social History Assessment and was available for all staff to review. The LSW indicated it was not her process to specifically communicate a resident's bathing preference to the nursing staff. On 10/31/13, at 9:40 a.m. the registered nurse (RN)-A reported that when a new resident was admitted to the facility, she offered them a bathing time based on openings in the bathing schedule. She stated it was typically while choosing their bath time that a resident requested a second bath, if they wished. She stated she was unaware that R13 typically bathed twice per week, prior to living at the facility and was unaware of R13's expressed preference to receive a shower twice weekly. She indicated the bathing schedule could have been adjusted to accommodate R13's wishes. R52's was diagnosed with congestive heart failure. The quarterly MDS dated 10/21/13, indicated R52 was alert, oriented and required extensive	F 242		

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F 242	Continued From page 3 assistance with activities of daily living. R52's POC dated 10/22/13, directed the staff to assist R52 with a weekly shower. R52's Initial Social History dated 10/4/11, identified R52's previous routine was to shower twice weekly. On 10/28/13, at 3:40 p.m. R52 stated she preferred to bathe more than once per week. On 10/30/13, at 11:15 a.m. R52 stated she received a weekly shower while at the facility, but verified she preferred to shower more frequently. On 10/30/13, at 1:45 p.m. NA-E verified R52 received a weekly bath on Monday evening. She stated R52 had not asked staff for a second bath but stated R52 would have benefited from bathing more frequently. On 10/31/13, at 9:40 a.m. RN-A stated she was not aware R52 wished to have a second bath. She indicated the bathing schedule could have been adjusted to accommodate R52's wishes. R98's diagnoses included hepatic encephalopathy and a fractured ankle. The quarterly MDS dated 9/20/13, indicated R98 was alert and oriented. The MDS noted R98 was independent with activities of daily living, but required some physical assistance with bathing. R98's POC dated 10/2/13, directed staff to assist R98 with a weekly shower, as needed. R98's Initial Social History Assessment dated 4/3/13, identified R98's previous life routine was	F 242		

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F 242	Continued From page 4 to shower daily. On 10/28/13, at 4:21 p.m. R98 stated staff assisted him with a shower once weekly, but this was not acceptable to him. R98 reported he used to shower daily prior to his stay at the facility, but wanted to have a shower at least three times weekly. On 10/30/13, at 1:26 p.m. NA-J stated R98 was very independent and received a weekly bath during the evening shift, but was unsure of which day of the week it was scheduled. On 10/31/13, at 8:49 a.m. RN-B stated R98 received a weekly shower, every Wednesday. CM-B reported she was not aware R98 wished to have more than one shower per week. CM-B added the bathing schedule could have been changed to accommodate his preference. R28's morning cares were provided in the early morning hours, which was inconsistent with her previous life routine. R28's diagnoses include dementia, Parkinson's disease and Alzheimer's disease. The annual MDS dated 8/11/13, indicated R28 was severely cognitively impaired and was totally dependent on staff for activities of daily living. The Preferences for Customary Routine and Activities assessment had not been completed for R28. R28's POC dated 6/5/13, revealed R28 required total assistance from staff for daily cares and personal hygiene. Review of R28's Social History Assessment dated	F 242		

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F 242	Continued From page 5 6/12/08, revealed her past routine was to go to bed at approximately 8:00 p.m. each evening. The assessment lacked documentation regarding R28's past routine or preferences for the time she liked to get out of bed each morning. On 10/30/13, at 7:09 a.m. R28 was observed lying in bed, dressed, with her eyes closed. On 10/30/13, at 7:43 a.m. NA-A revealed R28's morning cares were always done by the night shift NAs. NA-A stated the night staff completed morning cares on a few residents each day to make the day shift more manageable. On 10/30/13, at 11:17 a.m. licensed practical nurse (LPN)-A verified R28 was designated as one of the residents who received their morning cares by the night staff because R28 was one of the residents whose cares could be done without physically getting her out of bed. On 10/31/13, at 5:55 a.m. R28 was observed lying in her bed, dressed, with her eyes closed. On 10/31/13, at 5:57 a.m. NA-D confirmed R28's morning cares included all of the same tasks as a resident who received morning cares during the day shift, such as personal hygiene, grooming and dressing. NA-D revealed the night shift staff started morning cares on their assigned residents at 5:00 a.m. and finished before 6:00 a.m., when the day shift staff arrived. NA-D verified R28's morning cares were completed and then she was allowed to go back to sleep. NA-D stated R28 was typically woken up by staff when it was time for her morning cares. On 10/31/13, at 12:08 p.m. family member	F 242		

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F 242	Continued From page 6 (FM)-A stated R28's previous morning routine was to sleep until at least 8:00 a.m. FM-A did not consider R28 to be an early riser. FM-A also stated that during her weekly visits to the facility, she believed R28 seemed sleepy. The Resident Preferences policy dated 3/13, directed staff to conduct interviews with each resident to determine their preferences on items such as preferred time to get up and bathing frequency. The staff were to obtain this knowledge by completing a Social History on each resident, which was to be kept in the resident's medical record. This information was to be used to guide staff while developing the individualized resident care plan. Staff were to make changes as needed if a resident's preference changed.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide wheelchair cleaning for 1 of 1 resident (R28) in the sample with a soiled wheelchair. Findings include: On 10/28/13, at 6:00 p.m. R28 was seated in her wheelchair in the dining room area. R28's wheelchair was observed to have dried food	F 253	F 253 On 11/1/2013 R28's wheelchair was cleaned. R28's wheelchair has been set up on a routine cleaning schedule. All resident wheelchairs have been checked for cleanliness and cleaned as needed. All nursing staff will be educated regarding wheelchair cleanliness and the process for cleaning a wheelchair when needed. R28's wheelchair will be audited weekly for four weeks by the Director of Nursing or her designee to ensure wheelchair cleanliness is being maintained. Random audits	

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F 253	Continued From page 7 debris, dust and dirt adhered to the left break lever and the crevices along the sides of her wheelchair. On 10/31/13, at 7:01 a.m. director of nursing (DON) confirmed the facility had a wheelchair cleaning schedule, although her expectation was for nursing to spot check and clean wheelchairs when they appeared soiled. On 10/30/13, at 7:43 a.m. nursing assistant (NA)-A and NA-B verified R28's wheelchair was dirty and needed to be cleaned. NA-B confirmed the facility had a wheelchair cleaning schedule. On 10/31/13, at 9:42 a.m. licensed practical nurse (LPN)-A confirmed R28's wheelchair was dirty as it had dried food adhered to the side crevices. The facility's Wheelchair Washing schedule dated 7/19/13, through 10/18/13, revealed R28's wheelchair had been washed twice in the last three months (8/2/13 and 9/20/13). No facility policy was provided regarding frequency of wheelchair cleaning.	F 253	will be completed on resident wheelchairs weekly by the Director of Nursing or her designee for four weeks on other residents wheelchairs to ensure clenliness. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date: 12/10/2013	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	F280 Assistance is being provided with dental flossing for R75. The plan of care for R75 was reviewed and revised to include assistance with dental flossing. Corresponding updates have been made to care sheets for R75.	

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F 280	Continued From page 8 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident care plans were revised when appropriate, related to dental recommendations for nursing to provide daily tooth brushing and flossing assistance, for 1 of 3 residents (R75) reviewed for dental care. Findings include: R75's diagnoses included Alzheimer's disease and rheumatoid arthritis. R75's quarterly Minimum Data Set (MDS) dated 9/3/13, indicated she was severely cognitively impaired and required extensive assistance for personal hygiene tasks, including tooth brushing. R75's dental consult dated 7/22/13, indicated R75 had heavy plaque and moderate calculus. The consult directed the following instructions: "Nursing staff: Please assist patient with brushing and flossing if possible." R75's plan of care (POC) dated 9/15/13, indicated a self-care deficit related to her	F 280	Dental records and recommendations were reviewed for all residents. Care plans and care sheets were updated as needed. Staff education will be provided to all NA's regarding dental flossing and dental hygiene. The Director of Nursing or her designee will audit all dental records weekly for four weeks to assure care plans and care sheets are updated following dental appointments. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date 12/10/2013	

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F 280	Continued From page 9 diagnoses and inability to complete bathing, dressing, or personal hygiene tasks. The POC directed staff to set up supplies, prepare her tooth brush and brush her teeth. The POC indicated staff were to complete personal hygiene tasks, including brushing teeth. The POC did not identify staff needed to assist R75 with flossing. On 10/31/13, at 9:23 a.m. licensed practical nurse (LPN)-A stated she expected the NA assigned to R75's care to assist her with tooth brushing and flossing, daily. LPN-A confirmed R75's POC did not include the instructions identified on the dental consult dated 7/22/13, which instructed facility staff to assist R75 with brushing and flossing.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received repositioning and toileting assistance in accordance with their written plan of care for 1 of 1 resident (R69) reviewed for pressure ulcers and urinary incontinence. Findings include: R69's diagnoses included dementia, Parkinson's disease, benign prostatic hyperplasia (BPH) and	F 282	F 282 R69 is receiving repositioning and toileting per his plan of care. R69's plan of care has been reviewed and revised as needed. The plans of care for all residents have been reviewed and revised as needed relating to repositioning and toileting. Staff education will be provided to all NA's to stress the importance of following the plans of care and what approaches to attempt when a resident becomes resistive or refuses repositioning and toileting.	

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F 282	Continued From page 10 a history of stroke. R69's plan of care (POC) dated 10/22/13, indicated R69 required extensive assistance for turning and repositioning, every one hour. The POC also indicated R69 required extensive assistance for toileting every two to three hours. During observation on 10/30/13, R69 was observed seated in his wheelchair at 7:00 a.m., in the doorway of his room. At 7:30 a.m., R69 was observed to be in the dining room, waiting for breakfast. At 8:22 a.m., R69 was observed to wheel himself off the unit towards the therapy department. R69 was off the unit until 9:45 a.m., when he was observed to be sitting in his wheelchair, in his room. At that time, restorative aide (RA)-A arrived to assist him to a restorative therapy session. At 9:46 a.m., nursing assistant (NA)-J stated they planned to assist him with repositioning and toileting as soon as he came back from therapy. At this time, the observation ended. On 10/30/13, at 1:11 p.m. NA-J and NA-I were interviewed. NA-J and NA-I stated R69 had refused to go to bed or be repositioned or toileted earlier in the day. NA-J and NA-I confirmed R69 had been sitting in his wheelchair since 7:00 a.m., for a period of over five hours, without off-loading (pressure relief / redistribution) or changing his incontinence product. On 10/30/13, at 2:30 p.m. the registered nurse (RN)-B stated staff were to reposition R69 every hour, with toileting every two to three hours. RN-B verified R69 had a history of refusing to be repositioned and toileted, but indicated that if he refused, the staff were expected to report it to her	F 282	They will also be educated to report resistive behavior or refusal of services to the charge nurse. Random audits will be completed by the Director of Nursing or her designee weekly for four weeks to ensure care plans are being followed relating to repositioning and toileting. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date 12/10/2013	

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F 282	Continued From page 11 so she could offer to assist him. On 10/31/13 at 9:55 a.m. NA-J stated the care sheet directed staff to assist R69 with repositioning every one and a half hours. She was unaware he was to be positioned every hour. NA-J verified R69 was not repositioned or toileted on the morning of 10/30/13, as directed by the POC.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate positioning was provided during meals for 1 of 3 residents (R60) reviewed for positioning. Findings include: R60's diagnoses included dementia and multiple sclerosis with left sided weakness. R60's quarterly Minimum Data Set (MDS) dated 9/16/13, indicated R60 had cognitive impairment and was independent with eating after assistance with tray set up. R60's plan of care (POC) dated 9/18/13,	F 309	F309 R60 was moved to a table with appropriate positioning for dining. All residents were observed during meal time to assure proper table positioning for dining. Education will be provided to all nursing staff to observe for proper positioning during dining and to report to the charge nurse and make appropriate adjustments as needed. Random audits will be completed by the Director of Nursing or her designee weekly for four weeks to assure proper positioning of all residents during meal time. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date 12/10/2013	

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F 309	Continued From page 12	F 309		

indicated R60 was at risk for malnutrition related to her diagnoses of multiple sclerosis and dementia. The POC indicated R60 was independent with eating after staff set up the tray, opened and poured milk, buttered bread and arranged food items. The POC did not identify any concerns related to positioning during mealtimes.

During observation of the evening meal on 10/28/13, at 4:58 p.m. R60 was observed seated in a low to the floor, tilt-in-space, specialty wheelchair which was reclined to approximately 100 degrees, at least two feet away from the table. The table height was approximately even with the level of R60's chin. Due to her positioning, R60 was unable to reach her water, juice, milk and coffee from atop the table. When R60 was observed to feed herself, the food was observed to fall onto the table or onto R60's shirt protector as she brought the utensil from atop the table to her mouth. When her food fell onto the table or her shirt protector, R60 was observed to scoop the food from where it fell and brought it to her mouth. Two nursing assistants (NAs) and a licensed practical nurse (LPN) were present and assisting in the dining room throughout this observation. At no time did they attempt to reposition R60 to better accommodate her dining needs.

During observation of the breakfast meal on 10/30/13, at 7:53 a.m. R60 was observed in the same wheelchair, poorly positioned at the dining room table. R60 was observed seated in the low wheelchair, reclined to approximately 100 degrees. The table was observed at R60's chin level, and was at least two feet away from the table. R60 was observed to have difficulty

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F 309	Continued From page 13 bringing the food to her mouth without dropping it onto the floor, her shirt protector or the table. R60 was again observed to scoop her food from where it fell and bring it to her mouth. An interview was attempted with R60 at 8:15 a.m., during which she was asked how her breakfast was. R60 stated that everything was "fine" and indicated she wished not to be observed any further during mealtimes. The breakfast meal ended at 8:43 a.m. Two NA's and a LPN were present on the unit and assisting in the dining room throughout the observation. At no time did they attempt to reposition R60 to better accommodate her dining needs. On 10/30/13, at 8:59 a.m. LPN-A stated R60 would not allow staff to position her closer to the table or adjust her wheelchair to an upright position for meals. LPN-A stated R60 exhibited inappropriate behavior and pushed herself away from the table when staff attempted to position her closer to the table for meals. LPN-A further stated that the table R60 chose to be seated at, could not be adjusted down to accommodate her height. LPN-A confirmed R60 had not been assessed by any facility staff including occupational therapy for positioning while dining. Additionally, LPN-A confirmed R60's refusal to be seated closer to the table in an upright position was not documented in the medical record.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F312 Assistance is being provided with dental flossing for R75. The plan of care for R75 was reviewed and revised to include assistance with dental flossing. Corresponding updates have been made to care sheets for R75.	

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F 312	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assistance with flossing was provided according to dentist recommendations, for 1 of 3 residents (R75) reviewed for dental care. Findings include: R75's diagnoses included Alzheimer's disease and rheumatoid arthritis. R75's quarterly Minimum Data Set (MDS) dated 9/3/13, indicated R75 was severely cognitively impaired and required extensive assistance for personal hygiene tasks, including tooth brushing. During observation on 10/29/13, at 3:14 p.m. R75 was observed to have a large amount of white plaque covering the front of her upper and lower teeth. During observation on 10/30/13, at 7:05 a.m. R75 was observed asleep in a recliner in her room. R75 was also observed dressed and appeared to have already completed morning cares. During interview on 10/30/13, at 7:45 a.m. nursing assistant (NA)-A stated when she assisted R75 with morning cares, R75 told her that she had already brushed her teeth, so NA-A assumed her oral cares were completed. NA-A confirmed she did not assist R75 with oral cares, including brushing and flossing her teeth, on 10/30/13.	F 312	Dental records and recommendations were reviewed for all residents. Care plans and care sheets were updated as needed. Staff education will be provided to all NA's regarding dental flossing and dental hygiene. The Director of Nursing or her designee will audit all dental records weekly for four weeks to assure care plans and care sheets are updated following dental appointments. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date 12/10/2013	

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F 312	Continued From page 15 During interview on 10/31/13, at 8:15 a.m. NA-E stated she had assisted R75 with oral cares earlier that morning. NA-E stated R75 did not have a tooth brush, tooth paste or floss available for use in her room. NA-E stated after providing R75 with a tooth brush and tooth paste, she assisted her with brushing her teeth. NA-E also stated R75 was resistant to completing the task because her gums started bleeding. NA-E confirmed there was a large amount of heavy, white plaque on R75's teeth and foul breath was noted. NA-E stated she did not assist R75 with flossing her teeth because she did not have floss. Review of the dental consult dated 7/22/13, identified R75 had heavy plaque and moderate calculus. The consult directed the following instructions: "Nursing staff: Please assist patient with brushing and flossing if possible." Review of R75's plan of care (POC) dated 9/15/13, identified a self-care deficit related to her diagnoses and inability to complete bathing, dressing, or personal hygiene tasks. The POC directed staff to set up oral care supplies, prepare her tooth brush and brush her teeth. The POC also indicated staff were to complete personal hygiene tasks, including brushing teeth. The POC did not identify staff needed to assist R75 with flossing. On 10/31/13, at 9:23 a.m. licensed practical nurse (LPN)-A stated R75 lived in the memory care unit and indicated she most likely would not recall whether or not she brushed her teeth. LPN-A stated she expected the NA assigned to R75's care to assist her with tooth brushing and flossing, daily. LPN-A confirmed R75's POC did not included the 7/22/13, dental consult	F 312		

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F 312	Continued From page 16 instructions which instructed facility staff to assist R75 with brushing and flossing.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received repositioning assistance as necessary to promote the healing of present pressure ulcers and prevent the development of additional pressure ulcers, for 1 of 1 resident (R69) reviewed for pressure ulcers. Findings include: R69's diagnoses included dementia, Parkinson's disease and a history of stroke. The quarterly Minimum Data Set (MDS) dated 10/21/13, indicated R69 was severely cognitively impaired and required extensive assistance for transfers and bed mobility. The MDS revealed R69 was non-ambulatory and was at risk for the development of pressure ulcers. The MDS also indicated R69 had one current stage two (partial thickness skin loss) pressure ulcer on his left hip.	F 314	F314 R69 is receiving repositioning and toileting per his plan of care. R69's plan of care has been reviewed and revised as needed. The plans of care for all residents have been reviewed and revised as needed relating to repositioning and toileting. Staff education will be provided to all NA's to stress the importance of following the plans of care and what approaches to attempt when a resident becomes resistive or refuses repositioning and toileting. They will also be educated to report resistive behavior or refusal of services to the charge nurse. Random audits will be completed by the Director of Nursing or her designee weekly for four weeks to assure resident care plans are followed relating to toileting and repositioning. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date 12/10/2013	

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R69's comprehensive skin assessment completed 7/28/13, identified he was at high risk for skin breakdown related to bowel and bladder incontinence, his current diagnoses and his need for repositioning assistance while in his wheelchair. The assessment indicated R69 was to be repositioned every 1.5 hours while in his wheelchair and toileted every two to three hours.

R69's plan of care (POC) dated 10/22/13, indicated R69 required extensive assistance for turning and repositioning, every one hour. The POC also indicated R69 required extensive assistance for toileting every two to three hours.

Review of nursing progress notes revealed the following:
On 10/22/13, during wound rounds, an open area was identified on R69's left hip, over a bony prominence. At first an area of granulation was noted, but then an additional 0.6 x 0.7 centimeter (cm) slough covered area was identified. Interventions included a pressure reduction mattress, gel cushion in his wheelchair and hourly turns/repositioning. The following additional interventions were to be implemented: medihoney (a medical grade honey for wound management) to Allevyn and Arginaid (a nutritional supplement used to promote wound healing), twice daily.
On 10/29/13 R69's left hip was assessed. A dramatic improvement was noted to the open area on his hip, with only one surface opening of 0.5 x 0.4 cm and the appearance of the surrounding skin was pink. The recommendation was to continue with the current treatment plan.

During observation on 10/30/13, R69 was observed seated in his wheelchair at 7:00 a.m., in

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the doorway of his room. R69 stated he was up because he could not sleep. At 7:30 a.m., R69 was observed to be in the dining room, waiting for breakfast. At 8:22 a.m., R69 was observed to wheel himself off the unit towards the therapy department. R69 was off the unit until 9:45 a.m., when he was observed to be sitting in his wheelchair, in his room. At that time, restorative aide (RA)-A arrived to assist him to a restorative therapy session. At 9:46 a.m., nursing assistant (NA)-J stated they planned to assist R69 with repositioning and toileting as soon as he came back from therapy. At this time, the observation ended.

On 10/30/13, at 1:11 p.m. NA-J and NA-I were interviewed. NA-J and NA-I stated R69 had refused to go to bed or be repositioned or toileted earlier in the day. At approximately 1:15 p.m. R69 was observed to be assisted to bed with a Hoyer lift, a dressing was observed on his left hip and the rest of the skin was intact with no redness noted. However, R69's incontinence product was observed wet. NA-J and NA-I confirmed R69 had been sitting in his wheelchair since 7:00 a.m., for a period of of six hours and 15 minutes, without off-loading (pressure relief / redistribution) or changing his incontinence product.

On 10/30/13, at 2:12 p.m. RA-A stated she did not stand R69 during his restorative therapy session, nor was he toileted. Rather, she stated R69 did stretches with his lower extremities, while he remained seated in his wheelchair.

On 10/30/13, at 2:30 p.m. the registered nurse (RN)-B confirmed R69 had a stage two pressure ulcer on his left hip and stated staff were to

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F 314	Continued From page 19 reposition him every hour, with toileting every two to three hours. RN-B verified R69 had a history of refusing to be repositioned and toileted, but indicated that if he refused, the staff were expected to report it to her so she could offer to assist him. On 10/31/13 at 9:55 a.m. NA-J stated the care sheet directed staff to assist R69 with repositioning every one and a half hours. She was unaware he was to be positioned every hour. NA-J verified R69 was not repositioned on the morning of 10/30/13, as directed by the POC.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received timely toileting assistance as necessary in accordance with their assessed need, for 1 of 1 resident (R69) reviewed for urinary incontinence. Findings include:	F 315	F315 R69 is receiving toileting per his plan of care. R69's plan of care has been reviewed and revised as needed. The plans of care for all residents have been reviewed and revised as needed relating toileting. Staff education will be provided to all NA's to stress the importance of following the plans of care and what approaches to attempt when a resident becomes resistive or refuses toileting. They will also be educated to report resistive behavior or refusal of services to the charge nurse. Random audits will be completed to assure resident care plans are being followed relating to toileting by the Director of Nursing or her designee weekly for four weeks. The results of these audits will be reported to the Quality Assurance	

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F 315	Continued From page 20 R69's diagnoses included dementia, Parkinson's disease, benign prostatic hyperplasia (BPH) and a history of stroke. The quarterly Minimum Data Set (MDS) dated 10/21/13, indicated R69 was severely cognitively impaired and required extensive assistance for transfers and bed mobility. The MDS revealed R69 was non-ambulatory and frequently incontinent of bowel and bladder. R69's plan of care (POC) dated 10/22/13, indicated he required extensive assistance for toileting every two to three hours. During observation on 10/30/13, R69 was observed seated in his wheelchair at 7:00 a.m., in the doorway of his room. R69 stated he was up because he could not sleep. At 7:30 a.m., R69 was observed to be in the dining room, waiting for breakfast. At 8:22 a.m., R69 was observed to wheel himself off the unit towards the therapy department. R69 was off the unit until 9:45 a.m., when he was observed to be sitting in his wheelchair, in his room. At that time, restorative aide (RA)-A arrived to assist him to a restorative therapy session. At 9:46 a.m., nursing assistant (NA)-J stated they planned assist him with toileting as soon as he came back from therapy. At this time, the observation ended. On 10/30/13, at 1:11 p.m. NA-J and NA-I were interviewed. NA-J and NA-I stated R69 had refused to go to bed or be toileted earlier in the day. At approximately 1:15 p.m. R69 was observed assisted to bed with a Hoyer lift. R69's incontinence product was observed wet. NA-J and NA-I confirmed R69 had been sitting in his wheelchair since 7:00 a.m., for a period of six hours and 15 minutes, without toileting or	F 315	Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date 12/10/2013	

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F 315	Continued From page 21 changing his incontinence product. On 10/30/13, at 2:12 p.m. RA-A verified she did not toilet R69 during his restorative therapy session. On 10/30/13, at 2:30 p.m. the registered nurse (RN)-B stated R69 had a stage two pressure ulcer on his left hip and staff were to toilet him every two to three hours. RN-B verified R69 had a history of refusing to be toileted, but indicated that if he refused, the staff were expected to report it to her so she could offer to assist him. On 10/31/13 at 9:55 a.m. NA-J verified R69 was not toileted on the morning of 10/30/13, as directed by the POC.	F 315		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the correct therapeutic diet was provided for 1 of 1 resident (R26) in the sample who was observed for meal service and had a mechanically altered diet. The Findings include: The meal service for the memory care unit (Maple Lane) was observed on 10/30/13, from 11:30 to 12:30 a.m. The pureed menu for the noon meal called for the following: turkey pasta	F 367	F367 R26 is receiving the correct therapeutic diet with correct menu options and portion sizes. The Certified Dietary Manager completed a review of meal time serving on the memory care unit (Maple Lane) to ensure that all residents are getting the correct diets, correct portion sizes, and all menu options are available. Staff education will be provided to all NA's relating to the use of extensions to provide residents with appropriate portion sizes when serving on Maple Lane. All NA's will also be trained to report to dietary staff when menu options are	

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F 367	Continued From page 22 salad 2/3 cup; creamy cucumbers 1/3 cup; 1 slice wheat bread with margarine; 1, #8 scoop of homemade bar for dessert. Nursing assistant (NA)-F was observed dishing up R26's meal. NA-F was observed to dish up two large serving spoons (no measurement identified on the spoon) of pureed pasta salad, an unmeasured portion of pureed fruit and an unmeasured portion of pureed doughnuts. Pureed bread with margarine was not provided and there were no pureed cucumbers or vegetable available to serve. On 10/30/13, at 11:44 a.m. NA-F stated she was not sure what portion size the pureed diet or any diet she served called for. NA-F also stated she had not been trained on serving appropriate portions of food and she usually dished the amount she thought the resident would eat. Additionally NA-F stated she had not been provided the exchanges of the menu to reference so that she knew what portions to dish each resident for all diets served. On 10/13/13, at 11:44 a.m. NA-B stated when serving the resident meals he normally dished up and served each resident the amount of food he personally would eat. NA-B also stated training had not been provided to ensure the correct menu items including portion sizes were correctly provided to the residents. On 11/1/13, at 12:34 p.m. the certified dietary manager (CDM) stated the nursing assistants on the memory care unit were responsible for serving the residents not the dietary aides. The CDM also stated she had not provided any training for the nursing assistants related to	F 367	not available. Cooks will be educated to ensure that all menu options are available to residents with all therapeutic diets. Cooks review with Maple Lane staff responsible for serving the meals before each meal to ensure correct therapeutic diets and all menu options are available. If a substitute for a particular menu item is required the food item will be substituted with a food item with equal or greater nutritious value. Audits will be completed weekly by the Certified Dietary Manager for four weeks to ensure that all menu options are available to residents with all therapeutic diets and that proper portions are being served. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Certified Dietary Manager is responsible for compliance with this requirement. Completion Date 12/10/2013.	

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F 367	Continued From page 23 serving the correct menu options and portion sizes according to the menu exchanges. The CDM confirmed R26 should have received a pureed diet which consisted of all of the menu items according to what the menu exchanges called for when serving a pureed diet. The CDM also confirmed that not measuring the turkey pasta salad, substituting the pureed fruit for the creamy cucumbers and not measuring the amount of fruit and pureed dessert was not appropriate.	F 367		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F 441 A new infection surveillance log has been developed for daily monitoring of resident infections to determine any trends and potential infection outbreaks. The log will track/trend resident infections which did not require treatment with antibiotics. This log will be kept at each wing and will be reviewed by the Infection Control Nurse for patterns of infection. RN's will be educated on how to use this log and its purpose. NA's and LPN's will be educated to report signs and symptoms of illness to the charge nurse so appropriate action can be taken. Random audits will be completed by the Director of Nursing or her designee weekly for four weeks to assure proper monitoring of	

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	245397	A. BUILDING _____ B. WING _____	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure infection surveillance was completed timely to determine any trends and potential infection outbreaks. In addition, the facility did not track/trend any resident infections which did not require treatment with antibiotics. This practice had the potential to affect 70 of 70 residents currently residing in the facility. During review of the facility's Infection Control Logs for 1/1/13, through 10/31/13, the logs through September 30, 2013 identified the resident, date, location in the facility, type of infection, treatment, symptoms of infection, tests, antibiotic used, and outcome of treatment. There was no Infection Control Log for October 2013, even though it was the end of the month. When interviewed on 10/31/13, at 12:09 p.m. registered nurse (RN)-A stated she was scheduled one day a month to collect infection control data and then do data analysis, trending,	F 441	infections. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion Date 12/10/2013	

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F 441	Continued From page 25 and surveillance of infections. RN-A stated that is when she would generate a report of residents who had received an antibiotic or had lab work to support a diagnosis of infection. RN-A does not gather any information on residents who showed signs of infection, or had a viral infection, that did not require the use of an antibiotic. This information gathering is often four to six weeks after the infection occurred. RN-A confirmed with this practice, it is not possible to identify a trend or outbreak until it has already occurred and viral outbreaks may not be recognized at all. A facility infection control policy was requested, but not provided by the facility.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a sanitary and comfortable environment with walls free of chipped paint areas, scratched and worn foot boards and uncleanable, cracked, stained bathroom tiles for 6 of 60 resident rooms (room 46, 58, 103, 104, 105, 112). In addition, the facility failed to to provide wheelchair cleaning for 1 of 1 resident (R28) in the sample with a visibly soiled wheelchair. Findings Include:	F 465	F465 On 11/1/2013 R28's wheelchair was cleaned. R28's wheelchair has been set up on a routine cleaning schedule. In Room 46 the black foam and duct tape was removed from the toilet piping in the bathroom. The surface was then cleaned. In room 58 the crack in the flooring will be professionally repaired and the floor will be stripped and waxed to remove stained areas. In Room 103 the wall behind the bed was patched and painted. The wall behind the grab bar was also patched and painted. Finally, the	

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F 465	Continued From page 26 On 10/28/13, at 6:00 p.m. R28 was observed seated in her wheelchair in the dining room area. R28's wheelchair was observed to have dried food debris, dust and dirt adhered to the left break lever and the crevices along the sides of her wheelchair. On 10/31/13, at 7:01 a.m. director of nursing (DON) confirmed the facility had a wheelchair cleaning schedule, although her expectation was for nursing to spot check and clean wheelchairs when they appeared soiled. On 10/30/13, at 7:43 a.m. nursing assistant (NA)-A and NA-B verified R28's wheelchair was dirty and needed to be cleaned. NA-B confirmed the facility had a wheelchair cleaning schedule. On 10/31/13, at 9:42 a.m. licensed practical nurse (LPN)-A confirmed R28's wheelchair was dirty as it had dried food adhered to the side crevices. The facility's Wheelchair Washing schedule dated 7/19/13, through 10/18/13, revealed R28's wheelchair had been washed twice in the last three months (8/2/13 and 9/20/13). No facility policy was provided regarding frequency of wheelchair cleaning. On 10/31/13, at 9:19 a.m. during the environmental tour with the director of environmental services (DES) the following concerns were observed: Room 46: The toilet in the bathroom was observed to have loose, black foam duct tapped	F 465	broken handle on the night stand was replaced with a new one. In Room 104 the foot boards were refinished to repair scratches observed. In Room 105 the foot boards for Bed 1 were refinished to repair scratches observed. The wall next to Bed 1 was also patched and painted. In Room 105 the foot boards for Bed 2 were refinished to repair scratches observed. In Room 112 the foot boards for Bed 2 were refinished to repair scratches observed. All resident wheelchairs have been checked for cleanliness and cleaned as needed. Nursing staff will be educated regarding wheelchair cleanliness and the process for cleaning a wheelchair when needed. All resident rooms will be checked for repairs and repairs will be completed where needed. All staff will be educated on protocols for completing maintenance requests requisition slips for all observed maintenance issues.	

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F 465	Continued From page 27 to the piping. The surface was uncleanable. Room 58: The bathroom tile around the toilet was observed cracked and with black stained areas. Room 103: The wall behind the bed was observed to have large areas of chipped paint. R103's bathroom wall behind the grab bar was observed to have areas of chipped paint. In addition, the handle on the night stand was observed broken with a sharp edge. Room 104: The bed footboards of the bed was observed scratched with the finish worn off. Room 105 Bed 1: The footboard of the bed was observed scratched with the finish worn off. The wall next to the bed was observed to have black marks with stains on it. Room 105 Bed 2: The footboard of the bed was observed scratched with the finish worn off. Room 112 Bed 2 The footboard of the bed was observed scratched with the finish worn off. On 10/31/2013, at 9:40 am. the DES verified the above findings. The undated policy titled Housekeeping Policies and Procedures directed staff to report any needed repairs or any unusual cleaning problems or found items to the DES. On 10/31/13, at 11:45 a.m. during an interview with the DES and the administrator, the administrator stated the facility had provided training for all staff on how to report and fill out maintenance repair slips. The DES confirmed he	F 465	R28's wheelchair will be audited weekly for four weeks by the Director of Nursing or her designee to ensure wheelchair cleanliness is being maintained. Random audits will be completed on resident wheelchairs weekly by the Director of Nursing or her designee for four weeks on other residents wheelchairs. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Environmental Services will complete random audits weekly for four weeks to ensure that necessary repairs are being completed. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations. The Director of Nursing or her designee is responsible for compliance with this requirement relating to the cleanliness of wheelchairs. The Director of Environmental Services is responsible for compliance with this requirement relating to the upkeep and maintenance of resident rooms. Completion Date: 12/10/213	

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F 465	Continued From page 28 had not received any maintenance repair slips. Both verified the facility policy had not been followed.	F 465		

F 282
R69 is receiving repositioning and toileting per his plan of care. R69's plan of care has been reviewed and revised as needed.

The plans of care for all residents have been reviewed and revised as needed relating to repositioning and toileting.

Staff education will be provided to all NA's to stress the importance of following the plans of care and what approaches to attempt when a resident becomes resistive or refuses repositioning and toileting. They will also be educated to report resistive behavior or refusal of services to the charge nurse.

Random **observational** audits will be completed by the Director of Nursing or her designee weekly for four weeks to ensure care plans are being followed relating to repositioning and toileting. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations.

The Director of Nursing or her designee is responsible for compliance with this requirement.

Completion Date 12/10/2013

F312
Assistance is being provided with dental flossing for R75. The plan of care for R75 was reviewed and revised to include assistance with dental flossing. Corresponding updates have been made to care sheets for R75.

Dental records and recommendations were reviewed for all residents. Care plans and care sheets were updated as needed.

Staff education will be provided to all NA's regarding dental flossing and dental hygiene.

The Director of Nursing or her designee will audit all dental records weekly for four weeks to assure care plans and care sheets are updated following dental appointments. **The Director of Nursing or her designee will also complete random observational audits on oral hygiene cares weekly for four weeks to assure residents are being assisted with oral hygiene according to their care plan.** The results of these audits will be reported to the Quality Assurance Committee for review and recommendations.

The Director of Nursing or her designee is responsible for compliance with this requirement.

Completion Date 12/10/2013

F314
R69 is receiving repositioning and toileting per his plan of care. R69's plan of care has been reviewed and revised as needed.

The plans of care for all residents have been reviewed and revised as needed relating to repositioning and toileting.

Staff education will be provided to all NA's to stress the importance of following the plans of care and what approaches to attempt when a resident becomes resistive or refuses repositioning and toileting. They will also be educated to report resistive behavior or refusal of services to the charge nurse.

Random **observational** audits will be completed by the Director of Nursing or her designee weekly for four weeks to assure resident care plans are followed relating to toileting and repositioning. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations.

The Director of Nursing or her designee is responsible for compliance with this requirement.

Completion Date 12/10/2013

Reviewed 12/12/13
Approved 12/13/13
SB

F315
R69 is receiving toileting per his plan of care. R69's plan of care has been reviewed and revised as needed.

The plans of care for all residents have been reviewed and revised as needed relating toileting.

Staff education will be provided to all NA's to stress the importance of following the plans of care and what approaches to attempt when a resident becomes resistive or refuses toileting. They will also be educated to report resistive behavior or refusal of services to the charge nurse.

Random **observational** audits will be completed to assure resident care plans are being followed relating to toileting by the Director of Nursing or her designee weekly for four weeks. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations.

The Director of Nursing or her designee is responsible for compliance with this requirement.

Completion Date 12/10/2013

F367
R26 is receiving the correct therapeutic diet with correct menu options and portion sizes.

The Certified Dietary Manager completed a review of meal time serving on the memory care unit (Maple Lane) to ensure that all residents are getting the correct diets, correct portion sizes, and all menu options are available.

Staff education will be provided to all NA's **and dietary staff** relating to the use of extensions to provide residents with appropriate portion sizes when serving **on all wings**. All NA's will also be trained to report to dietary staff when menu options are not available. Cooks will be educated to ensure that all menu options are available to residents with all therapeutic diets. Cooks review with Maple Lane staff responsible for serving the meals before each meal to ensure correct therapeutic diets and all menu options are available. If a substitute for a particular menu item is required the food item will be substituted with a food item with equal or greater nutritious value.

Audits will be completed weekly by the Certified Dietary Manager **or her designee on all wings** for four weeks to ensure that all menu options are available to residents with all therapeutic diets and that proper portions are being served. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations.

The Certified Dietary Manager is responsible for compliance with this requirement.

F 441
A new infection surveillance log has been developed for daily monitoring of resident infections to determine any trends and potential infection outbreaks. The log will track/trend resident infections which did not require treatment with antibiotics. This log will be kept at each wing and will be reviewed by the Infection Control Nurse **weekly** for patterns of infection.

RN's will be educated on how to use this log and its purpose. NA's and LPN's will be educated to report signs and symptoms of illness to the charge nurse so appropriate action can be taken.

Random audits will be completed by the Director of Nursing or her designee weekly for four weeks to assure proper monitoring of infections. The results of these audits will be reported to the Quality Assurance Committee for review and recommendations.

The Infection Control Nurse is responsible for compliance with this requirement.

Completion Date 12/10/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5397023

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	245397	A. BUILDING 01 - NURSING HOME B. WING _____	10/29/2013

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K 000	INITIAL COMMENTS FIRE SAFETY 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	POC ok TB 12-13-13 RECEIVED DEC 4 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-10-13
EXIT: 10-31-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Bjerke	Administrator	12-4-2013

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Havenwood Care Center was built in 4 stages. The 1968 original building is 1- story, without a basement and was determined to be Type II (111) construction. In 1971 an addition to the south of the original building was built, is 1-story with a partial basement and was determined to be of a Type II (222) construction. The 1974 addition was built to the south of the 1971 addition, is 1-story without a basement and was determined to be of Type II (111) construction. In 1992 additions were built to the west of the 1968 building and east of the 1971 building. They are separated with 2-hour fire barriers and determined to be Type II(111) construction. The building is divided into 5 smoke compartments by fire barriers of at least 30 minutes. The building is completely protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition.	K 000		

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K 000	Continued From page 2 The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition and the remodeled Maple Lane Wing has single station smoke detection in the sleeping rooms that annunciates at the respective nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic notification of the local fire department. The facility has a capacity of 90 beds and had a census of 67 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018	K018 The door organizer for the double leaf corridor door to the Therapy Gym has been replaced and the door has been repaired and is now functioning properly.	12-4-13

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K 018	Continued From page 3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations and testing of corridor doors, it was determined that one double leaf corridor door did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.3.6.1. This deficient practice could allow a fire to spread beyond the room of origin and negatively impact all 90 residents, any visitors and staff of this facility. Findings include: During the facility tour on October 29, 2013 between 11:00 am and 2:00 pm, observations and testing of at least 50 corridor doors, by surveyor 03006, revealed that the double leaf corridor doors to PT did not close and latch properly. The "Inactive" leaf's automatic flush bolts did not operated and there coordinator had been removed. The Director of Maintenance and the Administrator verified this finding during the facility tour and during the exit conference.	K 018	The Director of Environmental Services is responsible for correction and monitoring to prevent reoccurrence of this deficiency. Completion Date: 11/27/2013	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		

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K 144	Continued From page 4 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on a review of facility maintenance records and an interview with staff revealed that the emergency generator is not tested in accordance with NFPA 110 The Standard for Emergency and Standby Power Systems 1999 edition section 6-4.2. This deficient practice could allow the generator to have a problem that would go unnoticed by staff and which could negatively impact the all 90 residents, any visitors and the staff in the facility. Findings include: Prior to the facility tour on October 29, 2013 at approximately 10:50 am, a review of the Havenwood Care Center, generator logs for 2012 & 2013 and an interview with the Director of Maintenance, by surveyor 03006, revealed that the emergency generator has not been run monthly under a load of 30% of the generator's capacity, nor has an annual load bank test been conducted. Last load bank was documented in June of 2008. The Director of Maintenance and the Administrator verified this finding during the facility tour and during the exit conference.	K 144	K144 Information was obtained from Zieggler Power Systems stating that a water temperature of 150-160 degrees Fahrenheit is likely at a load of 30%. It is now our practice to test our emergency generator monthly by allowing the generator to reach a water temperature of 150-160 degrees Fahrenheit and then to allow the emergency generator to run for at least 30 minutes from the time it reaches the operating temperature. The Director of Environmental Services is responsible for correction and monitoring to prevent reoccurrence of this deficiency. Completion Date 12/4/2013	