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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: L6PO

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 **01/30/2015** (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:

X A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

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

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

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):

17. SURVEYOR SIGNATURE Date :

Lyla Burkman, Unit Supervisor 02/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:

Mark Meath, Enforcement Specialist 02/17/2015 (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 **02/09/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

February 11, 2015

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

RE: Project Number S5397025

Dear Mr. Bjerke:

On December 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 18, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On February 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 29, 2015 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 December 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 27, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 18, 2014, effective January 27, 2015 and therefore remedies outlined in our letter to you dated December 31, 2014, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5397r15

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	(Y3) Date of Revisit
245397	A. Building B. Wing	2/1/2015

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 **F0176** Reg. # **483.10(n)** LSC	**01/26/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**01/26/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**01/26/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	**01/26/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**01/26/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**01/26/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**01/26/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**01/26/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**01/26/2015**
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	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/mm	02/11/2015	27200	02/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/18/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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	(Y3) Date of Revisit
245397	A. Building B. Wing 01 - NURSING HOME	1/29/2015

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 Reg. # NFPA 101 LSC K0056	Correction Completed 01/27/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	02/11/2015	38035	01/29/2015
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
12/17/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: L6PO
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 **12/18/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

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
X 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): A standard survey was completed that included an investigation of complaint number H5397017. The investigation determined the complaint was unsubstantiated. Refer to the CMS 2567 for both health and life safety code along with the provider's plan of correction.

17. SURVEYOR SIGNATURE
Vienna Andresen, HFE NEII
Date : 01/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath, Enforcement Specialist
Date: 02/04/2015 (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
Posted 02/09/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5353

December 31, 2014

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

RE: Project Number S5397025, H5397017

Dear Mr. Bjerke:

On December 18, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 18, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5397017 that was found to be substantiated.

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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;**

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

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

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

DEPARTMENT CONTACT

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

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

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

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 January 27, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 March 18, 2015 (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 June 18, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File 5397s15

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

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 ______	12/18/2014

RECEIVED JAN 14 2015

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 A standard recertification survey was conducted and complaint investigations were completed at the time of the survey. An investigation of complaint H5397017 was completed. The complaint was unsubstantiated. 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 verification 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 c Addendum 1/16/15 SB	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the ability to self administer medications had been assessed prior to the resident self administering medication for 1 of 1 resident (R53) reviewed for dialysis. The findings include: R53 was admitted to the facility and according to	F 176	F176 R53 was assessed and it was determined she was appropriate to self-administer her medications on 12/17/14. On 12/17/14 an RN obtained a physician's order for R53 to self-administer her medications. R53's care plan has been revised to reflect this change. All residents will be reviewed to ensure physician's orders and assessments have been	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandon Bjerke
TITLE: Administrator
(X6) DATE: 1-14-15

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.

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

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 ________	12/18/2014

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 176	Continued From page 1 the care plan dated 11/20/14, R53 had multiple diagnoses including end stage renal disease requiring hemodialysis. The quarterly Minimum Data Set (MDS) dated 11/18/14, identified R53 had no cognitive impairment, was able to make needs known, and received dialysis. Review of the physician orders for R53 dated 12/1-24/14 revealed an order for Renvela (a medication that binds phosphorous in food to minimize it's absorption) 600 mg 3 tablets with each meal. The order further directed must be given with meals to be effective. On 12/17/2014 7:51 a.m. R53 was observed in the dining room eating breakfast. R53 was asked if she had been given the Renvela when she started eating the meal. R53 indicated she had and stated she had forgotten to take them when she started eating the meal. Review of R53's medical record revealed that R53 had not been assessed for self administration of medications. Additionally, R53 did not have a physician's order to self-administer medication, and the care plan for R53 did not identify that R53 could self administer medication. Review of the facility policy for Self Administration of Medications revised 9/02, identified that residents would be assessed and a physician order would be obtained before any resident could self-administer their own medications. On 12/17/2014, 8:17 a.m. registered nurse (RN)-B confirmed that R53 had not been assessed to self administer medications, and R53	F 176	completed to self-administer medications. Education will be provide to all nurses regarding the self-administration of medications policy and procedure prior to 1/26/15. Random observational audits of medication passes will be completed by the DON or designee weekly x 4 weeks. The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or her designee is responsible for compliance with this requirement. Correction/completion date 1/26/15.	

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

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F 176	Continued From page 2 did not have a physician order to self administer any medications.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan based on identified needs for 3 of 37 residents (R70, R12,R19) reviewed in the stage II sample. Findings include: R70's comprehensive care plan lacked reference that R70 was receiving medication (Trazadone 25	F 279	**F279** R70's care plan was updated on 12/18/14 to reflect the concern of insomnia. Non-pharmacological interventions were listed on the care plan. The Trazodone was then discontinued on 12/18/14 by his primary care physician. R12's care plan was updated on 12/17/14 to reflect her diagnosis of depression. R19's care plan was updated on 12/17/14 to reflect her non-compliance with the physician's order for thickened liquids. All resident's care plans will be reviewed and revised prior to 1/26/15. Education will be provided to all charge nurses regarding	

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F 279 Continued From page 3

mg) for insomnia. The care plan further lacked non-pharmacological interventions and monitoring for insomnia.

R70's Physicians orders dated 11/18/14-12/18/14, identified R70's diagnoses as dementia, hypertension, and insomnia. The physician orders further indicated R70 was to receive Trazadone (antidepressant used for insomnia) 50 milligrams (mg); 1/2 tablet equaling 25 mg at bedtime for insomnia.

R70's care plan dated 12/11/14, identified the diagnosis of Insomnia. Further review of the nursing care plan indicated that there was no comprehensive care plan addressing R70's insomnia.

On 12/17/14, at 1:36 p.m. registered nurse (RN)-C stated, "I am aware that he is receiving Trazadone daily." RN-C further acknowledged there should have been a plan initiated when the medication was started.

On 12/17/14, at 11:55 a.m. RN-B stated the insomnia and non-pharmacological interventions were not addressed on the plan of care , "because his medication is prescribed" On 12/18/14, at 8:45 a.m. the DON verified that R70's care plan lacked non-homological interventions as well and she would update the care plan immediately.

The provided facility policy titled, 'Nursing Care Plans" revised 3/20/13, indicated revisions to the plan of care should by coordinated by the RN/LPN unit managers and members of the care plan team. The policy further identified care plans would be updated with changes in condition as

F 279 updating resident's care plans prior to 1/26/15.

The facility's policy on nursing care plans was reviewed on 1/7/15.

Random audits will be completed by the DON or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are updated appropriately. The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs.

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

Completion/Correction date 1/26/15.

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F 279	Continued From page 4 needed. R12's undated Resident Admission Record indicated R12 had multiple diagnoses including depressive disorder. The Physician Order Report dated 11/26/14 directed citalopram (an anti-depressant medication) 20 mg be given once a day with a start date of 2/24/14. R12's care plan dated 10/30/14, was not updated to address R12's diagnosis of depressive disorder nor the use of citalopram. On 12/18/2014, at 8:20 a.m. registered nurse (RN)-D confirmed that depression and the use of anti-depressant medication were not identified or addressed on R12's care plan. On 12/18/2014 at 8:59 a.m. director of nursing (DON) confirmed R12's care plan should have addressed R12's depression. R19 did not have a comprehensive care plan related to non-compliance with physician ordered thickened liquids. R19's diagnosis included acute respiratory infection and cerebral infarction. The Care Plan dated 11/13/14 directed staff to provide thickened liquids and to monitor for respiratory changes. The care plan did not address R19's dissatisfaction or non-compliance with the physician order for thickened liquids. A nursing note from 11/6/14 indicated staff informed R19's daughter that speech therapy had re-evaluated R19's diet including consistency of fluids and no changes were recommended.	F 279		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 5	F 282	F282	
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 care plan interventions for repositioning were followed for 1 of 1 resident (R36) identified with pressure ulcers. Findings include: R36 was not repositioned every hour as directed by her care plan. R36's Care Plan dated 10/9/14, identified R36 had decreased physical mobility with the potential for impaired skin integrity related to Parkinson's disease. The plan of care also identified chronic pain manifested by inability to transfer, wheel self, turn and reposition self, sit up, lie down, or get feet and legs into bed independently. The care plan directed staff to provide extensive assist of 2 staff to turn and reposition every 1 hour. On 12/17/14 from 8:12 a.m. until 9:47 a.m. (1 hour and 35 minutes) R36 was continuously observed to be positioned on her coccyx. On 12/17/2014, at 10:37 a.m. NA-K confirmed R36 had been positioned on her coccyx for 1 hour and 35 minutes. On 12/17/2014, at 2:00 p.m. NA-I confirmed that R36 was not repositioned off of her coccyx for 1 hour and 35	F 282	R36's pressure ulcer was assessed on 12/22/14 was noted to be improved, it was assessed again on 12/30/14 was also noted to be improved. R36's pressure ulcer was observed to be healed on 1/6/15. R36 is receiving repositioning per her care plan. R36's care plan has been reviewed and revised as needed. All residents care plans will be reviewed and updated for repositioning prior to 1/26/15. Staff education will be provided to all NA's prior to 1/26/15 to stress the importance of following care plans in regards to timely turning and repositioning. Random observational audits will be completed by the DON or designee weekly x 4 weeks to ensure residents are receiving turning and repositioning per their care plan. The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will	

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F 282	Continued From page 6 minutes. On 12/17/2014, at 2:42 p.m. RN-D confirmed for proper healing R36 should have been repositioned every hour as directed on the care plan. On 12/18/2014, at 8:54 a.m. the director of nursing (DON) stated R36 should have been repositioned every hour as directed on the care plan. DON confirmed R36's care plan had not been followed. A policy regarding care plan implementation was requested but none was provided.	F 282	determine further auditing needs. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion/Correction date 1/26/15.	
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 interview and document review, the facility failed to comprehensively assess and develop interventions for a foot wound for 1 of 1 resident (R67) who had identified open foot wounds. The facility also failed to assess the potential for additional pressure ulcers prior to the implementation of a splint. Findings include: R67 was admitted on 8/6/14 with diagnoses including diabetes, dementia, congestive heart failure (CHF), and peripheral vascular disease	F 309	**F309** R67 was discharged from Havenwood Care Center on 9/15/14. The facility's Skin Care Protocol has been reviewed and revised. All residents with orders for splints will have daily checks completed by the LPN to observe for skin breakdown. Concerns will be brought to the charge nurses attention to address any issues noted. Education will be provided to all nurses prior to 1/26/15	

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

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F 309	Continued From page 7 (PVD). R67 was discharged to Red Lake Hospital on 9/15/14. The Admission Minimum Data Set (MDS) dated 8/12/14 states R67 was at risk of developing pressure ulcers. R67 required extensive assistance with his Activities of Daily Living (ADL ' s), including bed mobility, transferring, personal hygiene, toileting and dressing. There was no initial comprehensive assessment of multiple lower extremity wounds identified on admission. The medical record did not include evidence of the type, location or appearance of each wound; nor a specific corresponding physical assessment for causative factors, treatment or monitoring. According to the National Pressure Ulcer Advisory Panel (NPUAP) wound documentation should include an exact location, type of wound (venous, arterial, diabetic, pressure, or Kennedy terminal ulcer), stage (if a pressure or Kennedy ulcer), dimensions (length, width, depth), undermining, wound base description, drainage, wound edges, odor, pain, and progress. Physician ' s Orders dated 8/9/14 indicated R67 was to have a Prafo Splint (An ankle-foot orthotic to control the positon of the foot and ankle. This type of splint also has positive heel suspension to prevent pressure on the heel) to left foot when in bed or reclining chair. The Braden dated 8/11/14 (5 days after admission) documented a Braden score of 17 (mild risk for developing pressure ulcers) and " 3 small shallow areas on Left LE [lower extremity]. 1 on shin, top of foot and 1 behind ankle. " The wound on the bottom of the left foot was not identified at that time. The Pressure Ulcer Care Area Assessment (CAA) dated 8/15/14 indicated R67 was admitted with open areas, " On foot, these appear to be diabetic ulcers per wound round team. " The	F 309	regarding the daily checks that are to be completed on all residents with orders for splints to observe for skin breakdown. Random audits will be completed by the DON or designee weekly x 4 weeks to ensure daily checks observing for skin breakdown are completed on residents with orders for splints. The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or her designee is responsible for compliance with this requirement. Correction/Completion date 1/26/15.	

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

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F 309	Continued From page 8 CAA identified R67 was, " At risk for pressure ulcers which could result in infection, sepsis, weight loss and discomfort. Complicated by Diabetes Mellitus with Neuropathy, PVD, Atrial Fib [fibrillation], CAD [coronary artery disease] " . The EZ Graph Wound Assessment dated 8/19/14, (13 days after admission), indicated wound on the bottom of the foot, dimensions of 1.2 cm long x 2.5 cm wide, with black and purple wound base. The corresponding skin condition report indicated, " deep tissue injury on bottom of left foot. " The wound was not assessed for potential causative factors, the physician was notified and monitoring was initiated. The EZ Graph on 8/26/14 indicated the wound dimensions of 1.5 cm x 1 cm with a wound base of eschar and slough (dead, unhealthy tissue). The wound base was also described as red. There was a small amount of bloody drainage. The periwound (area around the wound) was identified as macerated (softened skin from moisture). On 8/28/14 the Skin Condition report specified " deep tissue injury slightly larger in length " and to continue with same plan of care. On 9/2/14 the progress was described on the Skin Condition report as, " deep tissue smaller in size/dry skin at area " . The 9/9/14 the report noted the wound was " moist/macerated " . The wound on the bottom of the left foot was not identified on the Minimum Data Set (MDS) or the care plan dated 8/18/14. Although R67 had a Prafo Splint, pressure monitoring was not identified on the plan of care or the CAA. In addition to the lack of assessment for the bottom of R67 ' s left foot wound, the medical record also lacked evidence of tissue perfusion evaluation prior to implementation, or with use of the Prafo splint.	F 309		

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F 309	Continued From page 9 The facility ' s Skin Care Protocol specified bruises as " suspected deep tissue injury [DTI] " . DTI were to be monitored " times 5 days, then reassessed " . On 8/22/14 the Medication Administration Record (MAR) directed staff to monitor the DTI. The left foot wound was not addressed on the care plan. On 12/18/14 at 10:00 a.m., registered nurse (RN)-D stated R67 had skin issues upon admission, with multiple areas on his knee, shin and foot. RN-D stated the left foot DTI could have been caused by the Prafo Splint.	F 309		
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 ensure timely repositioning was provided for 1 of 3 residents (R36) who were identified with a pressure ulcers. Findings include: R36's undated Resident Admission Record indicated R36 had diagnoses that included paralysis agitans, chronic pain syndrome,	F 314	**F314** R36's pressure ulcer was assessed on 12/22/14 was noted to be improved, it was assessed again on 12/30/14 was also noted to be improved. R36's pressure ulcer was observed to be healed on 1/6/15. R36 is receiving repositioning per her care plan. R36's care plan has been reviewed and revised as needed. All residents care plans will be reviewed and updated for repositioning.	

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

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F 314	Continued From page 10 congestive heart failure, global decline, and osteoarthrosis R36's quarterly Minimum Data Set (MDS) dated 10/7/14, indicated R36 had moderate cognitive impairment, was not ambulatory, and was totally dependent upon two persons for assistance with bed mobility, transfers and toileting. The MDS also identified R36 was at risk for developing a pressure ulcer. R36's Pressure Ulcer Care Area Assessment (CAA) dated 4/24/14, identified R36 was at risk for pressure ulcers and skin rashes/breakdown complicated by her diagnoses of Parkinson's disease, chronic pain, and congestive heart failure. R36's Care Plan dated 10/9/14, identified R36 had decreased physical mobility with the potential for impaired skin integrity. The care plan directed staff to provide extensive assist of 2 staff to turn and reposition every 1 hour. The Skin Condition Report dated 12/9/14 identified R36 had new pressure ulcers on her coccyx. The E-Z Graph Wound Assessment Worksheet dated 12/9/14 identified two wounds that were assessed as not stageable due to 10% slough (dead skin or tissue). The wound sizes were measured to be #1) 0.7 centimeter (cm) x 1.1 cm and #2) 0.4 x 1 cm. R36's Braden Scale (for predicting pressure sore risk) dated 12/12/14, identified R36 was at high risk for the development of pressure sores. R36's Tissue Tolerance Assessment dated 12/12/14 indicated a skin change had been noted and recommended Laying - Reposition every hour. The Skin Condition Report dated 12/15/14	F 314	Staff education will be provided to all NA's prior to 1/26/15 to stress the importance of following care plans in regards to timely turning and repositioning. Random audits will be completed by the DON or designee weekly x 4 weeks to ensure residents are receiving turning and repositioning per their care plan. The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion/Correction date 1/26/15.	

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F 314	Continued From page 11	F 314		

indicated no slough and the wound beds looked cleaner. However, the E-Z Graph Wound Assessment Worksheet dated 12/15/14 identified three wounds to R36's coccyx. All three wounds were assessed to be stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough). The wound sizes were measured to be #1) 0.4 cm x 0.7 cm, #2) 1.3 cm x 0.6 cm and #3) 0.9 cm x 1.3 cm.

On 12/16/14, at 6:56 p.m. during evening cares, R36's pressure ulcers were observed. Three open areas were noted to R36's coccyx area. The wounds appeared as described on 12/15/14.

On 12/17/2014 from 8:12 a.m. until 9:47 a.m. (1 hour and 35 minutes) R36 was continuously observed to be positioned on her coccyx. There were no offers of repositioning. Although R36 was tilted back in her wheelchair during the observation, pressure remained on her coccyx in the area of the pressure ulcers. R36 remained in her wheelchair until transferred into bed at 9:48 a.m.

On 12/17/2014, at 10:37 a.m. NA-K verified R36 required repositioning every hour. NA-K confirmed R36 had been positioned on her coccyx for 1 hour and 35 minutes. NA-K stated he was unaware of the amount of time required for off-loading (one full minute of pressure relief) pressure.

On 12/17/2014, at 2:00 p.m. NA-I stated that R36 required turning and repositioning every hour. NA-I confirmed that R36 was not repositioned off of her coccyx for 1 hour and 35 minutes. NA-I indicated he had heard the term off-loading but

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

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F 314	Continued From page 12 did not know what that meant. On 12/17/2014, at 2:04 p.m. NA-J stated R36 required turning every hour due to pressure sores. NA-J indicated she had never heard of offloading. On 12/17/2014, at 2:42 p.m. R36's pressure ulcer history was reviewed with registered nurse (RN)-D. RN-D stated it was probably not enough pressure relief to go from a seated positioned to slightly tilted in the same chair. RN-D acknowledged R36 probably should have been positioned on her side when put back to bed. RN-D confirmed for proper healing R36 should have been repositioned every hour as directed by the care plan. On 12/18/2014, at 8:54 a.m. the director of nursing (DON) stated R36 should have been repositioned every hour as directed by the care plan.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	**F329** R70's care plan was updated on 12/18/14 to reflect the concern of insomnia. Non-pharmacological interventions were listed on the care plan. This resident's Trazodone was then discontinued on 12/18/14 by his primary care physician. All resident's care plans will be reviewed and revised prior to 1/26/14 to ensure non-	

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

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 ______	12/18/2014

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F 329	Continued From page 13 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify and implement non-pharmacological interventions for 1 of 1 resident (R70) receiving Trazadone (antidepressant) for insomnia. FINDINGS INCLUDE: R70 was receiving medication for sleep and did not have specific non-pharmacological interventions to assist in managing insomnia. R70's Physicians orders dated 11/18/14-12/18/14, identified R70's diagnoses included dementia and insomnia. The physician orders further indicated R70 was to receive Trazadone (antidepressant used for insomnia) 50 milligrams (mg); 1/2 tablet equaling 25 mg at bedtime for insomnia. The medication administration record showed this medication was given every day since it was ordered on 9/20/14. On 12/17/14, at 11:55 a.m. registered nurse (RN)-B stated the insomnia and	F 329	pharmacologic interventions are listed on the care plan. The pharmacy consultant reviewed all medication orders for resident's residing in the facility for unnecessary medications on 1/1/15. Education will be provided to all charge nurses regarding updating resident's care plans prior to 1/26/15. The facility's policy on nursing care plans was reviewed on 1/7/15. IDT meetings will be completed every month with the director of nursing (or designee) and pharmacy consultant. The purpose of these meetings is to eliminate unnecessary medications, identify target behaviors, and develop individualized interventions for each resident. Random audits will be completed by the DON or designee weekly x 4 weeks to ensure care plans are updated when changes occur. The results of these audits will be reported	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 14 non-pharmacological interventions were not addressed on the plan of care , "because his medication is prescribed" On 12/17/14, at 1:36 p.m. registered nurse (RN)-C stated, "I am aware that he is receiving Trazadone daily." RN-C further acknowledged there should have been a plan initiated when the medication was started. On 12/18/14, at 8:45 a.m. the DON verified that R70's care plan lacked non-homological interventions as well and she would update the care plan immediately. A policy regarding medication protocol/non-pharmological interventions was requested. The DON stated on 12/17/14 at 2:00 p.m. " I don't believe we have a policy for that."	F 329	to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion/Correction date 1/26/15.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356	**F356** All staff hours posting will be reviewed and revised if indicated. A policy for posting nursing staff hours has been developed. All charge nurses will be educated on this policy and procedure prior to 1/26/15.	

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F 356	Continued From page 15 of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the nurse posting was complete, accurate and/or posted timely for 4 out of 7 days reviewed. This had the potential to affect all 68 residents residing in the facility. Findings include: During the initial tour on 12/15/14, at 7:00 a.m. the Havenwood Care Center - Daily Report of Nursing Staff Directly Responsible for Resident Care posting was observed located on the wall in the entrance hallway encased in a clear plastic 8 x11 inch holder. The nurse staff posting dated 12/15/14, indicated the facility had three registered nurses (RNs) working the day shift (6:00 a.m. to 2:30 p.m.). The following other day shift hours were left blank: · 7:00 a.m. - 3:30 p.m. · 7:30 a.m. - 4:00 p.m. · 8:00 a.m. - 4:30 p.m.	F 356	Random audits will be completed by the DON or designee weekly x 4 weeks to ensure appropriate posting of staff hours is completed. The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion/Correction date 1/26/15.	

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F 356	Continued From page 16 On 12/16/14, at 4:30 p.m. the 12/15/14, nurse staff posting for the evening shift was blank. It included no staffing information. On 12/17/14, at 2:00 p.m. the most current nursing staff posting displayed was dated for 12/16/14. On 12/17/14, at 2:07 p.m. the director of nursing (DON) confirmed that the nursing staff posting for the day shift on 12/15/14, was incorrect. The facility had 3 RNs scheduled for the day shift on 12/15/14, however the RN hours worked were staggered with one RN working 6:00 a.m. - 2:30 p.m., one RN working 7:00 a.m.- 3:30 p.m. and one RN working 8:00 a.m.- 4:30 p.m. The DON also verified the nursing staff posting currently posted was dated 12/16/14. The DON further stated the updated staff posting was to be up after the 10:00 a.m. morning briefing. On 12/17/14, at 2:15 p.m. the DON further verified: · The 12/13/14, nurse staff posting was incomplete (the evening and night shift information was blank) · The 12/11/14, nurse staff posting was incomplete (the day shift information was blank) Although requested, no policy related to nursing staff posting was provided.	F 356		
F 441 SS=D	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	F 441	**F441** NA-B was educated regarding proper hand hygiene.	

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

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F 441	Continued From page 17 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 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 observation, interview, and document review the facility failed to ensure hand hygiene was performed appropriately during personal	F 441	LPN-C was educated on cleansing equipment with Cavi-wipes. The facility's hand washing policy has been reviewed. The facility's Dressing Change policy has been reviewed and revised to include cleaning equipment (scissors) with a Cavi-wipe when dressing changes are completed. All nurses will be educated regarding this change in policy and the proper technique. All nursing staff will be educated regarding the hand washing policy. Random audits will be completed by the DON or designee weekly x 4 weeks to ensure compliance with infection control policies regarding appropriate hand washing and disinfecting of	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 18 cares for 1 of 4 residents (R19) observed during personal cares; and ensure bandage scissors were cleansed appropriately after wound care for 1 of 1 resident (R93) observed during wound care. Findings include: On 12/17/2014, at 10:53 a.m. licensed practical nurse (LPN)-C was observed to gather dressing supplies. LPN-C washed her hands and donned gloves. R93 had a rolled conforming gauze bandage to her left lower leg. LPN-C cut the soiled bandage off R93's leg with a bandage scissors. LPN-C then discarded the soiled dressing into the trash. The dressing was observed to be soiled with serosanguinous drainage. LPN-C placed the soiled bandage scissors into her pocket without cleaning them. LPN-C then completed wound care for R93. LPN-C returned to the medication cart at the nurses station where she removed the scissors from her pocket and cleansed with an alcohol wipe. LPN-C stated she had always cleaned the scissors between residents utilizing alcohol wipes and utilized a CaviWipe (disinfecting towelette) at the end of the shift. LPN-C stated the facility standard was to use an alcohol wipe between residents, however, she would use the CaviWipe if a resident had a known issue such as MRSA [Methicillin-resistant Staphylococcus aureaus] (a contagious and antibiotic-resistant staph bacteria that leads to potentially dangerous infection). On 12/18/2014, at 8:27 a.m. registered nurse (RN)-D stated she was unsure of the policy regarding cleaning of scissors. RN-D confirmed alcohol would not clean as well as the CaviWipe and would not kill all the organisms a CaviWipe would kill.	F 441	equipment after dressing changes. The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or her designee is responsible for compliance with this requirement. Completion/Correction date 1/26/15.	

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F 441	Continued From page 19	F 441		

Continued From page 19

On 12/18/2014, at 9:02 a.m. the director of nursing (DON) confirmed they should have used a CaviWipe to clean scissors and not an alcohol wipe.

The Clean/Sterile Dressing Changes policy dated 3/28/13 directed staff to wash any equipment used, using an alcohol wipe.

R19's personal cares were observed and completed without proper handwashing.

During observation of personal cares for R19 on 12/17/14, at 8:05 a.m., nursing assistant (NA)-B filled a wash basin in the bathroom with soap and water. NA-B was wearing gloves. NA-B requested R19 wash her hands and face, NA-B washed R19's underarms then the chest and back. NA-B dried R19's back with towel, put R19's bra on and applied deodorant. NA-B took the gloves off and put on R19's shirt. NA donned gloves, rinsed the washcloth, sprayed it with a solution and began perineal cares. NA-B rinsed and sprayed washcloth again. NA-B completed washing R19's bottom, then took gloves off. NA-B draped R19 with a towel and completely removed the wet brief.

At 8:21 a.m. R19's roommate entered the room. NA-B pulled the privacy curtain. NA-B finished dressing R19 and assisted her to the wheelchair. R19 requested mouthwash. NA-B provided an emesis basin and Kleenex to R19 to wipe her mouth. NA-B still had not washed her hands following handling the soiled brief and providing perineal cares.

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F 441	Continued From page 20 NA-B donned clean gloves on. NA-B rinsed off dentures, applied polygrip and gave them to R19. NA-B removed the gloves. NA-B then gave R19 Chapstick, a makeup basket, and a mirror. NA-B made the bed, dumped the wash basin, flushed the toilet, refilled wet wipes and washed R19's bedside table. NA-B handled R19's snack and television remote while cleaning up. NA-B removed the garbage and disposed in soiled utility room at 8:40 a.m. No handwashing occurred. On 12/17/14 at 8:45 a.m. NA-B stated she usually washed her hands before assisting with oral cares. NA-B stated she did wash her hands in the bathroom before assisting with teeth and after perineal cares. However, NA-B was continually observed and did not wash her hands at the sink or use hand sanitizer. NA-B then stated not to worry (about hand washing) because 2 pairs of gloves were used. On 12/17/14 10:47 a.m. RN-B stated she would expect handwashing between perineal cares and oral-dental cares. She stated that wearing 2 sets of gloves is not acceptable, and this would be explained to NA-B. The undated Eldercare of Minnesota Hand washing Policy directed staff to wash hands before and after assisting residents with personal cares.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465	F465 In room 34 the trim on the wall near the bathroom has been replaced. In room 37 the gouges on the front of the door to the bathroom were repaired and refinished. In room 45 the broken tile behind the toilet will be replaced. In room 49 the trim on the bathroom door will be replaced. In room 58 the area noted to have black scuff marks has been painted. The area noted to have blue paint above the light fixture has also been painted.	

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F 465	Continued From page 21 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 appropriate maintenance to resident rooms (#34, 37, 45, 49, 58, 70, 84, 104, 110, 113) and the dining and common areas throughout the facility. Findings include: On 12/17/14, from 9:26 a.m. to 10:10 a.m. a tour of the facility was completed with the environmental service director (ESD). The ESD verified the following resident room concerns: · In room 34, the trim was missing from the wall by the bathroom. · In room 37, there were gouges on the front of the door to the entrance to the room. The gouges were at door knob level and were the width of the door. · In room 45, there was a broken tile behind the toilet on the bathroom wall. · In room 49, the trim on the bathroom door was torn. · In room 58, there were black scuff marks measuring three square feet on the bedside wall of bed 2. In addition, there was old blue paint that needed to be covered up above the light fixtures on the wall above beds 1&2. · In room 70, there were gouges in the bathroom door which were six inches from the bottom of the door and through the width of the door. · In room 84, the north wall had black scuff marks which measured four feet across with	F 465	In room 70 the gouges on the door have been repaired and refinished. In room 84 the area noted to have black scuff marks has been painted. In room 104 the ceiling tile above the entrance to the room has been replaced. In room 110 the area noted to have black scuff marks and paint peeling will be repaired and painted. The bathroom wall tile has been replaced. The black scuff marks located by the headboard and foot of the bed have been repaired and painted. In room 113 the area noted to have scuff marks will be repaired and refinished. The two carpet stains located outside of the Willow Way dining room have been cleaned. The refrigerator seal in the Walnut Grove medication room will be replaced. Our Corporate Director of Environmental Services was here on 1/2/15 to assess for best	

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

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F 465	Continued From page 22 areas of chipped paint. · In room 104, the ceiling tile above the entrance to the room was scraped and needed to be replaced. · In room 110, at entrance to the room on the right side of the wall had black scuff marks with paint peeling and scrapes down to the sheet rock; there was one bathroom wall tile located on the right of the bathroom door which was cracked and missing; behind the bed were black scuff mark; brown scuff marks located by the headboard and at the foot of the bed; on the bedside wall were two large areas missing paint and scraped down to the white wall. · Room 113 had black scuff marks on the bottom of the wall beside the bathroom. The ESD verified the following concerns in the dining and common areas: · There were two carpet stains measuring one foot in diameter and the other ½ foot in diameter located outside the willow dining room. · The refrigerator in the walnut medication room had a broken seal on the bottom of the door. · The white tile in the walnut dining room area was buckling with some of the edges of the tile being raised and chipped. This area totaled approximately 600 square feet. The ESD stated they are in the process of obtaining bids for replacing the flooring, however did not have a set date of when this would be able to be done. · The hand washing sink/cabinet in the walnut wing had a large scrape on the side of the cabinet and the molding was loose along the back of the cabinet. The ESD confirmed the cabinet needed to be replaced with a larger sink along with the molding. · In the walnut common area at the end of the	F 465	options for replacement of the tile flooring in the Walnut Grove dining room. A sales representative was here from CFS Interiors and Flooring on 1/5/15 to measure, review flooring options, and gather information to put together a bid for the replacement of the tile flooring. On 1/5/15 Arrowhead Consulting was contacted regarding the tile that needs to be removed. On 1/13/15 a bid was received for the removal of the existing tile and the replacement with new flooring product. Approval to replace the flooring has been granted, however a selection of flooring to be installed needs to take place. At the February board meeting a review of the bid will take place, and flooring options will be discussed, in order to select the type of flooring to be installed. Once the selection has been made scheduling the installer will take place. The hand washing sink/cabinet in the Walnut Grove wing will be replaced. The carpet baseboard molding noted to be separated from the wall in the common area of the Walnut Grove neighborhood will be repaired. The chipped paint	

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

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F 465	Continued From page 23 hallway, approximately 18 inches of the carpet baseboard molding was separated from the wall. There was an area of chipped paint in the corner above the carpet baseboard molding. · In the maple dining room area the radiators along the windows had black scuff marks measuring approximately ten feet. The ESD confirmed the black scuff marks were from the wheelchairs and the radiators needed to be repainted. On 12/18/14, at 9:45 a.m. the administrator provided some education information [undated] that had went out to all the staff after the last state survey. This educational information indicated that all staff were responsible for notifying the maintenance department of any issues related to the environment such as walls that needed patching, painting, or issues with tile. Although requested, no policy or procedure related to routine maintenance inspections was provided.	F 465	near the carpet baseboard molding will be repaired and painted. The radiators along the windows in the Maple Lane dining room noted to have black scuff marks will be painted. All resident rooms and common areas will be checked for needed repairs. All staff will be educated on protocols for completing maintenance requests requisition slips for all observed maintenance issues. A policy relating to routine maintenance inspections has been developed. All maintenance staff will be educated on this policy. The Administrator will complete random audits of resident rooms and common areas weekly for four weeks to ensure that necessary repairs are being completed. The Administrator is responsible for compliance with this requirement. Completion/Correction Date: 1/26/15	

Havenwood Care Center
Skilled Nursing and Rehabilitation
Cedar Cottage
Assisted Living
BirchHaven Village
A Retirement Community
Tamarack Court
Assisted Living Apartments

eldercare
of Bemidji

1633 Delton Avenue • Bemidji MN 56601

January 16, 2015

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933

RE: Addendum to F309

Dear Ms. Burkman,

Below is the addendum to our Plan of Correction submitted on January 14, 2015 regarding F309.

Thanks,

Brandon Bjerke

Brandon Bjerke
Administrator
Havenwood Care Center

Addendum to F 309

The facility will ensure that each resident receives 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.

The comprehensive assessment will be completed according to the facility skin care protocol. Interventions will be implemented based on the results of the comprehensive assessment.

Nursing staff will be educated regarding the comprehensive assessment and the facility skin care protocol. Included in this education will be information regarding the implementation of interventions based on the results of the comprehensive assessment.

Random audits will be completed by the DON or designee weekly x 4 weeks to ensure the comprehensive assessment is being completed according to the facility skin care protocol.

Random observational audits will be completed by the DON or designee weekly x 4 weeks to ensure the interventions are implemented according to the results of the comprehensive assessment.

The results of these audits will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine further auditing needs.

Completion/Correction Date: 1/26/15

Reply to:

❑ Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601
Phone: 218-444-1745
Fax: 218-444-1744

❑ Cedar Cottage
1711 Delton Avenue
Bemidji, MN 56601
Phone: 218-444-3047
Fax: 218-444-7668

❑ BirchHaven Village
1700 Norton Avenue
Bemidji, MN 56601
Phone: 218-444-1700
Fax: 218-444-1760

❑ Tamarack Court
1511 Delton Avenue
Bemidji, MN 56601
Phone: 218-444-4999
Fax: 218-444-5603

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

F5397024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING 01 - NURSING HOME B. WING	12/17/2014

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

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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 [handwritten initials] 1-15-15 RECEIVED JAN 14 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 12-18-14 Dc. 1-27-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Bjerke	Administrator	1-14-15

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.

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.kappenman@ state.mn.us 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 completely protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes corridor smoke detection, with additional	K 000		

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

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K 000	Continued From page 2 detection in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 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 71 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 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not	K 056	K056 All sprinkler heads were inspected by Fireline Sprinkler Corporation. Replacement of the sprinkler heads in the memory care unit, the Walnut Grove dining room, and any others identified will take place on 1/26/2015. The Administrator and Director of Environmental Services are responsible for correction and monitoring to prevent reoccurrence of this deficiency. Completion Date: 1/27/2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 056	Continued From page 3 installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 12/17/2014, observations have reveled that there were mixed response style (quick response mixed in with standard sprinkler heads) sprinkler heads that were found in the following locations: 1) There are two QR style sprinkler heads located next to standard style sprinkler heads in the memory care unit by the entry doors, and 2) There are QR style sprinkler heads mixed in with standard style sprinkler heads located in the Maple Lane dining room. This deficient practices was confirmed by the Facility Administrator (BB).	K 056		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5353

December 31, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5397025, H5397017

Dear Mr. Bjerke:

The above facility was surveyed on December 15, 2014 through December 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5397017. that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File   5397s15lic

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

RECEIVED
JAN 14 2015
Minnesota Department of Health
Bemidji

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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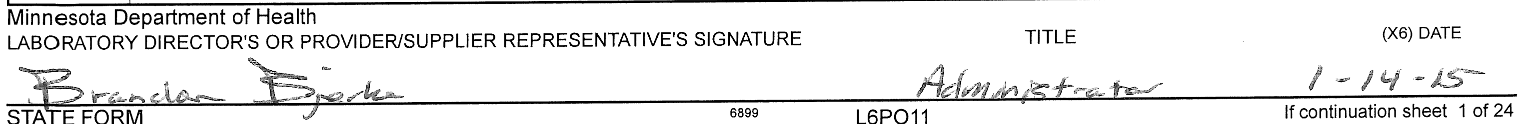
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 14-18, 2014 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

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



Minnesota Department of Health

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health 705 Fifth Street NW, Suite A, Bemidji, MN 56601-2933 c/o Lyla Burkman, Unit Supervisor	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		

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2 560	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan based on identified needs for 3 of 37 residents (R70, R12,R19) reviewed in the stage II sample. Findings include: R70's comprehensive care plan lacked reference that R70 was receiving medication (Trazadone 25 mg) for insomnia. The care plan further lacked non-pharmacological interventions and monitoring for insomnia. R70's Physicians orders dated 11/18/14-12/18/14, identified R70's diagnoses as dementia, hypertension, and insomnia. The physician orders further indicated R70 was to receive Trazadone (antidepressant used for insomnia) 50 milligrams (mg); 1/2 tablet equaling 25 mg at bedtime for insomnia. R70's care plan dated 12/11/14, identified the diagnosis of Insomnia. Further review of the nursing care plan indicated that there was no comprehensive care plan addressing R70's insomnia. On 12/17/14, at 1:36 p.m. registered nurse (RN)-C stated, "I am aware that he is receiving Trazadone daily." RN-C further acknowledged there should have been a plan initiated when the medication was started. On 12/17/14, at 11:55 a.m. RN-B stated the insomnia and non-pharmacological interventions were not addressed on the plan of care , "because his medication is prescribed" On 12/18/14, at 8:45 a.m. the DON verified that	2 560		

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2 560	Continued From page 3 R70's care plan lacked non-homological interventions as well and she would update the care plan immediately. The provided facility policy titled, 'Nursing Care Plans" revised 3/20/13, indicated revisions to the plan of care should by coordinated by the RN/LPN unit managers and members of the care plan team. The policy further identified care plans would be updated with changes in condition as needed. R12's undated Resident Admission Record indicated R12 had multiple diagnoses including depressive disorder. The Physician Order Report dated 11/26/14 directed citalopram (an anti-depressant medication) 20 mg be given once a day with a start date of 2/24/14. R12's care plan dated 10/30/14, was not updated to address R12's diagnosis of depressive disorder nor the use of citalopram. On 12/18/2014, at 8:20 a.m. registered nurse (RN)-D confirmed that depression and the use of anti-depressant medication were not identified or addressed on R12's care plan. On 12/18/2014 at 8:59 a.m. director of nursing (DON) confirmed R12's care plan should have addressed R12's depression. R19 did not have a comprehensive care plan related to non-compliance with physician ordered thickened liquids. R19's diagnosis included acute respiratory infection and cerebral infarction. The Care Plan dated 11/13/14 directed staff to provide thickened liquids and to monitor for respiratory changes. The care plan did not	2 560		

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2 560	Continued From page 4 address R19's dissatisfaction or non-compliance with the physician order for thickened liquids. A nursing note from 11/6/14 indicated staff informed R19's daughter that speech therapy had re-evaluated R19's diet including consistency of fluids and no changes were recommended. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review/revise all policies and procedures related to care planning. The DON or designee could educate all appropriate staff to comprehensively develop and update care plans based on individualized assessments. The DON could develop a system to ensure understanding and implementation through auditing. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions for repositioning were followed for 1 of 1 resident (R36) identified with pressure ulcers. Findings include:	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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) COMPLETE DATE
2 565	Continued From page 5	2 565		

R36 was not repositioned every hour as directed by her care plan.

R36's Care Plan dated 10/9/14, identified R36 had decreased physical mobility with the potential for impaired skin integrity related to Parkinson's disease. The plan of care also identified chronic pain manifested by inability to transfer, wheel self, turn and reposition self, sit up, lie down, or get feet and legs into bed independently. The care plan directed staff to provide extensive assist of 2 staff to turn and reposition every 1 hour.

On 12/17/14 from 8:12 a.m. until 9:47 a.m. (1 hour and 35 minutes) R36 was continuously observed to be positioned on her coccyx.

On 12/17/2014, at 10:37 a.m. NA-K confirmed R36 had been positioned on her coccyx for 1 hour and 35 minutes. On 12/17/2014, at 2:00 p.m. NA-I confirmed that R36 was not repositioned off of her coccyx for 1 hour and 35 minutes.

On 12/17/2014, at 2:42 p.m. RN-D confirmed for proper healing R36 should have been repositioned every hour as directed on the care plan. On 12/18/2014, at 8:54 a.m. the director of nursing (DON) stated R36 should have been repositioned every hour as directed on the care plan. DON confirmed R36's care plan had not been followed.

A policy regarding care plan implementation was requested but none was provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review/revise policies and procedures for utilizing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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) COMPLETE DATE
2 565	Continued From page 6 care plans. The DON could educate all staff on care plan implementation. The DON could develop a system to audit and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and develop interventions for a foot wound for 1 of 1 resident (R67) who had identified open foot wounds. The facility also failed to assess the potential for additional pressure ulcers prior to the implementation of a splint. Findings include: R67 was admitted on 8/6/14 with diagnoses including diabetes, dementia, congestive heart failure (CHF), and peripheral vascular disease	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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) COMPLETE DATE
2 830	Continued From page 7 (PVD). R67 was discharged to Red Lake Hospital on 9/15/14. The Admission Minimum Data Set (MDS) dated 8/12/14 states R67 was at risk of developing pressure ulcers. R67 required extensive assistance with his Activities of Daily Living (ADL ' s), including bed mobility, transferring, personal hygiene, toileting and dressing. There was no initial comprehensive assessment of multiple lower extremity wounds identified on admission. The medical record did not include evidence of the type, location or appearance of each wound; nor a specific corresponding physical assessment for causative factors, treatment or monitoring. According to the National Pressure Ulcer Advisory Panel (NPUAP) wound documentation should include an exact location, type of wound (venous, arterial, diabetic, pressure, or Kennedy terminal ulcer), stage (if a pressure or Kennedy ulcer), dimensions (length, width, depth), undermining, wound base description, drainage, wound edges, odor, pain, and progress. Physician ' s Orders dated 8/9/14 indicated R67 was to have a Prafo Splint (An ankle-foot orthotic to control the positon of the foot and ankle. This type of splint also has positive heel suspension to prevent pressure on the heel) to left foot when in bed or reclining chair. The Braden dated 8/11/14 (5 days after admission) documented a Braden score of 17 (mild risk for developing pressure ulcers) and " 3 small shallow areas on Left LE [lower extremity]. 1 on shin, top of foot and 1 behind ankle. " The wound on the bottom of the left foot was not identified at that time. The Pressure Ulcer Care Area Assessment (CAA) dated 8/15/14 indicated R67 was admitted with open areas, " On foot, these appear to be diabetic ulcers per wound round team. " The CAA identified R67 was, " At risk for pressure	2 830		

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	00017	A. BUILDING: ________ B. WING ________	12/18/2014

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

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2 830	Continued From page 8 ulcers which could result in infection, sepsis, weight loss and discomfort. Complicated by Diabetes Mellitus with Neuropathy, PVD, Atrial Fib [fibrillation], CAD [coronary artery disease] " . The EZ Graph Wound Assessment dated 8/19/14, (13 days after admission), indicated wound on the bottom of the foot, dimensions of 1.2 cm long x 2.5 cm wide, with black and purple wound base. The corresponding skin condition report indicated, " deep tissue injury on bottom of left foot. " The wound was not assessed for potential causative factors, the physician was notified and monitoring was initiated. The EZ Graph on 8/26/14 indicated the wound dimensions of 1.5 cm x 1 cm with a wound base of eschar and slough (dead, unhealthy tissue). The wound base was also described as red. There was a small amount of bloody drainage. The periwound (area around the wound) was identified as macerated (softened skin from moisture). On 8/28/14 the Skin Condition report specified " deep tissue injury slightly larger in length " and to continue with same plan of care. On 9/2/14 the progress was described on the Skin Condition report as, " deep tissue smaller in size/dry skin at area " . The 9/9/14 the report noted the wound was " moist/macerated " . The wound on the bottom of the left foot was not identified on the Minimum Data Set (MDS) or the care plan dated 8/18/14. Although R67 had a Prafo Splint, pressure monitoring was not identified on the plan of care or the CAA. In addition to the lack of assessment for the bottom of R67 ' s left foot wound, the medical record also lacked evidence of tissue perfusion evaluation prior to implementation, or with use of the Prafo splint. The facility ' s Skin Care Protocol specified bruises as "suspected deep tissue injury [DTI]" .	2 830		

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	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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) COMPLETE DATE
2 830	Continued From page 9 DTI were to be monitored " times 5 days, then reassessed " . On 8/22/14 the Medication Administration Record (MAR) directed staff to monitor the DTI. The left foot wound was not addressed on the care plan. On 12/18/14 at 10:00 a.m., registered nurse (RN)-D stated R67 had skin issues upon admission, with multiple areas on his knee, shin and foot. RN-D stated the left foot DTI could have been caused by the Prafo Splint. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies/procedures for wound care. The DON or designee could educate all appropriate staff on wound care systems. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to	2 900		

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

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2 900	Continued From page 10 promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed ensure timely repositioning was provided for 1 of 3 residents (R36) who were identified with a pressure ulcers. Findings include: R36's undated Resident Admission Record indicated R36 had diagnoses that included paralysis agitans, chronic pain syndrome, congestive heart failure, global decline, and osteoarthrosis R36's quarterly Minimum Data Set (MDS) dated 10/7/14, indicated R36 had moderate cognitive impairment, was not ambulatory, and was totally dependent upon two persons for assistance with bed mobility, transfers and toileting. The MDS also identified R36 was at risk for developing a pressure ulcer. R36's Pressure Ulcer Care Area Assessment (CAA) dated 4/24/14, identified R36 was at risk for pressure ulcers and skin rashes/breakdown complicated by her diagnoses of Parkinson's disease, chronic pain, and congestive heart failure. R36's Care Plan dated 10/9/14, identified R36 had decreased physical mobility with the potential for impaired skin integrity. The care plan directed staff to provide extensive assist of 2 staff to turn and reposition every 1 hour. The Skin Condition Report dated 12/9/14 identified R36 had new pressure ulcers on her	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	**1633 DELTON AVENUE BEMIDJI, MN 56601**

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2 900	Continued From page 11 coccyx. The E-Z Graph Wound Assessment Worksheet dated 12/9/14 identified two wounds that were assessed as not stageable due to 10% slough (dead skin or tissue). The wound sizes were measured to be #1) 0.7 centimeter (cm) x 1.1 cm and #2) 0.4 x 1 cm. R36's Braden Scale (for predicting pressure sore risk) dated 12/12/14, identified R36 was at high risk for the development of pressure sores. R36's Tissue Tolerance Assessment dated 12/12/14 indicated a skin change had been noted and recommended Laying - Reposition every hour. The Skin Condition Report dated 12/15/14 indicated no slough and the wound beds looked cleaner. However, the E-Z Graph Wound Assessment Worksheet dated 12/15/14 identified three wounds to R36's coccyx. All three wounds were assessed to be stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough). The wound sizes were measured to be #1) 0.4 cm x 0.7 cm, #2) 1.3 cm x 0.6 cm and #3) 0.9 cm x 1.3 cm. On 12/16/14, at 6:56 p.m. during evening cares, R36's pressure ulcers were observed. Three open areas were noted to R36's coccyx area. The wounds appeared as described on 12/15/14. On 12/17/2014 from 8:12 a.m. until 9:47 a.m. (1 hour and 35 minutes) R36 was continuously observed to be positioned on her coccyx. There were no offers of repositioning. Although R36 was tilted back in her wheelchair during the observation, pressure remained on her coccyx in the area of the pressure ulcers. R36 remained in her wheelchair until transferred into bed at 9:48 a.m.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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

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2 900	Continued From page 12	2 900		

On 12/17/2014, at 10:37 a.m. NA-K verified R36 required repositioning every hour. NA-K confirmed R36 had been positioned on her coccyx for 1 hour and 35 minutes. NA-K stated he was unaware of the amount of time required for off-loading (one full minute of pressure relief) pressure.

On 12/17/2014, at 2:00 p.m. NA-I stated that R36 required turning and repositioning every hour. NA-I confirmed that R36 was not repositioned off of her coccyx for 1 hour and 35 minutes. NA-I indicated he had heard the term off-loading but did not know what that meant.

On 12/17/2014, at 2:04 p.m. NA-J stated R36 required turning every hour due to pressure sores. NA-J indicated she had never heard of offloading.

On 12/17/2014, at 2:42 p.m. R36's pressure ulcer history was reviewed with registered nurse (RN)-D. RN-D stated it was probably not enough pressure relief to go from a seated positioned to slightly tilted in the same chair. RN-D acknowledged R36 probably should have been positioned on her side when put back to bed. RN-D confirmed for proper healing R36 should have been repositioned every hour as directed by the care plan.

On 12/18/2014, at 8:54 a.m. the director of nursing (DON) stated R36 should have been repositioned every hour as directed by the care plan.

SUGGESTED METHOD FOR CORRECTION:
The director of nursing (DON) could develop a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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) COMPLETE DATE
2 900	Continued From page 13 system to ensure pressure ulcer treatment and prevention is individually assessed for appropriate interventions and the interventions implemented. The Director of Nursing could assign the Quality Assurance Committee to provide on-going monitoring of the delivery of care to residents to ensure that pressure sores do not develop unless the resident ' s clinical condition demonstrates that they were unavoidable TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure hand hygiene was performed appropriately during personal cares for 1 of 4 residents (R19) observed during personal cares; and ensure bandage scissors were cleansed appropriately after wound care for 1 of 1 resident (R93) observed during wound care. Findings include: On 12/17/2014, at 10:53 a.m. licensed practical nurse (LPN)-C was observed to gather dressing supplies. LPN-C washed her hands and donned gloves. R93 had a rolled conforming gauze	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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) COMPLETE DATE
21375	Continued From page 14 bandage to her left lower leg. LPN-C cut the soiled bandage off R93's leg with a bandage scissors. LPN-C then discarded the soiled dressing into the trash. The dressing was observed to be soiled with serosanguinous drainage. LPN-C placed the soiled bandage scissors into her pocket without cleaning them. LPN-C then completed wound care for R93. LPN-C returned to the medication cart at the nurses station where she removed the scissors from her pocket and cleansed with an alcohol wipe. LPN-C stated she had always cleaned the scissors between residents utilizing alcohol wipes and utilized a CaviWipe (disinfecting towelette) at the end of the shift. LPN-C stated the facility standard was to use an alcohol wipe between residents, however, she would use the CaviWipe if a resident had a known issue such as MRSA [Methicillin-resistant Staphylococcus aureaus] (a contagious and antibiotic-resistant staph bacteria that leads to potentially dangerous infection). On 12/18/2014, at 8:27 a.m. registered nurse (RN)-D stated she was unsure of the policy regarding cleaning of scissors. RN-D confirmed alcohol would not clean as well as the CaviWipe and would not kill all the organisms a CaviWipe would kill. On 12/18/2014, at 9:02 a.m. the director of nursing (DON) confirmed they should have used a CaviWipe to clean scissors and not an alcohol wipe. The Clean/Sterile Dressing Changes policy dated 3/28/13 directed staff to wash any equipment used, using an alcohol wipe. R19's personal cares were observed and completed without proper handwashing.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ____ B. WING ____	12/18/2014

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) COMPLETE DATE
21375	Continued From page 15	21375		

During observation of personal cares for R19 on 12/17/14, at 8:05 a.m., nursing assistant (NA)-B filled a wash basin in the bathroom with soap and water. NA-B was wearing gloves. NA-B requested R19 wash her hands and face, NA-B washed R19's underarms then the chest and back. NA-B dried R19's back with towel, put R19's bra on and applied deodorant. NA-B took the gloves off and put on R19's shirt. NA donned gloves, rinsed the washcloth, sprayed it with a solution and began perineal cares. NA-B rinsed and sprayed washcloth again. NA-B completed washing R19's bottom, then took gloves off. NA-B draped R19 with a towel and completely removed the wet brief.

At 8:21 a.m. R19's roommate entered the room. NA-B pulled the privacy curtain. NA-B finished dressing R19 and assisted her to the wheelchair. R19 requested mouthwash. NA-B provided an emesis basin and Kleenex to R19 to wipe her mouth. NA-B still had not washed her hands following handling the soiled brief and providing perineal cares.

NA-B donned clean gloves on. NA-B rinsed off dentures, applied polygrip and gave them to R19. NA-B removed the gloves. NA-B then gave R19 Chapstick, a makeup basket, and a mirror. NA-B made the bed, dumped the wash basin, flushed the toilet, refilled wet wipes and washed R19's bedside table. NA-B handled R19's snack and television remote while cleaning up. NA-B removed the garbage and disposed in soiled utility room at 8:40 a.m. No handwashing occurred.

On 12/17/14 at 8:45 a.m. NA-B stated she usually washed her hands before assisting with oral cares. NA-B stated she did wash her hands in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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) COMPLETE DATE
21375	Continued From page 16 bathroom before assisting with teeth and after perineal cares. However, NA-B was continually observed and did not wash her hands at the sink or use hand sanitizer. NA-B then stated not to worry (about hand washing) because 2 pairs of gloves were used. On 12/17/14 10:47 a.m. RN-B stated she would expect handwashing between perineal cares and oral-dental cares. She stated that wearing 2 sets of gloves is not acceptable, and this would be explained to NA-B. The undated Eldercare of Minnesota Hand washing Policy directed staff to wash hands before and after assisting residents with personal cares. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise all facility policies and procedures regarding infection control such as handwashing and equipment cleaning. Education could be provided to all staff. The DON or designee could initiate a monitoring system for ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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

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21540	Continued From page 17	21540		

resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review the facility failed to identify and implement non-pharmacological interventions for 1 of 1 resident (R70) receiving Trazadone (antidepressant) for insomnia.

FINDINGS INCLUDE:

R70 was receiving medication for sleep and did not have specific non-pharmacological interventions to assist in managing insomnia.

R70's Physicians orders dated 11/18/14-12/18/14, identified R70's diagnoses included dementia and insomnia. The physician orders further indicated R70 was to receive Trazadone (antidepressant used for insomnia) 50 milligrams (mg); 1/2 tablet equaling 25 mg at bedtime for insomnia. The medication administration record showed this

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	00017	A. BUILDING: ______ B. WING ______	12/18/2014

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

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21540	Continued From page 18 medication was given every day since it was ordered on 9/20/14. On 12/17/14, at 11:55 a.m. registered nurse (RN)-B stated the insomnia and non-pharmacological interventions were not addressed on the plan of care , "because his medication is prescribed" On 12/17/14, at 1:36 p.m. registered nurse (RN)-C stated, "I am aware that he is receiving Trazadone daily." RN-C further acknowledged there should have been a plan initiated when the medication was started. On 12/18/14, at 8:45 a.m. the DON verified that R70's care plan lacked non-homological interventions as well and she would update the care plan immediately. A policy regarding medication protocol/non-pharmological interventions was requested. The DON stated on 12/17/14 at 2:00 p.m. " I don't believe we have a policy for that." Suggested Method of Correction: The DON or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The staff could be educated on unnecessary medications.The DON or designee could audit to determine if adequate monitoring and documentation was in place. Time Period for Correction: Twenty-one (21) days.	21540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		

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21565	Continued From page 19	21565		

Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure the ability to self administer medications had been assessed prior to the resident self administering medication for 1 of 1 resident (R53) reviewed for dialysis.

The findings include:

R53 was admitted to the facility and according to the care plan dated 11/20/14, R53 had multiple diagnoses including end stage renal disease requiring hemodialysis.

The quarterly Minimum Data Set (MDS) dated 11/18/14, identified R53 had no cognitive impairment, was able to make needs known, and received dialysis.

Review of the physician orders for R53 dated 12/1-24/14 revealed an order for Renvela (a medication that binds phosphorous in food to minimize it's absorption) 600 mg 3 tablets with each meal. The order further directed must be given with meals to be effective.

On 12/17/2014 7:51 a.m. R53 was observed in the dining room eating breakfast. R53 was asked if she had been given the Renvela when she started eating the meal. R53 indicated she had and stated she had forgotten to take them when

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21565	Continued From page 20 she started eating the meal. Review of R53's medical record revealed that R53 had not been assessed for self administration of medications. Additionally, R53 did not have a physician's order to self-administer medication, and the care plan for R53 did not identify that R53 could self administer medication. Review of the facility policy for Self Administration of Medications revised 9/02, identified that residents would be assessed and a physician order would be obtained before any resident could self-administer their own medications. On 12/17/2014, 8:17 a.m. registered nurse (RN)-B confirmed that R53 had not been assessed to self administer medications, and R53 did not have a physician order to self administer any medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures for self administration of medications (SAM). Appropriate staff could be educated on SAM. The DON or designee could develop a system to monitor for compliance with the SAM system. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		

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21665	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate maintenance to resident rooms (#34, 37, 45, 49, 58, 70, 84, 104, 110, 113) and the dining and common areas throughout the facility. Findings include: On 12/17/14, from 9:26 a.m. to 10:10 a.m. a tour of the facility was completed with the environmental service director (ESD). The ESD verified the following resident room concerns: · In room 34, the trim was missing from the wall by the bathroom. · In room 37, there were gouges on the front of the door to the entrance to the room. The gouges were at door knob level and were the width of the door. · In room 45, there was a broken tile behind the toilet on the bathroom wall. · In room 49, the trim on the bathroom door was torn. · In room 58, there were black scuff marks measuring three square feet on the bedside wall of bed 2. In addition, there was old blue paint that needed to be covered up above the light fixtures on the wall above beds 1&2. · In room 70, there were gouges in the bathroom door which were six inches from the bottom of the door and through the width of the door. · In room 84, the north wall had black scuff marks which measured four feet across with areas of chipped paint. · In room 104, the ceiling tile above the entrance to the room was scraped and needed to be replaced.	21665		

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21665	Continued From page 22 · In room 110, at entrance to the room on the right side of the wall had black scuff marks with paint peeling and scrapes down to the sheet rock; there was one bathroom wall tile located on the right of the bathroom door which was cracked and missing; behind the bed were black scuff mark; brown scuff marks located by the headboard and at the foot of the bed; on the bedside wall were two large areas missing paint and scraped down to the white wall. · Room 113 had black scuff marks on the bottom of the wall beside the bathroom. The ESD verified the following concerns in the dining and common areas: · There were two carpet stains measuring one foot in diameter and the other ½ foot in diameter located outside the willow dining room. · The refrigerator in the walnut medication room had a broken seal on the bottom of the door. · The white tile in the walnut dining room area was buckling with some of the edges of the tile being raised and chipped. This area totaled approximately 600 square feet. The ESD stated they are in the process of obtaining bids for replacing the flooring, however did not have a set date of when this would be able to be done. · The hand washing sink/cabinet in the walnut wing had a large scrape on the side of the cabinet and the molding was loose along the back of the cabinet. The ESD confirmed the cabinet needed to be replaced with a larger sink along with the molding. · In the walnut common area at the end of the hallway, approximately 18 inches of the carpet baseboard molding was separated from the wall. There was an area of chipped paint in the corner above the carpet baseboard molding. · In the maple dining room area the radiators	21665		

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21665	Continued From page 23	21665		

along the windows had black scuff marks measuring approximately ten feet. The ESD confirmed the black scuff marks were from the wheelchairs and the radiators needed to be repainted.

On 12/18/14, at 9:45 a.m. the administrator provided some education information [undated] that had went out to all the staff after the last state survey. This educational information indicated that all staff were responsible for notifying the maintenance department of any issues related to the environment such as walls that needed patching, painting, or issues with tile.

Although requested, no policy or procedure related to routine maintenance inspections was provided.

SUGGESTED METHOD OF CORRECTION: The ESD could review/revise policies and procedures related to the maintenance of the facility. The ESD or designee could educate all staff. The ESD or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.