

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 30, 2021

Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, MN 56601

RE: CCN: 245397 Cycle Start Date: October 15, 2021

Dear Administrator:

On November 24, 2021, we notified you a remedy was imposed. On November 23, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 9, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December
- 9, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 2, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 9, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 9, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 2, 2021

Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, MN 56601

RE: CCN: 245397 Cycle Start Date: October 15, 2021

Dear Administrator:

On October 15, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Havenwood Care Center November 2, 2021 Page 2

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

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

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

### DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor Fergus Falls District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Rd., Suite 300 Fergus Falls, Mn. 56537 Email: leann.huseth@state.mn.us Office: (218) 332-5140 Mobile: (218) 403-1100

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Havenwood Care Center November 2, 2021 Page 3

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 15, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 15, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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.

Havenwood Care Center November 2, 2021 Page 4

Feel free to contact me if you have questions.

Sincerely,

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Joanne Simon, Enforcement Specialist Minnesota Department of Health Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			I		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		C	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	CON	E SURVEY IPLETED
		245397	B. WING	i			C 15/2021
NAME OF F	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2021
	OOD CARE CENTER				1633 DELTON AVENUE		
					BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC	000			
F 580 SS=D	to conduct a compl was found to be NC requirements of 42 Requirements for L The following comp SUBSTANTIATED: H5397046C (M000 at F580. The facility's plan of as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an onsite revisit of you validate that substat regulations has been Notify of Changes ( CFR(s): 483.10(g)(14) Not (i) A facility must im consult with the resist representative(s) w (A) An accident invertiges of the constine to the the constine to the the test of the test of the test of the construction of the test of the construction of the constr	was completed at your facility aint investigation. Your facility DT in compliance with the CFR 483, Subpart B, ong Term Care Facilities. Alaint was found to be 77577), with a deficiency cited f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an r facility may be conducted to ontial compliance with the en attained. [Injury/Decline/Room, etc.) 14)(i)-(iv)(15) ification of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which I has the potential for requiring	F 5	580			11/11/21
		ange in the resident's physical, ocial status (that is, a					
		DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
	ically Signed						11/11/2021

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.

PRINTED: 11/15/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245397	B. WING				C 15/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HAVENW	OOD CARE CENTER				1633 DELTON AVENUE BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	status in either life-f clinical complication (C) A need to alter to a need to discontinue treatment due to ad commence a new fr (D) A decision to tra- resident from the far §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informa- is available and pro- physician. (iii) The facility mus- resident and the res- when there is- (A) A change in roo as specified in §483 (B) A change in res- State law or regulat (e)(10) of this section (iv) The facility mus- update the address- phone number of the representative(s). §483.10(g)(15) Admission to a com- that is a composite §483.5) must disclo- its physical configur locations that comp- part, and must spec- room changes betwo under §483.15(c)(9)	The mental, or psychosocial hreatening conditions or ms); reatment significantly (that is, ue an existing form of verse consequences, or to form of treatment); or ansfer or discharge the cility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the t also promptly notify the sident representative, if any, m or roommate assignment 8.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. t record and periodically (mailing and email) and the resident posite distinct part. A facility distinct part (as defined in the in its admission agreement ration, including the various rise the composite distinct cify the policies that apply to veen its different locations	F	580			

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	` ´COM	E SURVEY IPLETED
		245397	B. WING			C 15/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		15/2021
	OOD CARE CENTER	2		,		
				BEMIDJI, MN 56601	LAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 580	Continued From pa	ige 2	F 58	D		
	•	tion, interview and document		R1 was admitted t	o the hospital on	
	review, the facility f	ailed to promptly notify a			d for sepsis secondary	
		ge in condition for 1 of 2		to urinary tract infe		
		ed to on-going urinary tract			on 10/4/21 and has	
		ptoms who required			er signs or symptoms of	
	nospitalization revie	ewed for notification of change.		catheter for treatm	nues to have a foley	
	Findings include:				es flushes three times	
	r mangs molude.			per week to prever		
	R1's annual Minimu	um Data Set (MDS) dated			n reviewed on 11/10/21	
		R1 had moderate impaired			vith interventions to	
	cognition and had o	liagnoses which included:		mitigate risks of th		
		and indwelling catheter. The required extensive assistance		infection r/t use of	indwelling catheter.	
		pcomotion, toilet use, and		Residents who are		
		otal assistance with transfers			elayed notification to the	
		ncouragement and cueing)			ge in condition include	
	with eating.			all residents with p	redisposition to	
	R1's Care Area Ass	sessment (CAA) dated 6/3/21,			itions, and those who	
		rinary incontinence and an			others for care or are	
		The CAA indicated R1			icate their needs to	
		staff assistance with toileting		staff. On 11/9/21,		
		sepsis complicated by multiple		conducted of all re		
	. ,	rogenic bladder, and morbid			ary care provider of a	
	obesity.			change in condition		
	D1's physician's ar	dara datad 10/12/21 idantifiad			r residents have been nt practices regarding	
	the following:	ders dated 10/13/21, identified		delayed notification		
	o ionowing.				n related to an infection.	
	-5/11/21, Indwelling	catheter 18 French (Fr) with				
		loon to straight drainage.		Infection Control p	olicies for antibiotic	
				stewardship have		
		care to be done every shift:			antibiotic stewardship	
	day, evening, and r	night.			rence to and direction	
	0/21/21 Change F	alow 18 Er ovoru 4 waaka			w ongoing evaluation,	
	-9/21/21, Change F	oley 18 Fr every 4 weeks,		documentation and residents who are		
	once a day on the			infections are man		

Facility ID: 00017

If continuation sheet Page 3 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION		E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G			PLETED
		245397	B WING	WING			
	PROVIDER OR SUPPLIER	245397		STREET ADDRESS, CITY, STATE, ZIP		10/′	15/2021
NAME OF F	ROVIDER OR SUPPLIER				33 DELTON AVENUE		
HAVENW	OOD CARE CENTER	2			MIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 580	Continued From pa	ide 3	F 58	0			
1 000	- 1	ed 8/30/21, identified R1 had	F 30		notification to the provider if curre	ot	
		ry catheter related to MS,			antibiotics are effective in treating		
		nd neurogenic bladder and			intended infection, if the current o		
	was at risk for UTIs	<ol> <li>R1's infection prevention</li> </ol>			remain appropriate and directs sta	aff to	
		led: urine output record urine,			notify a resident's primary care pr		
		ges in behavior, lethargy,			should it be discovered that an an		
		n, respiratory changes and			no longer appropriate, if a residen		
		ID) updated as needed (PRN).			condition is not improving or if the needs to be reviewed. The Antib		
	R1's baseline temperature identified at 97.3 Fahrenheit (F).				Stewardship Policy directs staff or		
					to update a provider on stalled or		
		n of temperatures report from , identified the following:		i	ineffective treatments for infection	S.	
	T 07.0	°E 0/04/0004 44 40			Education to the licensed staff on		
		°F 9/21/2021 11:46 a.m. °F 9/22/2021 12:48 a.m.			Antibiotic Stewardship Policy will completed by 11/19/21. Additiona		
		°F 9/22/2021 11:57 p.m.			line list tracker was initiated on 11		
		2 °F 9/28/2021 12:47 a.m.			monitor residents' symptoms of in		
		°F 9/28/2021 3:35 p.m.			in real time to ensure staff awarer		
					both potential and active infection		
		eport from 9/16/21, through			proper interventions are in place a		
	10/4/21, identified t	he following:			appropriate notification to the prov		
	0/16/21 total 2/ hou	ur output documented as			occurred. Infection Preventionist of designee will monitor facility performance designee will monitor facility performance designee		
	none.	di output documented as			to make sure appropriate actions		
		ur output documented as			being taken when a resident is dis		
	none.			:	signs or symptoms of infection or		
		ur output documented 350 ml.			treated for an infection including		
		ur output documented 450 ml.			notification if improvement in sym		
		ur output documented 500 ml. ur output documented as			has not occurred with the treatme has been ordered. Audits on resid		
	none.	ar output documented as			being treated for infections and	Jonio	
		ur output documented as			appropriate monitoring and follow	up	
	none.			i	including notification to the PCP s	hould	
		ur output documented as			treatment become ineffective will		
	none.				5x/week for 2 weeks, 3x/week for	2	
		ur output documented 250 ml.			weeks, and 1x/week for 2 weeks. Immediate education by the IP or		
	9/28/21 through 10	4/2 i nospitalizeu.			designee will be provided to nursi		

Facility ID: 00017

If continuation sheet Page 4 of 12

		AND HUMAN SERVICES				FORM	11/15/202 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY PLETED
		245397	B. WING				C 15/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10,	10/2021
HAVENW	OOD CARE CENTER	R			633 DELTON AVENUE EMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	Continued From pa	age 4	F٤	580			
		e urine output report document ugh 9/28//21, identified the			should it be found that improvement status has stalled during course of treatment and PCP has not been	f	
	482 ml.	21/21 7 day average output 28/21 7 day average output //4/21 hospitalized.			The results of the monitoring com under this Plan of Correction will submitted to the QAPI Committee review and further follow-up at ne meeting.	be for	
	R1's oral intake rep 10/15/21, identified	oort from 9/5/21, through I the following:					
	documented. 10/9/21, 240 ml ora	/8/21, no oral intake al intake. 10/15/21, no oral intake					
	R1's progress note 9/28/21, identified:	s from 9/13/21, through					
		m. call placed to urology nurse follow up on R1's bladder					
		m. R1's urine very thick with nd had foul odor present.					
		o.m. R1's urine dark, cloudy, r. Urine collected for a e culture.					
	be started on antib	a.m. orders received for R1 to iotic, Macrobid 100 milligrams ) 4 times a daily times 5 days					
	-9/20/21, at 3:37 p.	m. writer left message with					

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		AND HUMAN SERVICES				FORM	11/15/2021 APPROVED 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245397	B. WING				C 15/2021
NAME OF PROVIDER O	R SUPPLIER		· [	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAVENWOOD CAR	RE CENTER				633 DELTON AVENUE SEMIDJI, MN 56601		
PREFIX (EACH	H DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
urology t due to he discolora -9/21/21, regarding on an an monitor. -9/22/21, dark, yel foul odor -9/24/21, with sedi reported are unde out that r they will -9/25/21, UTI. R1's had a fou -9/26/21, noted in regarding -9/28/21, 100.0 F. upset sto -9/28/21, current o complair been 99, due to hi	er new UTI ation of urin , at 11:23 a g urine and tibiotic for , at 1:24 p.1 low sedime , at 1:37 p.1 ment and I two ghosts r my bed a my husban not leave." , at 6:31 p.1 s urine darl ul smell. , through 9, R1's medic g her condi g he	restarting catheter flushes and increased odor and he since stopping on 9/13/21. m. spoke with urology today I sediment. She was currently UTI and will continue to m. R1's urine remained very ent noted in tubing, and had a m. R1's urine was tea colored had a very foul smell. R1 is remained in her room. "They and keep me awake. I found d brought them here, and now m. R1 completed antibiotic for k amber/thick sediment, and /27/21, no documentation cal record progress notes	F 5	580			

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		AND HUMAN SERVICES				FORM	11/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245397	B. WING			( 10/1	) 15/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAVENW	OOD CARE CENTER	1			633 DELTON AVENUE BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 6	F٤	580			
	emergency room (E physician related to ambulance. R1's ur in color with sedime signs and symptom cool/pale/clammy, o intake, decreased i encouraged fluids. -9/28/21, at 10:41 p local medical cente antibiotics for UTI, a fistula. Review of R1's Em- documentation date emergency medicir the indwelling Foley home had not been was particulate mat feculent material. T after the computed been completed. El catheter and immed brown, turbid fluid f collection bag and a to lab. The EMP ind irregular thickening with multiple bladder wa and/or UTIs) seen. surrounding inflamm pelvis. EMP identifi-	m. R1 transferred to ER) for evaluation per primary UTI and possible sepsis by ine smelled like feces, brown ent. R1 continued to show as of UTI: lethargic, fever, confusion, poor appetitive/oral in urine output despite staff o.m. R1 had been admitted to r, treated with intravenous (IV) and questioned a possible ergency room (ER) visit ed 9/28/21, at 7:54 p.m. he physician (EMP) identified y catheter from the nursing draining and verified there ther in the tube consistent with he existing tube was removed tomography (CT) scan had MP placed a new indwelling diate drainage of opaque lowed into the urinary a sample had been sent sent dicated there was marked of the urinary bladder wall er diverticuli (out pouching all caused by urinary retention Additionally, there was matory changes noted in the ed the appearance of the y have been related to chronic and/or chronic cystitis e bladder).					

If continuation sheet Page 7 of 12

		AND HUMAN SERVICES				FORM	: 11/15/2021 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DAT COM	E SURVEY IPLETED
		245397	B. WING	i			C 15/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
HAVENV	VOOD CARE CENTER	1			1633 DELTON AVENUE BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	Review of R1's ER identified the follow - Procalcitonin - abu liter (normal range of sepsis less than 0.5 infection). -White blood count (normal range 5,00 infection). -Urinalysis (UA) - a Clarity of urine: Tur urine: large +3, leuk infection) large +3, epithelial cells (dete Review of R1's hos dated 9/28/21, at 10 identified R1 had a acute cystitis with h associated with a c catheter had thick, colored urine, and u Review of R1's hos dated 10/4/21, at 10 physician (IMP) ide with a complicated cystitis. R1's compu- showed moderate to kidneys swelled up blockage or obstruct Review of R1's NP 10/11/21, at 11:24 a indwelling catheter	lab values dated 9/28/21, ing: normal 0.21 micrograms per 0 to 0.05 and low risk for 5) (identified a bacterial (WBC) - abnormal 14.3 ml 0 - 10,000/ml) (identified bnormal color of urine: brown bid (milky/cloudy), Blood in cocytes (blood cells that detect bacteria many, and squamous ect UTI/infection). pital admission document 0:53 p.m. hospitalist (AH) complicated UTI that included: ematuria (blood in the urine) hronic foley catheter. R1's foul smelling, light brown urinary irritation. pital discharge summary 0:36 a.m. internal medicine ntified R1 had been admitted UTI and acute and chronic uted tomography (CT) scan pilateral hydronephrosis (both due to a build up of urine from	F	580			

If continuation sheet Page 8 of 12

		AND HUMAN SERVICES				FORM	11/15/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245397	B. WING	i			C 15/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HAVENV	VOOD CARE CENTER	Ł			633 DELTON AVENUE BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	occlusion of the tub discontinued on 9/1 9/20/21, R1 had a U antibiotics, symptor febrile, and transfer NP had not been no been discontinued. During an interview stated she has had During an interview licensed practical n been considered a verified a doctor ha 9/21/21, and 9/28/2 of R1's urine being concentrated. LPN- expected to contact R1's ongoing urinar requested a follow of R1's urine had been she had been sent had been plugged. day nurse never rep for that day. During a follow up i a.m. LPN-A verified documentation of F through 9/27/21. LF expected to docum if the catheter had b could have been m During an interview nursing assistant (N had been a dark tea	obing. The flushes had been 11/21, per R1's request. On UTI and had been treated with ms worsened, R1 became rred to the ER on 9/28/21. The otified the foley flushes had of on 10/14/21, at 11:40 a.m. R1 many UTIs. of 10/14/21, at 11:40 a.m. R1 many UTIs. of 00 10/14/21, at 11:24 p.m. hurse (LPN)-A stated R1 had high risk for a UTI. LPN-A ad not been notified between 21, about continued concerns dark, foul smelling, and -A identified staff were t a doctor right away regarding ry symptoms and should have up UA/UC. LPN-A verified n brown with thick sediment; to the ER, and her catheter LPN-A stated on 9/28/21, the ported R1 had no urine output	F	580			

Facility ID: 00017

If continuation sheet Page 9 of 12

		AND HUMAN SERVICES				FORM	11/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COMI	E SURVEY PLETED
		245397	B. WING				C 15/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HAVENV	OOD CARE CENTER				1633 DELTON AVENUE BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	output each shift af been emptied. NA-/ expected to inform in status. NA-A indic changed with noted hallucinations of se During an interview NA-B stated R1's u with a strong odor r 9/27/21. NA-B indic groggy and not her Additionally, NA-B indic groggy and not her Additionally, NA-B indic 9/28/21. NA-B indic nurse regarding the During an interview LPN-B stated R1's documented at the verified staff would contact a doctor rig continued urinary tr low urinary output. During a phone inte a.m. primary provid should have been of R1's ongoing urinar and change in cond scan identified infla with cystitis as well carries urine from th bladder) concerning bacteria and starts could have been fro a plugged urinary of facility nurses would	ter the collection bag had A indicated staff were the nurse about R1's changes cated R1's behaviors had I increased confusion, and eing ghosts. Toon 10/14/21, at 2:12 p.m. rine had been dark in color noted on the evening of sated R1 had been very usual self when she spoke. stated R1 had been confused ons of seeing ghosts on sated she had updated the	Fξ	580			

Facility ID: 00017

If continuation sheet Page 10 of 12

		AND HUMAN SERVICES				FORM	11/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		245397	B. WING				C 15/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	:	
HAVENW	OOD CARE CENTER	1			633 DELTON AVENUE BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	During an interview assistant director of had been a continu condition and her d ADON indicated sta addressed the cond 9/28/21, and should physician or the on ADON verified R1 of documented for 9/2 ADON stated staff document R1's urin ADON stated R1's i been stopped, the of to be removed and room on 9/28/21, and admitted to the hos Facility policy titled Assistants reviewed assistant's respons help prevent infection should help to prevent with catheters by ch catheter was drainin output in the proper were expected to en the spigot on the bo each shift and reco Facility policy titled 4/2015, identified sta hour period. The pr certified nursing assistants and states assistants and states assistants assistants and states and a states and states and states as a state and states and a states as a states as a states assistants and records assistants and records assistants and records assistants as a states as a states as a states and a states as a states as a states as a states and a states as a states as a states as a states and a states as a states as a states as a states as a states and a states as a states	been monitored closer. To n 10/15/21, at 10:49 a.m. f nursing (ADON) stated there ed concern regarding R1's ecreased urinary output. aff were expected to have beens much sooner than d have contacted a primary call after hours physician. did not have any urine output 25/21, 9/26/21, or 9/27/21. were expected to monitor and ary output on every shift. indwelling catheter flushes had catheter became plugged, had replaced in the emergency nd R1 had subsequently been pital. Catheter Care for Nursing d 4/2015, identified the nursing ibility in catheter care was to on. The nursing assistant ent infection in the residents hecking to make sure the ng properly and recording manner. Additionally, they mpty the drainage bag from ottom of the bag at the end of rd the output. Intake and Output reviewed taff were to keep an accurate aken in and put out in a 24 ocedure indicated each sistant (CNA) would keep a	F 5	580			
	measure of fluids ta hour period. The pr certified nursing as running record of in	aken in and put out in a 24 ocedure indicated each					

If continuation sheet Page 11 of 12

		AND HUMAN SERVICES				FORM	: 11/15/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245397	B. WING				C 1 <b>5/2021</b>
NAME OF	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAVENV	OOD CARE CENTER	ł			633 DELTON AVENUE BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 580	designated to be or When a resident we intake amount wou sheet in the dining it was to be emptied	age 11 n intake (I) and output (O). as given fluids at mealtime the ld be recorded on the intake room. If a resident had a Foley d at the end of the shift, orded on the CNA's treatment	F 5	580			

Facility ID: 00017

If continuation sheet Page 12 of 12



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 2, 2021

Administrator Havenwood Care Center 1633 Delton Avenue Bemidji, MN 56601

Re: State Nursing Home Licensing Orders Event ID: 4PEP11

Dear Administrator:

The above facility was surveyed on October 14, 2021 through October 15, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Havenwood Care Center November 2, 2021 Page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

LeAnn Huseth, RN, Unit Supervisor Fergus Falls District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Rd., Suite 300 Fergus Falls, Mn. 56537 Email: leann.huseth@state.mn.us Office: (218) 332-5140 Mobile: (218) 403-1100

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00017	B. WING		0 ( 10/1	) 5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAVENW	OOD CARE CENTER	1633 DEL	TON AVENU MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Ple plan of correction ye	TS: 15/21, a complaint survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 11/11/21

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 13

Minnesc	ta Department of He	alth			FURIN	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00017	B. WING			C 15/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
	VOOD CARE CENTER	, 1633 DEI	TON AVENUE	E		
HAVENV		BEMIDJI	, MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED:	plaints were found to be 1077577), with licensing order				
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." For	nent of Health is documenting Correction Orders using Tag numbers have been tota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix nute/rule out of compliance is nary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyor's findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Depa Informational Bullet https://www.health. n/infobulletins/ib14_ orders are delineate	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota Ith orders being submitted to				
	State Statutes/Rule "CORRECTED" in t must then indicate licensure process, date, the date your to electronically sub	f correction is necessary for es, please enter the word the box available for text. You in the electronic State under the heading completion orders will be corrected prior omitting to the Minnesota Ith. The facility is enrolled in				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		СОМ ( COM	E SURVEY PLETED C	
		00017	B. WING 1			0/15/2021	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
HAVENV	OOD CARE CENTER		TON AVENUE MN 56601				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
2 000	Continued From pa	ge 2	2 000				
		e a signature is not required at st page of state form.					
	FOURTH COLUMN "PROVIDER'S PLA	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.					
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			11/11/21	
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	st develop and implement off decisions to consult an assistants, and nurse known, notify the resident's or an interested family nt's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:					
		involving the resident which has the potential for requiring on;					
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening I complications;					
	example, a need to	er treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY
			A. BUILDING		
		00017	B. WING	10	C / <b>15/2021</b>
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	OOD CARE CENTER	, 1633 DEL	TON AVENU	JE	
		BEMIDJI,	MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
2 265	Continued From pa	age 3	2 265		
	D. a decision resident from the n	to transfer or discharge the ursing home; or			
	E. expected ar	nd unexpected resident deaths.			
	by:	ent is not met as evidenced ion, interview and document		R1 was admitted to the hospital on	
	review, the facility f physician of a char residents (R1) rela	ailed to promptly notify a ige in condition for 1 of 2 ted to on-going urinary tract		9/28/21 and treated for sepsis secondary to urinary tract infection. Resident returned to facility on 10/4/21 and has	
		ptoms who required ewed for notification of change.		displayed no further signs or symptoms o infection. R1 continues to have a foley catheter for treatment of neurogenic	f
	Findings include:			bladder and receives flushes three times per week to prevent further infection.	
	8/25/21, identified I cognition and had on neurogenic bladder	um Data Set (MDS) dated R1 had moderate impaired diagnoses which included: r and indwelling catheter. The		Care plan has been reviewed on 11/10/21 and is up to date with interventions to mitigate risks of the development of infection r/t use of indwelling catheter.	
	with bed mobility, lo personal hygiene, t and supervision (er	required extensive assistance ocomotion, toilet use, and otal assistance with transfers ncouragement and cueing)		Residents who are at risk for complications of delayed notification to th provider with change in condition include	е
		sessment (CAA) dated 6/3/21,		all residents with predisposition to infection, compromised immune systems fragile health conditions, and those who	,
	indwelling catheter required extensive	rinary incontinence and an The CAA indicated R1 staff assistance with toileting		are dependent on others for care or are unable to communicate their needs to staff. On 11/9/21, an audit was	
		sepsis complicated by multiple irogenic bladder, and morbid		conducted of all residents related to notification of primary care provider of a change in condition resulting from an infection. No other residents have been	
	R1's physician's or the following:	ders dated 10/13/21, identified		affected by deficient practices regarding delayed notification to providers for a change in condition related to an infectior	1.
	-5/11/21 Indwelling	catheter 18 French (Fr) with			

If continuation sheet 4 of 13

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		00017	<u> </u>		10/15/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
HAVENW	VOOD CARE CENTER		TON AVENU MN 56601	JE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPL
2 265	Continued From pa	ige 4	2 265		
	30 milliliter (ml) ball	loon to straight drainage.		Infection Control policies for antibioti stewardship have been reviewed on	
	-9/21/21, Catheter	care to be done every shift:		11/2/21. Within the antibiotic steward	
	day, evening, and r			policy there is reference to and direc nursing staff how ongoing evaluation	tion to
		oley 18 Fr every 4 weeks,		documentation and assessment of	
	once a day on the 1	1st of every month.		residents who are being treated for	
	Dila sana mlan data	d 0/20/21 identified D1 had		infections are managed. This includ	les
		ed 8/30/21, identified R1 had		notification to the provider if current antibiotics are effective in treating the	0
		nd neurogenic bladder and		intended infection, if the current orde	
		R1's infection prevention		remain appropriate and directs staff	
		led: urine output record urine ,		notify a resident's primary care provi	
	monitored for chang	ges in behavior, lethargy,		should it be discovered that an antib	iotic is
		, respiratory changes and		no longer appropriate, if a resident's	
		ID) updated as needed (PRN).		condition is not improving or if the or	
		erature identified at 97.3		needs to be reviewed. The Antibioti	
	Fahrenheit (F).			Stewardship Policy directs staff on w to update a provider on stalled or	vnen
	R1's documentation	n of temperatures report from		ineffective treatments for infections.	
		, identified the following:			
	,,			Education to the licensed staff on	
		°F 9/21/2021 11:46 a.m.		Antibiotic Stewardship Policy will be	
		°F 9/22/2021 12:48 a.m.		completed by 11/19/21. Additionally	
		°F 9/22/2021 11:57 p.m.		list tracker was initiated on 11/4/21 to	
		2 °F 9/28/2021 12:47 a.m. °F 9/28/2021 2:35 p m		monitor residents' symptoms of infec	
	remperature: 99.4	°F 9/28/2021 3:35 p.m.		in real time to ensure staff awarenes both potential and active infections, t	
	R1's urine output re	eport from 9/16/21, through		proper interventions are in place and	
	10/4/21, identified t			appropriate notification to the provide	
	,	5		occurred. Infection Preventionist or	
	9/16/21 total 24 hou	ur output documented as		designee will monitor facility perform	
	none.			to make sure appropriate actions are	
		ur output documented as		being taken when a resident is displa	
	none. $0/18/21$ total 24 has	in output doourcosted 250 ml		signs or symptoms of infection or is	being
		ur output documented 350 ml. ur output documented 450 ml.		treated for an infection including notification if improvement in symptom	me
		ur output documented 500 ml.		has not occurred with the treatment	
		ur output documented as		has been ordered. Audits on resider	
	none.			being treated for infections and	

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00017		LE CONSTRUCTION	COMF	SURVEY PLETED
						5/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAVENV	VOOD CARE CENTER		LTON AVENU , MN 56601	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLE DATE
2 265	Continued From pa	ge 5	2 265			
2 203	9/26/21 total 24 hou none. 9/27/21 total 24 hou none. 9/28/21 total 24 hou 9/28/21 total 24 hou 9/28/21 through 10/ R1's 7 day average from 9/15/21, through 9/2 482 ml. 9/22/21 through 9/2 550 ml. 9/29/21 through 9/2 550 ml. 9/29/21 through 10/ R1's oral intake rep 10/15/21, identified 9/5/21, through 10/8 documented. 10/9/21, 240 ml ora 10/10/21, through 1 documented. R1's progress notes 9/28/21, identified: -9/13/21, at 1:24 p.r practioner (NP) to fe irrigation orders. -9/15/21, at 8:16 p.r yellow sediment and -9/16/21, at 10:35 p	ar output documented as ar output documented as ar output documented 250 ml. 24/21 hospitalized. arine output report document gh 9/28//21, identified the 21/21 7 day average output 24/21 hospitalized. art from 9/5/21, through the following: 26/21, no oral intake		appropriate monitoring and including notification to the treatment become ineffectiv 5x/week for 2 weeks, 3x/we weeks, and 1x/week for 2 w Immediate education by the designee will be provided to should it be found that impr status has stalled during co treatment and PCP has not The results of the monitorin under this Plan of Correctio submitted to the QAPI Com review and further follow-up meeting.	PCP should ve will occur eek for 2 veeks. e IP or o nursing staff ovement in ourse of been notified. ag completed on will be mittee for	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 6	2 265			
	be started on antibi	a.m. orders received for R1 to iotic, Macrobid 100 milligrams ) 4 times a daily times 5 days				
	urology to consider due to her new UTI	m. writer left message with restarting catheter flushes and increased odor and ne since stopping on 9/13/21.				
	regarding urine and	a.m. spoke with urology today d sediment. She was currently UTI and will continue to				
		m. R1's urine remained very ent noted in tubing, and had a				
	with sediment and reported two ghosts are under my bed a	m. R1's urine was tea colored had a very foul smell. R1 s remained in her room. "They and keep me awake. I found id brought them here, and now				
		m. R1 completed antibiotic for k amber/thick sediment, and				
		/27/21, no documentation cal record progress notes ition.				
		a.m. low grade temperature ired than normal, and had				
	-9/28/21, at 6:20 p. current condition. F epartment of Health	m. Staff concerned about R1's R1 pale in color and				

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2 265	Continued From pa	ge 7	2 265			
	been 99.4 F. R1 en due to history of UT	g cold. R1's temperature had couraged to drink more water Is and refused supper. Staff er to document output in				
	emergency room (E physician related to ambulance. R1's ur in color with sedime signs and symptom cool/pale/clammy, o	m. R1 transferred to ER) for evaluation per primary o UTI and possible sepsis by rine smelled like feces, brown ent. R1 continued to show as of UTI: lethargic, fever, confusion, poor appetitive/oral n urine output despite staff				
	local medical cente	o.m. R1 had been admitted to r, treated with intravenous (IV) and questioned a possible				
	documentation date emergency medicin the indwelling Foley home had not been was particulate mat feculent material. T after the computed been completed. El catheter and immed brown, turbid fluid f collection bag and a	ergency room (ER) visit ed 9/28/21, at 7:54 p.m. he physician (EMP) identified y catheter from the nursing h draining and verified there tter in the tube consistent with he existing tube was removed tomography (CT) scan had MP placed a new indwelling diate drainage of opaque lowed into the urinary a sample had been sent sent dicated there was marked				
	irregular thickening with multiple bladde from the bladder wa and/or UTIs) seen. surrounding inflam	of the urinary bladder wall of the urinary bladder wall er diverticuli (out pouching all caused by urinary retention Additionally, there was matory changes noted in the ed the appearance of the				

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outflow obstruction	and/or chronic cystitis				
liter (normal range	0 to 0.05 and low risk for				
Clarity of urine: Tur urine: large +3, leul infection) large +3,	bid (milky/cloudy), Blood in kocytes (blood cells that detec bacteria many, and squamous				
dated 9/28/21, at 10 identified R1 had a acute cystitis with h associated with a c catheter had thick,	0:53 p.m. hospitalist (AH) complicated UTI that included nematuria (blood in the urine) hronic foley catheter. R1's foul smelling, light brown	:			
dated 10/4/21, at 10 physician (IMP) ide with a complicated cystitis. R1's complicated showed moderate b kidneys swelled up	0:36 a.m. internal medicine ntified R1 had been admitted UTI and acute and chronic uted tomography (CT) scan bilateral hydronephrosis (both due to a build up of urine from				
	OF CORRECTION PROVIDER OR SUPPLIER <b>JOOD CARE CENTER</b> <b>JOOD CARE CENTER</b> <b>SUMMARY STA</b> (EACH DEFICIENCY REGULATORY OR L Continued From pa urinary bladder ma outflow obstruction (inflammation of that Review of R1's ER identified the follow - Procalcitonin - ab liter (normal range sepsis less than 0.4 infection). -White blood count (normal range 5,00 infection). -Urinalysis (UA) - a Clarity of urine: Tur urine: large +3, leul infection) large +3, epithelial cells (dete Review of R1's host dated 9/28/21, at 11 identified R1 had a acute cystitis with h associated with a co catheter had thick, colored urine, and the Review of R1's host dated 10/4/21, at 11 physician (IMP) ide with a complicated cystitis. R1's compli- showed moderate I kidneys swelled up	OF CORRECTION         IDENTIFICATION NUMBER:           00017         00017           PROVIDER OR SUPPLIER         STREET A           1633 DE BEMIDJI         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 8         urinary bladder may have been related to chronic outflow obstruction and/or chronic cystitis (inflammation of the bladder).           Review of R1's ER lab values dated 9/28/21, identified the following:         -           - Procalcitonin - abnormal 0.21 micrograms per liter (normal range 0 to 0.05 and low risk for sepsis less than 0.5) (identified a bacterial infection).           -White blood count (WBC) - abnormal 14.3 ml (normal range 5,000 - 10,000/ml) (identified infection).         -           -Urinalysis (UA) - abnormal color of urine: brown Clarity of urine: Turbid (milky/cloudy), Blood in urine: large +3, bacteria many, and squamous epithelial cells (detect UTI/infection).           Review of R1's hospital admission document dated 9/28/21, at 10:53 p.m. hospitalist (AH) identified R1 had a complicated UTI that included acute cystitis with hematuria (blood in the urine) associated with a chronic foley catheter. R1's catheter had thick, foul smelling, light brown colored urine, and urinary irritation.           Review of R1's hospital discharge summary dated 10/4/21, at 10:36 a.m. internal medicine physician (IMP) identified R1 had been admitted with a complicated UTI and acute and chronic cystitis. R1's computed tomography (CT) scan showed moderate bilateral hydronephrosis (both	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF CORRECTION       IDENTIFICATION NUMBER:       A.BUILDING:         00017       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         2000 CARE CENTER       1633 DELTON AVENUE BEMIDJI, MN 56601         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDE BE PRECDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF (EACH DEFICIENCY WIDE BE PRECDED BY FULL TAG         Continued From page 8       2 265         urinary bladder may have been related to chronic outflow obstruction and/or chronic cystitis (inflammation of the bladder).       PREFIX         Review of R1's ER lab values dated 9/28/21, identified the following:       -         - Procalcitonin - abnormal 0.21 micrograms per liter (normal range 0 to 0.05 and low risk for sepsis less than 0.5) (identified a bacterial infection).       -         -Urinalysis (UA) - abnormal color of urine: brown Clarity of urine: Turbid (milky/cloudy), Blood in urine: large +3, leukocytes (blood cells that detect infection) large +3, backrait many, and squamous epithelial cells (detect UTI/infection).         Review of R1's hospital admission document dated 9/28/21, at 10:53 p.m. hospitalist (AH) identified R1 had a complicated UTI that included: acute cystitis with hematuria (blood in the urine) associated with a chronic foley catheter. R1's catheter had thick, foul smelling, light brown colored urine, and urinary irritation.         Review of R1's hospital discharge summary dated 10/4/21, at 10:36 a.m. internal medicine physician (IMP) identified R1 had been admitted with a complicat	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     10/       00017     B. WING     10/       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     10/       COD CARE CENTER     1633 DELTON AVENUE     BEMIDJI, MN 56601       SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REQUARTORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX     PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ON USE DENTIFYING INFORMATION)       Continued From page 8     2 265       urinary bladder may have been related to chronic outflow obstruction and/or chronic cystitis (inflammation of the bladder).     2 265       Review of R1's ER lab values dated 9/28/21, identified the following:     -       - Procalcitonin - abnormal 0.21 micrograms per lifer (normal range 0 to 0.05 and low risk for sepsis less than 0.5) (identified a bacterial infection).       -White blood count (WBC) - abnormal 14.3 ml (normal range 4.3, bacteria many, and squamous epithelial cells (detect UT/linfection).       -Urinalysis (UA) - abnormal color of urine: brown Clarity of urine: Turbid (milky/cloudy), Blood in urine: large 4.3, bacteria many, and squamous epithelial cells (detect UT/linfection).       Review of R1's hospital admission document dated 9/28/21, at 10:53 p.m. hospitalist (AH) isosciated With a chronic foley catheter. R1's catheter had thick, foul smelling, light brown colored urine, and urinary irritation.       Review of R1's hospital admission document dated 10/4/21, at 10:53 a.m. internal medicine physician (IMP) identified R1 had been admitted with a complicated UTI and acute and

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2 265	Continued From pa	age 9	2 265			
	indwelling catheter had decreased the occlusion of the tub discontinued on 9/7 9/20/21, R1 had a antibiotics, symptor febrile, and transfer NP had not been no been discontinued.	/ on 10/14/21, at 11:40 a.m. R1				
	licensed practical n been considered a verified a doctor ha 9/21/21, and 9/28/2 of R1's urine being concentrated. LPN expected to contac R1's ongoing urinal requested a follow R1's urine had bee she had been sent had been plugged.	v on 10/14/21, at 1:24 p.m. hurse (LPN)-A stated R1 had high risk for a UTI. LPN-A ad not been notified between 21, about continued concerns dark, foul smelling, and -A identified staff were et a doctor right away regarding ry symptoms and should have up UA/UC. LPN-A verified n brown with thick sediment; to the ER, and her catheter LPN-A stated on 9/28/21, the ported R1 had no urine output				
	a.m. LPN-A verified documentation of F through 9/27/21. LF expected to docum	interview on 10/15/21, at 9:15 d there had been no R1's urine output from 9/25/21, PN-A stated staff were lent the output every shift even been leaking so the output lonitored.				
		/ on 10/14/21, at 1:52 p.m. NA)-A stated R1's urine color				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		COM	E SURVEY PLETED C
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Continued From pa	ge 10	2 265			
<ul> <li>2 265 Continued From page 10</li> <li>had been a dark tea color on 9/28/21. NA-A stated staff were expected to document the urine output each shift after the collection bag had been emptied. NA-A indicated staff were expected to inform the nurse about R1's changes in status. NA-A indicated R1's behaviors had changed with noted increased confusion, and hallucinations of seeing ghosts.</li> <li>During an interview on 10/14/21, at 2:12 p.m. NA-B stated R1's urine had been dark in color with a strong odor noted on the evening of 9/27/21. NA-B indicated R1 had been very groggy and not her usual self when she spoke. Additionally, NA-B stated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated she had updated the nurse regarding those changes.</li> </ul>					
LPN-B stated R1's documented at the verified staff would contact a doctor rig	urine output should have been end of each shift. LPN-B have been expected to ht away when R1 had				
a.m. primary provid should have been of R1's ongoing urinar and change in cond scan identified infla with cystitis as well carries urine from th bladder) concerning bacteria and starts could have been fro	er (PP) stated a provider contacted sooner regarding y tract infection symptoms lition. PP indicated R1's CT mmatory changes consistent as dilated ureters (a tube that he kidney to the urinary g for ascending (caused by in the bladder) infection and om the back up of urine due to				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pathad been a dark tea stated staff were ex- output each shift af been emptied. NA-/ expected to inform in status. NA-A indic changed with noted hallucinations of se During an interview NA-B stated R1's u with a strong odor r 9/27/21. NA-B indic groggy and not her Additionally, NA-B indic groggy and not her Additionally, NA-B indic groggy and not her Additionally, NA-B indic nurse regarding the During an interview LPN-B stated R1's documented at the verified staff would contact a doctor rig continued urinary tr low urinary output. During a phone inter a.m. primary provid should have been of R1's ongoing urinar and change in cond scan identified infla with cystitis as well carries urine from th bladder) concerning bacteria and starts could have been from	OF CORRECTION         IDENTIFICATION NUMBER:           00017         00017           PROVIDER OR SUPPLIER         STREET AI           1633 DEI         BEMIDJI           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         If an	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00017       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         YOOD CARE CENTER       1633 DELTON AVENUE BEMIDJI, MN 56601         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 10       2 265         had been a dark tea color on 9/28/21. NA-A stated staff were expected to document the urine output each shift after the collection bag had been emptied. NA-A indicated staff were expected to inform the nurse about R1's changes in status. NA-A indicated R1's behaviors had changed with noted increased confusion, and hallucinations of seeing ghosts.       2         During an interview on 10/14/21, at 2:12 p.m. NA-B stated R1's urine had been dark in color with a strong odor noted on the evening of 9/27/21. NA-B indicated Staff when she spoke. Additionally, NA-B stated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated she had updated the nurse regarding those changes.         During an interview on 10/14/21, at 3:45 p.m. LPN-B stated R1's urine output should have been documented at the end of each shift. LPN-B verified staff would have been expected to contact a doctor right away when R1 had continued urinary tract symptoms which included low urinary output.         During a phone interview on 10/15/21, at 9:13 a.m. primary provider (PP) stated a provider should have been contacted sooner regarding R1's ongoing urinary tract infection symptoms and change in condition. PP indicated R1's CT scan identified inflammatory changes consistent wit	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:         00017       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         2000 CARE CENTER       1633 DELTON AVENUE BEMIDJI, MN 56601         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDCIES REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIDER CORRECTIVE ACI (EACH CORRECTIVE ACI (EA	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     100       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     100       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     100       SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE       REQUINTORY ON LSC IDENTIFYING INFORMATION)     PREPRX     IEACH CORRECTIVE ACTION SHOULD BE       Continued From page 10     2 265     2 265       had been a dark tea color on 9/28/21. NA-A stated staff were expected to document the urine output each shift after the collection bag had been emptied. NA-A indicated staff were expected to inform the nurse abult R1's changes in status. NA-A. Andicated R1's behaviors had changed with noted increased confusion, and hallucinations of seeing ghosts.     2 265       During an interview on 10/14/21, at 2:12 p.m.     NA-B stated R1's urine had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated R1 had been orbug 20/27/21. NA-B indicated R1 had been confused and had hallucinations of seeing ghosts on 9/27/21. NA-B indicated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated R1 had been confused and had hallucinations of seeing ghosts on 9/28/21. NA-B indicated R1 had been confused informatexi many movider (PP) stated a provider should have been c

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2 265	Continued From pa	ge 11	2 265			
		had been plugged sooner if been monitored closer.				
	assistant director of had been a continu condition and her d ADON indicated sta addressed the cond 9/28/21, and should physician or the on ADON verified R1 of documented for 9/2 ADON stated staff document R1's urin ADON stated R1's been stopped, the of to be removed and	on 10/15/21, at 10:49 a.m. f nursing (ADON) stated there ed concern regarding R1's ecreased urinary output. aff were expected to have cerns much sooner than d have contacted a primary call after hours physician. did not have any urine output 25/21, 9/26/21, or 9/27/21. were expected to monitor and lary output on every shift. indwelling catheter flushes had catheter became plugged, had replaced in the emergency nd R1 had subsequently been pital.				
	Assistants reviewed assistant's respons help prevent infection should help to prevent with catheters by ch catheter was draining output in the proper were expected to end the spigot on the boo each shift and recon Facility policy titled	Intake and Output reviewed				
	measure of fluids ta hour period. The pr certified nursing as running record of in	taff were to keep an accurate aken in and put out in a 24 ocedure indicated each sistant (CNA) would keep a take and output on their shift pockets on those residents				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00017			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED C 10/15/2021	
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2 265	designated to be or When a resident we intake amount wou sheet in the dining it was to be emptie measured and reco sheets. SUGGESTED MET administrator or de and implement poli the resident's physic change in a resider to alter treatment, a requirements. The assurance committa audits to ensure co	n intake (I) and output (O). as given fluids at mealtime the ild be recorded on the intake room. If a resident had a Foley d at the end of the shift, orded on the CNA's treatment THOD OF CORRECTION: The signee could develop/revise icies and procedures to assure ician is notified of significant nt's condition and/or the need and educate staff on these quality assessment and tee could perform random					