DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 21, 2022

Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

RE: CCN: 245397
Cycle Start Date: June 2, 2022

Dear Administrator:

On July 20, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 21, 2022

Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

Re: Reinspection Results
Event ID: 2Y6K12

Dear Administrator:

On July 20, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
June 15, 2022

Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

RE: CCN: 245397
Cycle Start Date: June 2, 2022

Dear Administrator:

On June 2, 2022, 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.

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 2, 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 December 2, 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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING _____ B. WING _____	C 06/02/2022

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 On 5/31/22 through 6/2/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H53972031C (MN83768) at F550 and F677 H53972032C (MN83770) at F550 and F677 The following complaints were found to be UNSUBSTANTIATED: H53971902C (MN83744); however, a deficiency was cited at F550 H53971815C (MN83785); however, a deficiency was cited at F550 H53972029C (MN83742) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		6/24/22

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

Electronically Signed | 06/22/2022

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

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F 550	Continued From page 1 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: During observation, interview and document	F 550	All residents have the right to a dignified	

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F 550	Continued From page 2 review the facility failed to provide respect and dignity in common areas for 2 of 4 residents (R1, R2) reviewed for dignity. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/24/22, identified R1 had moderate cognitive impairment with verbal and physical behaviors directed towards others 1-3 days out of 7 days. R1's diagnoses included Parkinson's disease, non-Alzheimer's dementia, and anxiety. R1's care plan dated 4/8/22, did not identify an intervention for touching, tickling, or tapping R1's ears or nose. The undated internal investigation identified on 5/30/22, the facility interviewed nursing assistant (NA)-B who identified she and other staff were poking and tapping R1's ears and R1 became more agitated. Then a nurse came by and told the staff to stop, and they did. NA-B stated she did not do anything to purposefully hurt R1. During observation on 5/31/22, at 3:56 p.m. R1 was sitting by the nurse's station reading a newspaper and talking with residents and staff as they went by. R1 did not display any behaviors. During an interview on 6/1/22, at 11:15 a.m. licensed practical nurse (LPN)-A stated she saw NA-F pulling on R1's ears and messing with his hearing aide which agitated him. LPN-A told NA-F to stop, and NA-F did. LPN-A was not sure of when the incident occured. On 6/2/22, at 9:47 a.m. NA-A was interviewed and stated R1 did not like anyone touching his	F 550	existence and Havenwood Care Center continues to strive to provide care and support that supports residents□ rights while maintaining dignity and respect in all situations and encounters. R1□s care plan was reviewed and updated to include additional specific resident-centered interventions to assist staff with managing behaviors and encourage acceptance of assistance with ADL□s. 1 of 3 staff involved were allowed to return to work following education on resident rights, preventing abuse, and managing difficult behaviors and resident specific interventions for addressing behaviors. 2 of 3 staff involved are no longer employed by the facility. R2□s care plan was reviewed however no updates were needed. Staff involved were educated on conflict management, the facility expectations for employee conduct including not using offensive language, the facility policy on resident rights-dignity, and the facility policy for quality of care. Staff involved were also required to take an educational course on conflict management. During the process of internal investigation-17 direct care staff members including CNA□s, TMA□s and nurses were interviewed. All staff were asked if there were any other incidents, events or concerns that needed to be reported or followed up on in regard to inappropriate, unprofessional or undignified treatment to residents by staff with no further events being reported during the initial interviews.	

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F 550	Continued From page 3 ears or face. Even if R1's shirt brushed on his ears it would cause R1 distress. Touching or tickling R1's ears or nose was not part of the care plan and it was known R1 did not like his face or ears touched. During an interview on 6/2/22, at 10:15 a.m. NA-E identified at times R1 became agitated when staff placed his hearing aids in his ears and would swat at staff's hands because he did not like his ears to be messed with. There was no way staff should flick R1's ears and should only touch R1's ears if he agreed to it Touching his ears would make R1 more upset and did not have a calming effect. During an interview on 6/2/22, at 10:35 a.m. NA-D stated when R1 was agitated or angry he did not like his ears or nose messed with and it may cause behaviors to increase. R1 was assisted with cares this morning and during shaving became agitated when they reached the area of the mustache and pushed the razor away. NA-D stopped shaving R1 and he calmed down. NA-D would not try to agitate R1 by touching his nose or ears. A reasonable person would not like to be treated in that manner. During an interview on 6/2/22, at 1:46 p.m. registered nurse (RN)-A stated R1 did not like his ears or nose touched and staff should not touch anyone's ears unless it was medically necessary. It would not be dignified to touch, tickle, poke or do anything to an adult's nose or ears to try to redirect them or cheer them up. That would be undignified. During an interview on 6/2/22, at 2:06 p.m. licensed social worker (LSW) stated to do	F 550	The facility policies for Quality of Care and Residents Rights-Dignity were reviewed by the administrator, corporate RN and social worker on 6/2/22 with no changes being made to the facility policy. All direct care staff including CNA□s, TMA□s, Nurses, and Activity Personel were verbally educated either 1:1 or in small groups on the above policies along with resident specific interventions to assist in managing R1□s behaviors. This training was implemented on 5/25/22 and completed on 6/21/22 with all direct care staff listed above. As training was conducted, staff had the opportunity to ask questions on the policies and items covered and a signature was required to indicate they have received and understood the content of the training/reeducation. Audits will be initiated on 6/23/22 in the following manner: Interviews will be conducted in private and include questions to determine if staff conduct has been appropriate and if residents feel they are being treated with dignity and respect. The DON, SW or designee will interview two random direct care staff and two interviewable residents 5x/wk x2 weeks, to 3x/week x2 weeks, and then 1x/wk for 4 weeks. Staff interviews will be conducted on all shifts in an attempt to ensure 100% compliance with facility policy, and state/federal regulation. Results of audits will be reviewed each weekday in morning meeting by the IDT to ensure proper follow up for any concerns identified. Following the 8 weeks of	

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F 550	Continued From page 4 anything to a resident's ears or nose in an attempt to cheer them up or redirect them would be childlike and not something to do to an adult. Three staff members (NA-B, NA-F, NA-G) stated they had played, poked, touched or tickled R1's ears in an attempt to cheer him up. LSW stated that was treating R1 like a child. During an interview on 6/2/22, at 3:56 p.m. the director of nursing (DON) stated the staff actions related to R1's ears and nose were not appropriate. She would find it very aggravating if it were done to her. It was undignified to be treated in such a manner. R2's quarterly MDS dated 4/28/22, identified R2 was cognitively intact and exhibited no physical or verbal behaviors. R1 required assistance from staff for activities of daily living. The Vulnerable Adult Maltreatment Report dated 5/23/22, identified R2 was seated in the doorway of her room and nursing assistant (NA)-E yelled and cursed profanities regarding R2 in hallway of the resident care area to other staff members. During interview on 5/31/22, at 2:31 p.m. NA-E stated she yelled and cursed to another staff member while standing in the doorway of R2's room. The yelling was not directed at the resident. During interview on 6/2/22, at 9:13 a.m. NA-A stated she overheard NA-E yelling in the hallway regarding R2 but had not observed where NA-A was standing or if residents were within earshot.	F 550	audits, results will be brought to QAPI for review to determine need for further action.	

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F 550	Continued From page 5 -At 2:27 p.m. the DON stated NA-A reported NA-E yelled cuss words in the hallway of the resident care area on 5/28/22. It was inappropriate for NA-E to yell in the resident care areas and was undignified resident care. -At 3:57 p.m. the clinical nurse consultant (CNC) and the LSW were interviewed together. The CNC stated NA-E reported she yelled in the resident care area and the yelling was loud enough for residents and other staff to hear. The LSW stated NA-E's actions were unprofessional, inappropriate and should not have occurred in the resident care areas. The facility's Dignity Policy dated 11/19/18, identified residents should always be treated with dignity and respect. The policy defined "...being treated with dignity..." as the residents would be assisted in maintaining and enhancing his or her self-esteem and self-worth.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents received timely incontinent care for 1 of 3 residents (R4) reviewed for activities of daily living (ADL's) who were dependent on staff. R4's annual Minimum Data Set (MDS) dated 3/31/22, identified R4 had moderate cognitive	F 677	Havenwood Care Center strives to ensure that residents who are unable to carry out activities of daily living on their own receive services to maintain good nutrition, grooming and personal and oral hygiene. Upon identification of missed opportunities for toileting and repositioning on 5/23/22 R4 was assessed for skin	6/29/22

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F 677	Continued From page 6 impairment and was totally dependent on staff for toileting. The assessment further identified R4 had not displayed physical, verbal or other behavioral symptoms including rejection of care. R4's diagnoses included multiple sclerosis, neurogenic bladder, and dementia. R4's care plan dated 10/11/21, identified R4 was dependent on staff for ADL's and was always incontinent of bowel and bladder. The plan directed staff to check R4's incontinent brief, change the incontinent brief every 2-3 hours, and provide peri-care with every incontinent episode (check/change). During interview on 5/31/22, at 2:01 p.m. nursing assistant (NA)-H stated during day shift on 5/21/22 and 5/22/22, on the Walnut Grove unit, NA-H and NA-E decided to keep R4 in bed all day. R4 was unable to move independently and staff had a plan in place to check/change, reposition and assist the resident with feeding per the care plan. During interview on 6/2/22, at 9:13 a.m. NA-A stated she worked on 5/21/22, at 6:00 p.m. R4 was not on NA-A's assignment therefore had not checked on R4 until approximately 10:15 p.m. for evening rounds. R4's sheets had a dried yellow area from the knee area to the neck area and R4's brief was wet with urine. According to R4's care plan, R4 should have been checked/changed every 2-3 hours. - At 10:15 a.m. NA-E stated she worked until 6:30 p.m. on 5/21/22 and last checked/changed R4 at approximately 2:30 p.m. - At 1:23 p.m. NA-I stated on 5/21/22, during	F 677	breakdown, injury, redness and s/sx of infection with no complications noted. On 5/23/22, R4 was assisted out of bed per usual routine and has had no days spend in bed without services as care planned since 5/22/22. R4 is unable to be interviewed however has had no changes in mood, behavior or routine since 5/21/22 -5/22/22 when services were not provided per the residents care plan or facility policy. An audit of all facility residents was conducted on 6/21/22 via review of POC documentation for the previous 7 days and most recent MDS assessments with intent of identifying all residents who require full physical assistance with toileting tasks and additionally cannot reliably communicate their needs or direct their care as indicated by a BIMS score of 12 or less. The audit identified 24 residents who are fully dependent on staff for all tasks involved with toileting and have a BIMs score of 12 or less. The 24 residents will have their plans of care reviewed to ensure proper care planning interventions are in place to ensure toileting needs are being anticipated and met by 6/29/22. Any changes to plans of care will be communicated to staff both verbally at shift report and via updates to the care guides that staff carry with them during shift. A review of the Quality-of-Care Policy on 5/31/22 by the Administrator, SW and Corporate RN resulted in no changes to the policy. On 5/25/22 training was	

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F 677	Continued From page 7 evening rounds at approximately 10:30 p.m. R4's gown was soaked from front to back and R4's incontinent brief was wet with urine. R4's bed linens had dried urine up to R4's neck. R4 was unable to verbalize her needs. - At 1:45 p.m. registered nurse (RN)-A stated she was unaware R4 did not receive her cares as care planned. - At 2:04 p.m. the director of nursing (DON) stated on 5/23/22, she was notified R4 was left in bed all day. R4's brief was not checked/changed according to the residents care plan during the weekend of 5/21/22 and 5/22/22. R4's care plan directed staff to check/change resident every 2 hours and as needed. - At 3:57 p.m. the clinical nurse consultant (CNC) and licensed social worker (LSW) were interviewed together. The LSW stated R4 should have been checked/changed according to her care plan and R4's care plan was not followed. The facility's Quality of Care policy dated 3/22, identified quality of care as a fundamental principle that applies to all treatment and care provided to facility residents, and all residents would receive treatment and care according to professional standards of practice, their comprehensive care plan and their personal preferences.	F 677	initiated for all direct care staff including CNA□s, TMA□s, and nurses and was fully completed on 6/21/22. All direct care staff were educated verbally in small groups or on a 1:1 basis on the facility policy for Quality of Care including expectations that residents receive treatment and care in accordance with professional standards of practice, their comprehensive care plan, and their personal preferences. These expectations were further explained with an emphasis put on residents being provided with assistance with toileting as per their individual care plan. The training allowed staff to ask questions and required a signature indicating they had received and understand the training and expectations of the facility policy. Additionally, each wings care guides will be updated by 6/29/22 with a space for staff to track toileting by writing completion times as tasks are completed. The changes to the care guides and expectations for use will be communicated at shift report via the charge nurses, unit managers, DON or other designee beginning 6/29/22. Beginning 6/29/22 audits will also be completed to ensure toileting is occurring as expected and per resident care plans. Audits will be conducted via observation of residents (timing toileting tasks), and spot-checking care guides for compliance with documenting completion times. The audits will be conducted by the DON or designee at the rate of 10x/day x2wks on all shifts, 5x/day x2wks on all shifts, 5x/wk	

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 _____	C 06/02/2022

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F 677	Continued From page 8	F 677	x2wks on all shifts and then 3x/wk x2wk on all shifts. After the 8 weeks of audits, results will be brought to QAPI for further review and determination if further action is needed.	

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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 5/31/22 through 6/2/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H53972031C (MN83768) at MN Rule 4658.0520 subpart 6 B and MN St. Statute 144.651 Subd. 5 H53972032C (MN83770) at MN Rule 4658.0520 subpart 6 B and MN St. Statute 144.651 Subd. 5 The following complaints were found to be UNSUBSTANTIATED: H53971902C (MN83744); however, a licensing order was issued at MN St. Statute 144.651 Subd. 5 H53971815C (MN83785); however, a licensing order was issued at MN St. Statute 144.651 Subd. 5 H53972029C (MN83742) 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to	2 000		

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2 000	Continued From page 2 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents received timely incontinent care for 1 of 3 residents (R4) reviewed for activities of daily living (ADL's) who were dependent on staff. R4's annual Minimum Data Set (MDS) dated 3/31/22, identified R4 had moderate cognitive	2 920	Corrected	6/29/22

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2 920	Continued From page 3 impairment and was totally dependent on staff for toileting. The assessment further identified R4 had not displayed physical, verbal or other behavioral symptoms including rejection of care. R4's diagnoses included multiple sclerosis, neurogenic bladder, and dementia. R4's care plan dated 10/11/21, identified R4 was dependent on staff for ADL's and was always incontinent of bowel and bladder. The plan directed staff to check R4's incontinent brief, change the incontinent brief every 2-3 hours, and provide peri-care with every incontinent episode (check/change). During interview on 5/31/22, at 2:01 p.m. nursing assistant (NA)-H stated during day shift on 5/21/22 and 5/22/22, on the Walnut Grove unit, NA-H and NA-E decided to keep R4 in bed all day. R4 was unable to move independently and staff had a plan in place to check/change, reposition and assist the resident with feeding per the care plan. During interview on 6/2/22, at 9:13 a.m. NA-A stated she worked on 5/21/22, at 6:00 p.m. R4 was not on NA-A's assignment therefore had not checked on R4 until approximately 10:15 p.m. for evening rounds. R4's sheets had a dried yellow area from the knee area to the neck area and R4's brief was wet with urine. According to R4's care plan, R4 should have been checked/changed every 2-3 hours. - At 10:15 a.m. NA-E stated she worked until 6:30 p.m. on 5/21/22 and last checked/changed R4 at approximately 2:30 p.m. - At 1:23 p.m. NA-I stated on 5/21/22, during evening rounds at approximately 10:30 p.m. R4's	2 920		

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2 920	Continued From page 4 gown was soaked from front to back and R4's incontinent brief was wet with urine. R4's bed linens had dried urine up to R4's neck. R4 was unable to verbalize her needs. - At 1:45 p.m. registered nurse (RN)-A stated she was unaware R4 did not receive her cares as care planned. - At 2:04 p.m. the director of nursing (DON) stated on 5/23/22, she was notified R4 was left in bed all day. R4's brief was not checked/changed according to the residents care plan during the weekend of 5/21/22 and 5/22/22. R4's care plan directed staff to check/change resident every 2 hours and as needed. - At 3:57 p.m. the clinical nurse consultant (CNC) and licensed social worker (LSW) were interviewed together. The LSW stated R4 should have been checked/changed according to her care plan and R4's care plan was not followed. The facility's Quality of Care policy dated 3/22, identified quality of care as a fundamental principle that applies to all treatment and care provided to facility residents, and all residents would receive treatment and care according to professional standards of practice, their comprehensive care plan and their personal preferences. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could educate responsible staff to provide care to residents who are dependant on facility staff, based on the residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently.	2 920		

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2 920	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: During observation, interview and document review the facility failed to provide respect and dignity in common areas for 2 of 4 residents (R1, R2) reviewed for dignity. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/24/22, identified R1 had moderate cognitive impairment with verbal and physical behaviors directed towards others 1-3 days out of 7 days. R1's diagnoses included Parkinson's disease, non-Alzheimer's dementia, and anxiety. R1's care plan dated 4/8/22, did not identify an intervention for touching, tickling, or tapping R1's ears or nose. The undated internal investigation identified on 5/30/22, the facility interviewed nursing assistant (NA)-B who identified she and other staff were poking and tapping R1's ears and R1 became more agitated. Then a nurse came by and told	21805	Correct	6/24/22

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21805	Continued From page 6 the staff to stop, and they did. NA-B stated she did not do anything to purposefully hurt R1. During observation on 5/31/22, at 3:56 p.m. R1 was sitting by the nurse's station reading a newspaper and talking with residents and staff as they went by. R1 did not display any behaviors. During an interview on 6/1/22, at 11:15 a.m. licensed practical nurse (LPN)-A stated she saw NA-F pulling on R1's ears and messing with his hearing aide which agitated him. LPN-A told NA-F to stop, and NA-F did. LPN-A was not sure of when the incident occured. On 6/2/22, at 9:47 a.m. NA-A was interviewed and stated R1 did not like anyone touching his ears or face. Even if R1's shirt brushed on his ears it would cause R1 distress. Touching or tickling R1's ears or nose was not part of the care plan and it was known R1 did not like his face or ears touched. During an interview on 6/2/22, at 10:15 a.m. NA-E identified at times R1 became agitated when staff placed his hearing aids in his ears and would swat at staff's hands because he did not like his ears to be messed with. There was no way staff should flick R1's ears and should only touch R1's ears if he agreed to it Touching his ears would make R1 more upset and did not have a calming effect. During an interview on 6/2/22, at 10:35 a.m. NA-D stated when R1 was agitated or angry he did not like his ears or nose messed with and it may cause behaviors to increase. R1 was assisted with cares this morning and during shaving became agitated when they reached the area of the mustache and pushed the razor away.	21805		

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21805	Continued From page 7 NA-D stopped shaving R1 and he calmed down. NA-D would not try to agitate R1 by touching his nose or ears. A reasonable person would not like to be treated in that manner. During an interview on 6/2/22, at 1:46 p.m. registered nurse (RN)-A stated R1 did not like his ears or nose touched and staff should not touch anyone's ears unless it was medically necessary. It would not be dignified to touch, tickle, poke or do anything to an adult's nose or ears to try to redirect them or cheer them up. That would be undignified. During an interview on 6/2/22, at 2:06 p.m. licensed social worker (LSW) stated to do anything to a resident's ears or nose in an attempt to cheer them up or redirect them would be childlike and not something to do to an adult. Three staff members (NA-B, NA-F, NA-G) stated they had played, poked, touched or tickled R1's ears in an attempt to cheer him up. LSW stated that was treating R1 like a child. During an interview on 6/2/22, at 3:56 p.m. the director of nursing (DON) stated the staff actions related to R1's ears and nose were not appropriate. She would find it very aggravating if it were done to her. It was undignified to be treated in such a manner. R2's quarterly MDS dated 4/28/22, identified R2 was cognitively intact and exhibited no physical or verbal behaviors. R1 required assistance from staff for activities of daily living. The Vulnerable Adult Maltreatment Report dated 5/23/22, identified R2 was seated in the doorway of her room and nursing assistant (NA)-E yelled and cursed profanities regarding R2 in hallway of	21805		

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21805	Continued From page 8 the resident care area to other staff members. During interview on 5/31/22, at 2:31 p.m. NA-E stated she yelled and cursed to another staff member while standing in the doorway of R2's room. The yelling was not directed at the resident. During interview on 6/2/22, at 9:13 a.m. NA-A stated she overheard NA-E yelling in the hallway regarding R2 but had not observed where NA-A was standing or if residents were within earshot. -At 2:27 p.m. the DON stated NA-A reported NA-E yelled cuss words in the hallway of the resident care area on 5/28/22. It was inappropriate for NA-E to yell in the resident care areas and was undignified resident care. -At 3:57 p.m. the clinical nurse consultant (CNC) and the LSW were interviewed together. The CNC stated NA-E reported she yelled in the resident care area and the yelling was loud enough for residents and other staff to hear. The LSW stated NA-E's actions were unprofessional, inappropriate and should not have occurred in the resident care areas. The facility's Dignity Policy dated 11/19/18, identified residents should always be treated with dignity and respect. The policy defined "...being treated with dignity..." as the residents would be assisted in maintaining and enhancing his or her self-esteem and self-worth. SUGGESTED METHOD FOR CORRECTION: The DON or designee could develop and implement policies and procedures related to resident dignity and educate all staff. Then develop monitoring systems to ensure ongoing	21805		

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21805	Continued From page 9 compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		

Electronically delivered
June 15, 2022

Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: 2Y6K11

Dear Administrator:

The above facility was surveyed on May 31, 2022 through June 2, 2022 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File