



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
November 8, 2023

Administrator  
Havenwood Care Center  
1633 Delton Avenue NW  
Bemidji, MN 56601

RE: CCN: 245397  
Cycle Start Date: September 21, 2023

Dear Administrator:

On October 19, 2023, we notified you a remedy was imposed. On November 2, 2023 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 October 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 21, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 19, 2023, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 6, 2023. 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
October 3, 2023

Administrator  
Havenwood Care Center  
1633 Delton Avenue NW  
Bemidji, MN 56601

RE: CCN: 245397  
Cycle Start Date: September 21, 2023

Dear Administrator:

On September 21, 2023, a survey was completed at your facility by the Minnesota Department of Health 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

October 3, 2023

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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:

Susie Haben, Rapid Response  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Midtown Square  
3333 Division Street, Suite 212  
Saint Cloud, Minnesota 56301-4557  
Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334

## 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

Havenwood Care Center

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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 December 21, 2023 (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 March 21, 2024 (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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_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](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.

Havenwood Care Center

October 3, 2023

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a small dot above the 'i' in Downing.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



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October 3, 2023

Administrator  
Havenwood Care Center  
1633 Delton Avenue NW  
Bemidji, MN 56601

Re: Event ID: 0QJH11

Dear Administrator:

The above facility survey was completed on September 21, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

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

PRINTED: 10/27/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245397</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/21/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HAVENWOOD CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1633 DELTON AVENUE NW BEMIDJI, MN 56601</b>
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(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 9/21/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed with no deficiencies cited:                      H53975484C (MN96836)                      H53975358C (MN96799)                      H53975808C (MN93856)(MN93751)                      The following complaint was reviewed:                      H53975842C (MN94876)(MN84730)(MN94693) with a deficiency cited at F684.</p> <p>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.</p> <p>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.</p>	F 000		
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure</p>	F 684		10/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>10/15/2023</b>
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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 684	<p>Continued From page 1</p> <p>that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to assess 1 of 3 residents (R4) reviewed for nursing care assessment. While receiving assistance with a transfer, staff heard an audible tear which was not assessed by nursing staff on duty at the time of the incident.</p> <p>Findings include:</p> <p>R4's quarterly Minimum Data Set dated 5/10/23, identified severe cognitive impairment and indicated she required total assistance from two staff to complete bed mobility and transfers. R4's care plan dated 4/11/23, identified impaired physical mobility related to Multiple Sclerosis, obesity and an inability to transfer. The care plan directed staff to provide assistance from two staff for bed mobility and provide total assistance from two staff for transfers using a bariatric ceiling lift.</p> <p>A report to the state agency (SA) dated 6/22/23, indicated on the morning of 6/22/23, nursing staff reported to unit manager that R4 appeared to have some swelling and increased pain to her right shoulder. Unit manager assessed R4 and determined that her shoulder was swollen with pain and decreased range of motion (ROM). Unit manager called writer to report a possible injury related to a transfer that had occurred on 6/20/23. Unit manager reported that on 6/20/22, two nursing assistants (NA)'s reported that they had heard a noise and thought they had ripped residents clothing when removing the sling from</p>	F 684	<p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Not ensuring residents receive timely treatment and care in accordance with professional standards of practice, the care plan, physician orders and resident choices places residents at risk for deterioration in condition and stagnation in meeting goals set forth by the resident and care team. R4 obtained an injury during a transfer, however documentation in the medical record was not completed timely indicating a delay of assessment. An audit of current resident medical records was completed going back 3 months to determine if delay in documentation and/or assessment had occurred following injury/change in condition was completed on 10/11/23. Late entries concerning change in condition or events were noted for 16/54 residents reviewed. All notes were further reviewed with evidence of appropriate and timely actions being noted within the documentation including EMAR/ERTAR administrations, follow up notes and physician visits. The facility policies for Quality of Care, Recordkeeping and Documentation and Resident Incidents/Change in Resident Health Status were reviewed on 10/11/23. The policy for Resident Incidents/Change</p>	

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F 684	<p>Continued From page 2</p> <p>under her after being assisted to bed with the Hoyer lift. Unit manager, her orientee and the director of nursing did assess resident on that day and didn't find any rips in clothing, sling or injury/changes in residents ROM or pain at that time. Upon reports of change in condition, the unit manager requested resident be seen by the nurse practitioner (NP) who was rounding the morning of 9/22/23. The NP believed that R4 obtained an anterior right shoulder dislocation.</p> <p>A second report to the SA dated 6/27/23, indicated on 6/20/2023, around 1:00 p.m. two NA's were removing a transfer sling from under R4 when an audible ripping/tearing sound was heard. NA's questioned whether R4's clothing had ripped. Unsure if clothing was assessed following the above, as nothing was mentioned/documented. Writer reviewed facility documentation in R4's medical record and late entries noted regarding above. Writer was notified of the above two days after the incident occurred. R4 was assessed by writer and had visible deformity and discoloration noted to anterior right shoulder, acromion process (bony process on the shoulder blade) and proximal humerus (largest bone in the upper arm). The report indicated R4 was currently on Hospice Care and had been stable. However, this added trauma/injury led to undue suffering for R4.</p> <p>R4's medical record lacked evidence an assessment was completed at the time of the incident.</p> <p>R4's Resident Progress Notes identified the following:</p> <p>6/21/23, R4 had a shower this afternoon. Skin</p>	F 684	<p>in Resident Health Status was updated on 10/11/23 to include expectations of notes being placed into the medical record by end of shift to accurately reflect assessments and appropriate follow-up a timely manner as to reflect Recordkeeping and Documentation policy expectations. Licensed nursing staff will be educated on the updated policies and on a 1:1 or small group basis with the DON, ADON or Corporate RN beginning on 10/13/23. Education will include a policy review, signature of staff receiving the training and signature of nurse manager completing the training with a date of when the training occurred included on the signature page. Education will include specifically expressing the expectations for timely note complete by end of shift for any resident incidents and assessments d/t change in condition and are to include details of the incident/change in condition and actions that were taken to ensure timely follow up and care. Auditing for compliance with timely assessment and progress notes will begin on 10/18/23 and will be completed by the DON and/or Corporate Nurse following reeducation of all licensed nursing staff. This audit will be done via chart review following the morning meeting where a 24 hour report is given each week day to verify all changes in condition or incidents are documented in real time. This will be completed 5x/week by 1000 for 4 weeks. Late entries and lack of documentation of timely assessment will be addressed by DON/Corporate RN immediately with re-education and reiteration of</p>	

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F 684	<p>Continued From page 3</p> <p>assessment completed. Right shoulder upper chest appeared to have some edema/erythema. Neckline had redness as well which did occur. Skin intact to this area, no increased warmth at this time.</p> <p>6/22/23, Right shoulder pain noted and swollen on top with decreased ROM and pain. Physician to assess.</p> <p>6/22/23, back dated to 6/20/23, Staff reported to unit charge manager and orientee that clothes may have ripped during a transfer. This writer and orientee assessed ROM to bilateral lower extremities and no decrease in ROM noted at time of assessment. This writer touched left arm and R4 stated "ow", writer touched right shoulder/arm and R4 reported same "ow" with no Wong-Baker (a self-assessment tool that can help people communicate about their physical pain. It uses a combination of faces, numbers, and words) pain noted. Regular pain reported as R4 had chronic pain. Will observe for changes in condition.</p> <p>6/22/23, back dated to 6/20/23, NA's reported to writer that while removing sling from under resident, it appeared residents elbow got stuck on the sling, leaving a red mark on the elbow. Writer went to R4's room to assess arm for any other signs of injury. R4 had contractures and ROM was difficult to assess for any change due to the contracture. R4 did yell when being touched on any area of her upper extremities, which was her normal response. Writer assessed left shoulder and elbow, resident did yell "ow", writer assessed right shoulder and elbow and resident yelled "ow" which was her normal response. Writer did not believe there was any injury present due to no</p>	F 684	<p>expectations for accurate and timely recordkeeping and immediate assessment of residents with incidents and changes in condition. Ongoing noncompliance by nursing staff will be addressed with progressive disciplinary action if noted. Results of audits will be shared with the QAPI team at the first meeting following completion for further discussion and action based on the results. Date corrected will be 10/18/23.</p>	

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F 684	<p>Continued From page 4</p> <p>change in R4's typical behavior. Staff education to be provided on proper removal of Hoyer sling.</p> <p>6/22/23, Per hospice nurse who was at the emergency department with R4, R4 had a proximal humerus fracture, non-operable. Plan to place sling, limit movement, gowns and nothing with sleeves and no rolling onto right shoulder.</p> <p>During interview on 9/21/23, at 4:33 p.m. licensed social worker (LSW)-A stated she remembered the incident and said two days after the incident occurred a NA who frequently worked with R4 reported R4's arm was flaccid which was unusual for R4. LSW-A stated the NA knew right away something was wrong and the NP happened to be in the facility so she assessed R4 and felt the shoulder had been dislocated.</p> <p>Facility policy Resident Incidents/Change In Resident Health Status dated January 2003, indicated upon discovery of an incident and after the resident's immediate safety has been assured; the charge nurse shall be notified. For purposes of internal review only, details of the incident will be recorded on a Resident Incident Report. A progress note will be made in the resident's medical record with the details of the incident as well as family and physician notification. Following a fall, injury or acute illness, the resident will be observed and charted on at least once each shift for 24 hours. The RN supervisor will assess the situation &amp; implement &amp; care plan changes needed for the safety of the resident.</p>	F 684		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/21/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HAVENWOOD CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1633 DELTON AVENUE NW BEMIDJI, MN 56601</b>
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> On 9/21/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed with no licensing orders cited.</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>10/15/23</b>
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Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p>Continued From page 1</p> <p>H53975484C (MN96836) H53975358C (MN96799) H53975808C (MN93856) (MN93751) H53975842C (MN94876) (MN84730) (MN94693)</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		
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