Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 6, 2026

Administrator
Assumption Home
715 NORTH FIRST STREET
COLD SPRING, MN 56320

RE: CCN: 245446
Cycle Start Date: November 20, 2025

Dear Administrator:

On January 5, 2026, 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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 6, 2026

Administrator
Assumption Home

715 NORTH FIRST STREET
COLD SPRING, MN 56320

Re: Reinspection Results
Event ID: 1DB468-H2

Dear Administrator:

On January 5, 2026 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 November 20, 2025. 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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 11, 2025

Administrator
Havenwood Care Center

1633 DELTON AVENUE NW
BEMIDJI, MN 56601

RE: CCN:245397
Cycle Start Date: December 11, 2025

Dear Administrator:

On December 11, 2025, a survey was completed at your facility by the Minnesota Departments 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.

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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: 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 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 March 11, 2026(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 June 11, 2026(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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

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Electronically delivered

December 11, 2025

Administrator
Havenwood Care Center
1633 DELTON AVENUE NW
BEMIDJI, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: 1D9936-H1

Dear Administrator:

The above facility survey was completed on December 11, 2025 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 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 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
20000	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 10/20/25 through 10/22/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		12/21/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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20000	Continued from page 1 The following complaint was reviewed: H53975992C (2646000) with no licensing orders issued. Additionally, as a result of the investigation, a licensing order was issued at 1610. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were secured at all times in 1 of 3 medication carts used. This had the potential to affect 20 residents whose medications were stored in medication cart. Additionally, the facility failed to ensure medication was labeled with clear and unaltered administration instructions to prevent potential error for 1 of 3 residents (R4) observed to receive medication. Findings include: R4's admission Minimum Data Set (MDS) dated 9/2/25, diagnosis: multiple sclerosis (MS) (a chronic autoimmune disease affects the central nervous system damaging the protective covering of nerve fibers with symptoms of muscle weakness, spasms or stiffness, and problems with balance and coordination). R4's provider order dated 9/6/25, identified: -Baclofen (muscle relaxant) tablet 20 milligrams (mg); amount 1 ½ tabs (30mg); oral twice a day 7:00 a.m. and 9:00 p.m. -Baclofen tablet 20 mg 1 tablet oral twice a day 12:00 p.m. and 5:00 p.m. Special instructions: please wake resident to give this medication if she is sleeping. She needs it. During an observation/interview on 10/21/25 at 8:20 am., medication cart was in the hallway of Walnut Grove, no staff were seen in the hallway. The computer	21610	Corrected.	12/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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21610	Continued from page 2 screen was left open with R4's identifying information readable, medication cart unlocked, a small plastic cup ½ full of clear liquid with tongue blade in it, and 3 white pills in a medication cup were located on top of the cart. At 8:25 am., an unidentified resident pushed herself down the hallway in a wheelchair past the medication cart. At 8:30 a.m., trained medication assistant (TMA)-A opened R4's room door located rooms away from the medication cart and walked out into the hallway to the medication cart. TMA-A stated staff had requested assistance with a total lift for R4. She moved the medication cart closer to R4's room, left the computer screen open, cart unlocked with R4's medications left on top of the cart, unattended and was in R4's room for approximately five minutes. She verified the clear liquid in the cup was MiraLAX (laxative) prepared with water and the three white pills were Baclofen (muscle relaxant) 10mg each. TMA-A stated she was running late with the medications and was in a hurry. TMA-A stated this was not good practice and would have been expected to have locked the medication cart and computer screen, with all medications placed inside the cart prior to walking away. During an interview on 10/21/25 at 1:55 p.m., RN-B stated nursing staff were expected to protect all resident personal health information by locking the computer screen prior to leaving the area. A violation of Health Insurance Portability and Accountability Act (HIPPA) would mean that anyone walking by an open computer would have access to personal information. Medication cart should be locked and no mediations left on top when unattended. Anyone could have grabbed them, and it would be a safety hazard (syringes, oral/injectable medications). During a follow up interview on 10/22/25 at 10:45 a.m., TMA-A searched the medication cart and unable to locate R4's Baclofen 30 mg pills (labeled bottle on top 2) she had administered yesterday. She located one bottle of Baclofen label information included: R4's name, Baclofen 10 mg tablets, bottled filled on 6/9/25 by local pharmacy, instructions take 2 tablets by mouth (po) 8:00 a.m., 2 tablets at 12:00 p.m., 2 tablets at 4:00 p.m., and 3 tablets at 8:00 p.m. Handwritten on the bottle with a black marker, direction change refer to electronic medication administration record (EMAR) BAC 1 of 2. She verified the label was wrong. Yesterday she placed three pills into a pill cup, and a staff nurse split two of them in ½. The three half pills went back into the container so that they could be given later. She was unaware she had administered R4 the wrong doses of Baclofen yesterday and today until now	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/22/2025**

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21610	Continued from page 3 and considered medication errors. Staff were expected to have placed an orange sticker on the medication bottle direction change refer to EMAR. She verified there was not an orange sticker on the bottle. She had been off work for 6 weeks and just returned yesterday. TMA-A verified located in the Baclofen pill bottle label 2 on top (10 mg tablets) were 73 whole pills and 5 half pills. She stated there had to be other staff that had made medication errors on this same medication, yesterday she had placed 3 half pills back into the medication bottle and now there were five. The pills were 10 mg each and there would be no reason to cut them in half. At 11:07 a.m. TMA-A placed an orange-colored label direction sticker printed, DIRECTIONS CHANGED REFER TO CHART, over the written directions on the pill bottle and back into the located medication cart. She notified the staff nurse and requested the half pills be destroyed, reported to the DON, a mediation error filed, to avoid further errors. During an interview on 10/22/25 at 11:46 a.m. director of nursing (DON) verified R4's Baclofen dose was increased on 8/28/25 to 30 mg twice a day 7:00 a.m. and 9:00 p.m. and the other dose remained the same 20 mg twice a day at 12:00 p.m. and 5:00 p.m. On 9/6/25, the pharmacy sent over enough pills for two weeks in a bubble pack each one had 1 ½ tabs. They ran out of that dose on 9/20/25, and staff started to use the 10 mg tablet bottle (her own she brought in from home), there were times when staff used home medications brought in. The order should have ben reactivated to take 30 mg at 7:00 a.m. and 9:00 p.m. and was not done. The order was correct, but label and order did not match: label 20 mg 1 ½ tablets twice a day and the label on the Baclofen bottle indicated 10 mg tablets. The staff had not completed the rights of medication administration and unfortunately R4 received the wrong dose (1/2 of what was ordered) from 9/21/25, through today 10/22/25. R4 was prescribed the Baclofen for spasms and had not seen any increased pain that she was aware of. TMA-A reported medication errors this morning and explained as to what happened. Facility policy General Policies in Administrating Medications dated 12/2023, identified the labels of all medicine bottles and cards will be neat and legible. The nurse may never re-label a medication. It must be sent to pharmacy if re-labeling is necessary or a new label brought in by the pharmacist and applied by them. Labels shall include prescription number, name of drug, strength, quantity of drug, expirations date, directions for use, name of resident, physician's name, date of refill and if a generic the name of medication	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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21610	Continued from page 4 being given for. Errors of omission, dosage or type of medication must be reported at once to the registered nurse (RN) supervisor and an incident report filled out. Requested facility policy medication cart safety and was not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for secured storage of medications located in medication carts. Nursing staff could be educated as necessary to the importance of safe storage of mediations and clear and unaltered medication label instructions to prevent potential errors. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 56601**

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F0000	INITIAL COMMENTS On 10/20/25 through 10/22/25, 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. The following complaint was reviewed H53975992C (2646000) with deficiency F760. Deficient practice was identified related to incidental findings of F761. 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.	F0000		12/21/2025
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the correct administration of insulin per physician orders for 1 of 3 residents (R1) who received 20 units of Novolog (rapid acting used to lower blood sugar levels onset in 15 minutes) instead of the physician ordered Lantus (long-acting onset 3 to 4 hours and duration of 24 hours).	F0760	Failure to administer insulin per physician orders and industry standards places all residents receiving insulin at increased risk for negative outcomes and adverse effects. R-1 received intervention both in the facility and at the emergency department following identification of medication error and receipt of short acting insulin. She returned to the facility with no new orders and no lasting affects of medication error. An audit of all residents receiving both long and short acting insulin was completed on 12/19/2025 to identify others at risk for a similar event. 5 residents were identified in audit and were further reviewed for medication errors involving long and/or short acting insulin with no other incidents being identified in the previous 3 months.	12/22/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havenwood Care Center	**1633 DELTON AVENUE NW , BEMIDJI, Minnesota, 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
F0760 SS = D	Continued from page 1 Findings included: R1's annual Minimum Data Set (MDS) dated 9/10/25, identified intact cognition with no behaviors. Her diagnoses include diabetes mellitus (DM) and received insulin injections 7 out of 7 days a week. R1's care plan dated 9/18/25, identified a potential for alteration in nutrition related to obesity, diabetes, and chronic pain. Staff were directed to offer snacks two times a day. Medicate as ordered. Follow diabetic protocols. Monitor continuous glucose monitoring (CGM) as ordered. Monitor for signs and symptoms of hypoglycemia/hyperglycemia (low blood/high blood sugars). R1's physician orders identified: -Start date 3/21/25, bedside glucose monitoring to be performed four times a day; call primary care provider or family provider if blood sugars (BS) are greater than 300 or less than 60 at 7:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. -Start date 3/21/25, Novolog (lowers blood glucose levels quickly after meals, typically starting to work within 5 to 10 minutes after injection, with a maximum effect after 1 to 3 hours, and a duration of action of 3 to 5 hours) U-100 insulin solution; 100 units/milliliter (ml) amount per sliding scale, if BS less than 70 call medical doctor. Blood sugar 200 to 250, give 2 units, if BS 251 to 300; give 4 units. If BS 301 to 350; 6 units. If BS 351 to 400; give 10 units. If BS greater than 400 all MD. Three times a day; 8:00 a.m., 12:00 p.m., 5:00 p.m. -Start date 4/1/25, Novolog U-100 insulin solution 100 unit/ml; amount 4 units subcutaneously (SQ) with meals; 8:00 a.m., 12:00 p.m. and 5:00 p.m. Special instructions: hold insulin if eats less than 25% of meal. -Start date 9/24/25, Lantus (long-acting insulin works over a 24-hour period to provide a steady, continuous release of insulin, helping to keep BS levels consistent between meals and overnight) U-100 insulin solution 100 unit/ml; amount 20 units; subcutaneously (SQ) at bedtime 8:00 p.m. R1's Electronic Medication Administration Record (EMAR) on October 16th, 2025, identified: -Lantus Units (U)-100 insulin solution; 100	F0760	Continued from page 1 Medication Administration policy was reviewed and revised on 12/19/2025. On 10/22/2025, Director of Nursing implemented corrective action/remediation with RN-A. Direct observation and competency evaluation of injection practices and medication administration for RN-A began 10/22/2025. On 12/19/2025 and 12/20/2025, RN-A also completed training via online module. On 10/28/2025 and 10/29/2025 a nursing meeting was held on injection practices and medication administration. This re-training also included in-house interventions to prevent and treat hypoglycemia. This content was covered again during All Staff Meetings in November and December. Beginning 12/22/2025, any staff that have not completed this education will not be allowed to work. Audits for ongoing competency and compliance will begin on 12/22/2025 and include direct observation of insulin injections by DON or designee. Observation includes emphasis on 6 rights of medication administration and verbal confirmation on steps to take when trying to treat or prevent hypoglycemia. Audits will be conducted at a rate of 6 observations per day for 5 days, followed by 10 observations each week for a period of 2 weeks, followed by 5 observations per week for a period of 2 weeks. Results of audits will be discussed at upcoming QAPI meeting with ongoing auditing needs being identified at that time.	

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F0760 SS = D	Continued from page 2 units/milliliters (ml) administer 20 units subcutaneous (SQ) at bedtime. At 8:00 p.m. Documented as not administered by RN-A --Novolog U-100 insulin Rapid acting insulin; 100 U/ml administer 4 units SQ with meals and hold if eats less than 25 % of meal. BS 129 milligrams per deciliter (mg/dl) prior to meal and she ate 75% of supper. RN-A Charted late at 6:43 p.m. administered 4 U. -Novolog U-100 insulin per sliding scale; at 4:50 p.m. not administered BS 129 mg/dl. R1's progress notes from 10/16/25 through 10/17/25, identified: -on 10/16/25 at 9:26 p.m., R1 was given her short acting insulin at 8:37 p.m. when noted by writer immediately called DON and the on call for family practice. While she waited for the on-call writer called the ambulance for transport . . . sent to emergency room (ER) for evaluation and treatment. -on 10/16/25 at 12:38 a.m., writer called ER department and was notified she was given carbohydrates along with fluids. Last two blood sugars obtained were stable. While in ER, chest x-ray was completed for her wet, productive cough and diagnosed with pneumonia and placed on antibiotics. -on 10/17/25 at 4:32 a.m., ambulance transported R1 back to facility. R1's BS record on 10/16/25, identified: -documented at 4:49 p.m. 129 mg/dL -documented at 9:42 p.m. 182 mg/dL R1's Emergency Department (ED) visit dated 10/16/25 at 9:20 p.m. through 10/17/25 4:20 a.m., identified clinical impressions hypoglycemic (low blood sugar) reaction to insulin type 2 diabetes mellitus (DM), insulin overdose, accidental or unintentional, initial encounter, conjunctivitis of left eye, bronchitis, and bronchial pneumonia. - on 10/16/25 at 9:31 p.m., BS 127 mg/dl -on 10/16/25 at 10:13 p.m., glucose dropped despite having eaten. Will give some dextrose and continue to monitor closely. Neurological status remains intact. -on 10/16/25 at 10:15 p.m., dextrose 10% intravenous	F0760		

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F0760 SS = D	Continued from page 3 (IV) solution 250 milliliters (ml), glucagon injection 1mg vial, and glucose chewable tablet 16 grams (g) administered. -on 10/16/25 at 10:20 p.m., BS 89 mg/dl -on 10/16/25 at 11:14 p.m., BS 134 mg/dl -on 10/17/25 at 12:22 a.m., BS 141 mg/dl -on 10/17/25 at 12:23 a.m., Should have passed the peak effects of insulin she was given. Will check one more to ensure stability. -on 10/17/25 at 1:16 a.m., BS 173 mg/dl -on 10/17/25 at 1:18 am., Glucose has stabilized. Passed the peak effects of the insulin. At this time will discharge back to care center with new treatment for pneumonia and conjunctivitis as well. -on 10/17/25 at 4:15 a.m., BS 136 mg/dl. Discharged from ED at 4:20 p.m. back to care center. Medication Error Report dated 10/16/25 at 9:00 p.m., R1 was given short acting insulin 20 units instead of Lantus 20 units by RN-A. R1 was sent to ER, no negative outcome. Plan to correct the problem: double check insulin prior to administration by another staff. During an interview on 10/21/25 at 11:15 a.m., RN-A stated on 10/16/25 just after 8:30 p.m., R1's blood sugar was 182 ml/dl. Other residents and a staff asked questions while RN-A attempted to draw up R1's insulin at the medication cart. RN-A became distracted. She entered the insulin expiration date and site where it would be administered into the EMAR and administered the insulin. RN-A returned to the medication cart, realized she had picked up the wrong insulin vial and administered 20 units of the wrong type of insulin (fast acting versus long acting). RN-A was aware R1's BS would drop quickly and could have gone into a coma. RN-A immediately called DON, checked for an order of glucagon (an injectable medication used in an emergency to raise blood sugars) but order stated should only be given for blood sugars below 70. RN-A called the on-call provider, waited 15 minutes, then called the on-call back and was informed it would be another 30 minutes before they called her back. RN-A called an ambulance to get emergency medical technician (EMT) on site. The EMTs arrived the same time the provider called back. R1's BS was not checked again prior to the EMT arrival, RN-A prepared transfer paperwork to send	F0760		

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F0760 SS = D	Continued from page 4 R1 to the hospital for evaluation. RN-A stated she had made a horrible medication mistake, knew it could happen, became distracted, and was an accident. During an interview on 10/21/25 at 1:55 p.m., RN-B stated the nurse was expected to follow the rights of medication administration when preparing insulin. The staff nurse would be expected to contact provider, charge nurse, DON, and administrator if a significant medication error occurred. The nurse would be expected to have completed a full assessment, check blood sugars and if low follow facility protocol for use of glucagon from the E-Kit, call 911, and possibly have them transferred to ER. During an interview on 10/21/25 at 2:09 p.m., R1 stated she had diabetes and received insulin injections for quite a while now. Last week the staff nurse gave her a large dose of the wrong insulin (fast acting) and should have been the long acting, was taken to emergency room (ER), stayed overnight to be monitored closer. R1 stated received intravenous fluids, sweet foods/drink such as apple juice, four graham crackers, cookies, and rice krispie bar after her blood sugar started to drop down. She returned to the facility around 5:30 a.m. the following day. During an interview on 10/21/25 at 3:10 p.m., DON stated RN-A worked as the treatment nurse on 10/16/25. DON was contacted by RN-A between 8:30 p.m. and 9:00 p.m. regarding a significant medication error. R1 had received 20 units of the wrong type of insulin, Novolog instead of Lantus as ordered. RN-A was instructed to call the on-call provider, monitor blood sugars, watch for symptoms of hypoglycemia (low blood sugars), and stay with R1 until EMTs arrived. RN-A stated to DON, she was scared so called EMT for assistance, and stayed with R1. DON was unsure if RN-A rechecked the BS as instructed. The root cause analysis identified the cause of the medication error was lack of communication between the two nurses working that evening, distraction, lack of the rights of medication administration and EMAR/orders were not followed. The following morning, DON discussed the medication error with RN-A on the telephone and how to proceed going forward. The rights of medication administration would be expected to be followed, vital signs and blood sugars should have been monitored, improved communication among nurses, and to limit distractions. RN-A was allowed to work the weekend, and a plan was created to have a second nurse check all RN-A's insulin doses prior to administration. RN-A was also instructed, when distracted during medication preparation move the cart and relocate to a different	F0760		

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F0760 SS = D	Continued from page 5 location to help prevent medication errors, required further re-education now, ongoing, and disciplinary action. During an interview on 10/22/25 at 12:37 p.m., assistant administrator stated she was contacted on 10/16/25 at 8:53 p.m., by RN-A regarding a medication error. RN-A informed her she was about to prepare R1's insulin, was interrupted, grabbed the wrong insulin (short acting versus long acting), had not realized it until after it was administered. DON and provider were contacted with a significant amount of time without a call back. RN-A called 911. Assistant administrator stated our investigation identified the root cause of the medication error was distraction. R1 was not harmed and could have possible been treated here at the facility. Facility Standards of Care and Protocols for Diabetes Management dated 3/2013, identified report hypoglycemia incident to physician. Call if less than 80. Facility policy Administering Medications dated 12/2023, identified all RN's, LPNs, and TMAs employed at the facility will be trained to do the medication passes according to industry standards. Conversations or other distractions should be avoided while preparing medications. The labels of all medicine bottles and cards will be neat and legible. The nurse may never re-label a medication. It must be sent to pharmacy or a new label brought in by the pharmacist and applied by them. Injectable medications will be administered according to facility policy for safe injection practices and by only a licensed nursing staff. TMAs cannot administer injectable medications. High risk medications: a list of high-risk medications will be available at each nurse's station and on each medication cart. The identity of medication will be verified three times with the MAR, when taking the container from the cart, as preparing it, and before replacing it in the cart. Facility policy Insulin Administration – Pen identified verification of the insulin medication/prescription (RX) label matches the medication administration record (MAR): right resident, medication, dose, dosage form, frequency and route.	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	Failure to properly label and store medications has the potential to negatively affect all residents who receive medication management from the facility. Upon notification of medication cart being left unlocked,	12/22/2025

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F0761 SS = D	Continued from page 6 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were secured at all times in 1 of 3 medication carts used. This had the potential to affect 20 residents whose medications were stored in medication cart. Additionally, the facility failed to ensure medication was labeled with clear and unaltered administration instructions to prevent potential error for 1 of 3 residents (R4) observed to receive medication. Findings include: R4's admission Minimum Data Set (MDS) dated 9/2/25, diagnosis: multiple sclerosis (MS) (a chronic autoimmune disease affects the central nervous system damaging the protective covering of nerve fibers with symptoms of muscle weakness, spasms or stiffness, and problems with balance and coordination). R4's provider order dated 9/6/25, identified: -Baclofen (muscle relaxant) tablet 20 milligrams (mg); amount 1 ½ tabs (30mg); oral twice a day 7:00 a.m. and 9:00 p.m.	F0761	Continued from page 6 TMA-A locked cart immediately correcting unsecured medications. On 10/22/2025, R4's medications were reconciled to include matching orders and labeled medication bottles. On 12/19/2025, an audit was conducted on all medication carts to identify residents with orders not matching their medication supply. This audit revealed 3 medication labels as not matching orders. A sticker was placed on these medication bottles/cards instructing staff to refer to chart as orders differed from current label. Pharmacy was notified via fax and telephone call on 12/19/2025 of these mismatched medication supply/orders and request was made for proper labeling and or new supply of medications. Medication Administration policy was reviewed on 12/19/2025, with clarification added to place a "refer to chart" sticker on the bottle/card while waiting for new label to come from the pharmacy. On 10/23/2025, Director of Nursing implemented corrective action/remediation with TMA-A. On 12/19/2025, TMA-A also assigned training via online module that will need to be completed prior to her next scheduled shift. Education with all staff who may administer medications regarding expectation for storage and labeling of medications was initiated on 12/19/2025. This education includes policy and procedure review with an emphasis on ensuring medication carts are locked when out of sight, not leaving medications unattended, expectations that orders and labels are to match along with steps to take if new orders result in mismatched labels/orders including placing sticker on the drug to remain in place until new label arrives from the pharmacy. Any staff who have not completed the education will be required to do so before their next shift beginning on 12/22/2025. Audits for compliance in regards to storage and labeling of medications will begin on 12/22/2025. Audits will be conducted at random by the DON or designee, and include checks for locked carts 21 times per week across all shifts for 2 weeks, then reducing to 14x/week for 2 weeks, followed by 7x/week for 2 weeks. Additional audits for drug labeling will be conducted by the DON or designee and include a review of 10 medication orders being compared to supply to ensure matching direction and orders. This will be	

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F0761 SS = D	Continued from page 7 -Baclofen tablet 20 mg 1 tablet oral twice a day 12:00 p.m. and 5:00 p.m. Special instructions: please wake resident to give this medication if she is sleeping. She needs it. During an observation/interview on 10/21/25 at 8:20 am., medication cart was in the hallway of Walnut Grove, no staff were seen in the hallway. The computer screen was left open with R4's identifying information readable, medication cart unlocked, a small plastic cup ½ full of clear liquid with tongue blade in it, and 3 white pills in a medication cup were located on top of the cart. At 8:25 am., an unidentified resident pushed herself down the hallway in a wheelchair past the medication cart. At 8:30 a.m., trained medication assistant (TMA)-A opened R4's room door located rooms away from the medication cart and walked out into the hallway to the medication cart. TMA-A stated staff had requested assistance with a total lift for R4. She moved the medication cart closer to R4's room, left the computer screen open, cart unlocked with R4's medications left on top of the cart, unattended and was in R4's room for approximately five minutes. She verified the clear liquid in the cup was MiraLAX (laxative) prepared with water and the three white pills were Baclofen (muscle relaxant) 10mg each. TMA-A stated she was running late with the medications and was in a hurry. TMA-A stated this was not good practice and would have been expected to have locked the medication cart and computer screen, with all medications placed inside the cart prior to walking away. During an interview on 10/21/25 at 1:55 p.m., RN-B stated nursing staff were expected to protect all resident personal health information by locking the computer screen prior to leaving the area. A violation of Health Insurance Portability and Accountability Act (HIPPA) would mean that anyone walking by an open computer would have access to personal information. Medication cart should be locked and no mediations left on top when unattended. Anyone could have grabbed them, and it would be a safety hazard (syringes, oral/injectable medications). During a follow up interview on 10/22/25 at 10:45 a.m., TMA-A searched the medication cart and unable to locate R4's Baclofen 30 mg pills (labeled bottle on top 2) she had administered yesterday. She located one bottle of Baclofen label information included: R4's name, Baclofen 10 mg tablets, bottled filled on 6/9/25 by local pharmacy, instructions take 2 tablets by mouth (po) 8:00 a.m., 2 tablets at 12:00 p.m., 2 tablets at	F0761	Continued from page 7 conducted 3x/week for 4 weeks. Results of audits will be reviewed at upcoming QAPI meeting with further auditing needs being identified at that time.	

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F0761 SS = D	Continued from page 8 4:00 p.m., and 3 tablets at 8:00 p.m. Handwritten on the bottle with a black marker, direction change refer to electronic medication administration record (EMAR) BAC 1 of 2. She verified the label was wrong. Yesterday she placed three pills into a pill cup, and a staff nurse split two of them in ½. The three half pills went back into the container so that they could be given later. She was unaware she had administered R4 the wrong doses of Baclofen yesterday and today until now and considered medication errors. Staff were expected to have placed an orange sticker on the medication bottle direction change refer to EMAR. She verified there was not an orange sticker on the bottle. She had been off work for 6 weeks and just returned yesterday. TMA-A verified located in the Baclofen pill bottle label 2 on top (10 mg tablets) were 73 whole pills and 5 half pills. She stated there had to be other staff that had made medication errors on this same medication, yesterday she had placed 3 half pills back into the medication bottle and now there were five. The pills were 10 mg each and there would be no reason to cut them in half. At 11:07 a.m. TMA-A placed an orange-colored label direction sticker printed, DIRECTIONS CHANGED REFER TO CHART, over the written directions on the pill bottle and back into the located medication cart. She notified the staff nurse and requested the half pills be destroyed, reported to the DON, a mediation error filed, to avoid further errors. During an interview on 10/22/25 at 11:46 a.m. director of nursing (DON) verified R4's Baclofen dose was increased on 8/28/25 to 30 mg twice a day 7:00 a.m. and 9:00 p.m. and the other dose remained the same 20 mg twice a day at 12:00 p.m. and 5:00 p.m. On 9/6/25, the pharmacy sent over enough pills for two weeks in a bubble pack each one had 1 ½ tabs. They ran out of that dose on 9/20/25, and staff started to use the 10 mg tablet bottle (her own she brought in from home), there were times when staff used home medications brought in. The order should have been reactivated to take 30 mg at 7:00 a.m. and 9:00 p.m. and was not done. The order was correct, but label and order did not match; label 20 mg 1 ½ tablets twice a day and the label on the Baclofen bottle indicated 10 mg tablets. The staff had not completed the rights of medication administration and unfortunately R4 received the wrong dose (1/2 of what was ordered) from 9/21/25, through today 10/22/25. R4 was prescribed the Baclofen for spasms and had not seen any increased pain that she was aware of. TMA-A reported medication errors this morning and explained as to what happened. Facility policy General Policies in Administrating	F0761		

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F0761 SS = D	Continued from page 9 Medications dated 12/2023, identified the labels of all medicine bottles and cards will be neat and legible. The nurse may never re-label a medication. It must be sent to pharmacy if re-labeling is necessary or a new label brought in by the pharmacist and applied by them. Labels shall include prescription number, name of drug, strength, quantity of drug, expirations date, directions for use, name of resident, physician’s name, date of refill and if a generic the name of medication being given for. Errors of omission, dosage or type of medication must be reported at once to the registered nurse (RN) supervisor and an incident report filled out. Requested facility policy medication cart safety and was not received.	F0761		