Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 4, 2024

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

RE: CCN: 245397
Cycle Start Date: December 4, 2023

Dear Administrator:

On December 15, 2023, we notified you a remedy was imposed. On December 29, 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 December 28, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 30, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 15, 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 December 4, 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,

Kamala Fiske-Downing

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

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Electronically delivered

January 4, 2024

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

Re: Reinspection Results
Event ID: 8SVI12

Dear Administrator:

On December 29, 2023 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 December 4, 2023. 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
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

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Electronically Submitted
December 15, 2023

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

RE: CCN: 245397
Cycle Start Date: December 4, 2023

Dear Administrator:

On December 4, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substantial quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On December 4, 2023, the situation of immediate jeopardy to potential health and safety cited at F760 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 30, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 30, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 30, 2023, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 4, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Havenwood Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 4, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "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
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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132

Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Kamala Fiske-Downing
Minnesota Department of Health

Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING ______ B. WING ______	12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	**1633 DELTON AVENUE NW 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 11/30/23 through 12/1/23 and 12/4/23, 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. The following complaints were reviewed with no deficiencies cited: H53977603C (MN98714) H53977602C (MN97895) The following complaint H53977232C (MN98622) was reviewed with a deficiency cited at F760 and resulted in an immediate jeopardy (IJ). The IJ began on 11/16/23, when The facility failed to administer three consecutive doses of a high-risk medication to prevent or reduce the risk of seizures resulting in repetitive seizures and hospitalization for R1. The facility failed to implement a plan to secure the medication at the facility or develop alternative interventions via provider notification. The administrator in training, licensed social worker (LSW) and corporate nurse (CN) were notified of the IJ on 12/1/23, at 3:50 p.m. The IJ was removed on 12/4/23, at 2:50 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted on 12/4/23. In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/22/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 the Minnesota Department of Health to determine compliance with §483.73 Infection Control. The facility was in compliance. 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 760 SS=J	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 develop and implement a process to ensure high risk medications were administered and failed to implement a process to report missed doses and/or lack of availability of medications to the provider for 1 of 3 residents (R1) reviewed for medication errors. This resulted in an Immediate Jeopardy (IJ) for R1 when the facility's failure to obtain and administer anti-epileptic medication (used to treat seizures) resulted in increased seizure activity and hospitalization. The IJ began on 11/16/23, when The facility failed	F 760	Failure to ensure administration of high-risk medications as ordered by the physicians has the potential to affect all residents residing in the facility that have active orders for high-risk medications. Resident R1 was treated in the ED for seizure like activity when a change of condition was identified on 11/16/23. Medications were delivered from the pharmacy in the evening on 11/16/23 and the physician was notified of omissions and change in condition on 11/17/23. Between the dates of 12/21/23 and	12/28/23

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F 760

Continued From page 2

to administer three consecutive doses of a high-risk medication to prevent or reduce the risk of seizures resulting in repetitive seizures and hospitalization for R1. The facility failed to implement a plan to secure the medication at the facility or develop alternative interventions via provider notification. The administrator in training, licensed social worker (LSW) and corporate nurse (CN) were notified of the IJ on 12/1/23, at 3:50 p.m. The IJ was removed on 12/4/23, at 2:50 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy.

Findings include:

R1's undated, facility Continuity of Care Document identified a diagnosis of localization-related (focal) (partial) symptomatic epilepsy (neurological disorder that causes seizures) and epileptic syndromes (identification of specific seizure type) with simple partial seizures, not intractable (hard to control), without status epilepticus (seizure involves abnormal electrical activity in the brain affecting both the mind and the body).

R1's significant change Minimum Data Set dated 9/1/23, identified R1 had intact cognition. R1's care plan updated 11/20/23, identified a potential for alteration in electrical impulse related to seizure disorder and had a self-care deficit related to hemiplegia (paralysis of one side of the body), dementia and failure to thrive.

R1's physician orders dated 11/15/23, included the following orders:
- Levetiracetam (anti-epileptic drug used to treat

F 760

12/28/23 a record review for all current residents will be completed with goal of identifying all residents who receive medications in drug classes of opioids, anticoagulants, antiplatelets, hypoglycemics, and antiepileptics. The sample of residents who receive high risk medications will have further review of administration records for the months of October, November and December 2023 to determine any similar errors of omission. All residents who have an omission of a high-risk medication during the look back will have a thorough chart review completed to determine the effect on resident, if proper actions were taken by staff and additionally to identify further education needs.

Beginning on 11/18/23 all staff who were qualified to administer medications were educated and competency evaluated on proper medication administration techniques including an emphasis on the 6 rights of medication administration to minimize the risk of medication errors and ensure proper techniques and expectations. This education occurred prior to the start of next scheduled shift following implementation date.
Additionally, on 12/4/23 education with all staff qualified to pass medications began on the updated Medication Administration Policy which included steps to take if medications are unavailable and/or medications in a high-risk drug category were omitted. This education was completed with all staff who have worked in the facility since 12/4/23 via verbal

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F 760

Continued From page 3

partial, myoclonic, and tonic-clonic seizures) 1500 milligrams (mg) twice daily in the a.m. and p.m.
- Levetiracetam 500 mg daily between 11:30 a.m. and 1:00 p.m.

R1's Medication Administration History dated 11/1/23 through 11/17/23, identified R1's 11/16/23 a.m. dose of levetiracetam was not administered, listed as "drug/item unavailable." R1's 11/16/23, midday dose of levetiracetam was not administered, listed as "drug/item unavailable." The facility investigation related to the error indicated R1's p.m. dose of levetiracetam was documented as administered on 11/15/23, however, it was determined to be documented in error as the medication had not been delivered to the facility.

An undated, Medication Error Report identified a medication error on 11/15/23. R1's levetiracetam 1500 mg was marked as given but medication was not at facility per pharmacy. The plan to correct the problem was identified as "VA [vulnerable adult] investigation, follow-up POC."

R1's progress notes identified the following:

- 11/16/23, Staff went to R1's room to provide cares at approximately 6:35 a.m. and asked writer to check on R1 because she thought something was wrong with her. Upon entering the room R1 was tense with hands and arms constricted and her head was stiff to the right side. Upon neurological checks R1 did not follow commands such as squeezing hands and her eyes were fixed and not reactive to light. The right side of R1's face was drooping and she was verbally unresponsive. After assessment an ambulance was called for transport to the

F 760

instruction on a 1:1 basis with the DON, Corporate Nurse and/or Education RN.

On 12/11/23 audits began to determine competency the rights of medication administration and the expectations of staff in the event of an omission or in unavailability of a high risk medication. Audits have been completed via verbal interview questioning staff□s knowledge on high risk medication examples, rights of medication administration, and expectations on notification to the DON and PCP following identification of omission in drug that is unavailable. Audit frequency will be completed as follows: 3x/day across all shifts for 2 weeks ending on 12/24/23. Beginning on 12/25/23 audits will continue at a rate of 5x/week across all shifts for 2 weeks followed by 2 weeks of audits at least 3x/week across all shifts. Following the 6 weeks of audits, results of audits will be reviewed by QAPI team for determination of further auditing and education needs.

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F 760	Continued From page 4	F 760		

emergency department (ED). Ambulance crew arrived approximately 7:05 p.m. at which time R1 stared coming around but was very confused and kept stating her "head and right-side hurts" resident also kept stating "please help me."

- 11/17/23, Contacted Sanford ED regarding an update on R1. ED staff stated R1 had been admitted to the intensive care unit (ICU) with seizures.

R1's Hospital Admission History and Physical (H and P) dated 11/16/23, identified R1 presented to the ED with encephalopathy and concern for seizures at nursing home with several seizures in the hospital in the context of under dosing her anti-epileptic medications. The H and P indicated the physician suspected R1's presentation was related to seizures and indicated clear seizure like activity in the ED related to under-dosing of R1's levetiracetam at facility because they were not able to fill the medication. Admit to ICU given she had two witnessed seizures in the hospital.

R1's undated hospital Continuity of Care Document identified a Keppra (levetiracetam) level of 2.5. (The therapeutic index of Keppra is approximately 12.0 - 46 mg/Liter.)

During interview on 12/1/23, at 9:00 a.m. CN stated during the medication exchange with the pharmacy staff on 11/15/23, it was identified R1's levetiracetam had not been delivered. Staff contacted the pharmacy between 2:30 p.m. and 3:30 p.m. and the pharmacy stated it would be sent with the evening medication delivery. The levetiracetam did not show up; however, that was not identified by the evening staff. CN added, the evening staff member reported she thought she

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F 760	Continued From page 5	F 760		

had given the medication but could not have since it was not delivered. Staff contacted the pharmacy again on 11/16/23, and the medication still was not delivered so R1 missed both her a.m. and midday doses of levetiracetam. CN confirmed the physician was not notified of the missed doses because the pharmacy kept telling staff the medication would be delivered. The unit manager was aware the medication was not delivered but there was no evidence the DON was updated. The facility had been performing medication administration audits and general education on medication administration but there was no evidence of education related to how to respond or who to notify when a medication was not available other than providing staff with a 24 hour phone number for the pharmacy.

During interview on 12/1/23, at 9:29 a.m. licensed practical nurse (LPN)-A stated when the pharmacy dropped off medications staff compared the medication cards against the orders. If something was missing LPN-A made a list and normally they called the pharmacy. The day R1's medication was not delivered the unit manager (LPN-C) was there and called the pharmacy. LPN-A thought the facility was going to consider doing the medication checks differently but had not received any training or direction related to who to notify if a medication was missing. LPN-A was not aware of a list of medications that were deemed higher importance.

During interview on 12/1/23, at 9:24 a.m. LPN-B stated usually two staff did the medication exchange from the pharmacy. If a medication was missing staff would call the pharmacy right away and if a medication was needed right away

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	245397	A. BUILDING ______ B. WING ______	12/04/2023

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F 760	Continued From page 6	F 760		

they could have someone pick it up from the pharmacy. LPN-B was not aware of the incident with R1's missing medications and had not received any education. Further, LPN-B indicated the charge nurse and the physician should have been notified on a missing anti-seizure medication.

During interview on 12/1/23 at 10:06 a.m., the DON stated there was currently no evidence staff were educated on a process that directed what to do if a medication was not available.

During interview on 12/1/23 at 10:09 a.m., registered nurse (RN)-A stated she was providing education related to medication administration and if a medication was not available staff were to notify the charge nurse and the charge nurse would get a hold of the pharmacy. The pharmacy had an after-hours phone number if the need was urgent. The medication audits were reviewed and lacked evidence staff were trained on what to do when a medication was not available.

During interview on 12/1/23, at 10:26 a.m. LPN-C (unit manager) stated when the pharmacy sent out the medications on 11/15/23, they let the pharmacy know R1's levetiracetam had not been delivered. The next day LPN-C worked until 6:00 p.m. and the medication had not arrived. LPN-C did not follow up with pharmacy but had let the oncoming nurse know. After the incident the facility posted a number for the after-hours pharmacy.

On 12/1/23, at 12:39 p.m. the CN and DON were interviewed. The CN stated the facility did not have a policy or procedure for identification of high risk medications or a procedure for staff to

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F 760	Continued From page 7	F 760		

follow if medications were not available. The CN did not think a lot of the TMA's knew what was considered a high risk medication. The CN stated after R1 was sent to the hospital her physician was notified and said the physician felt the missed medication resulted in R1's seizures. The DON stated she was not aware R1's medications had not been administered as ordered and there was a lack of follow through. The DON said the staff on duty had reported to the unit manager and the process was started but not completed.

During interview on 12/1/23, at 1:01 p.m. R1's physician stated, "I do think the missed medications contributed to the seizures," and ultimately the hospitalization, adding R1 had not had seizures for several months and had been very stable. If the facility was unable to obtain a medication for any reason a call should have been made to the provider or an on-call to determine next steps.

The facility General Policies in Administering Medications policy dated 7/20/22, identified errors of mission, dosage, or type of medication must be reported at once to the RN supervisor and an incident report filled out.

The IJ that began on 11/16/23, was removed on 12/4/23, at 2:50 p.m. when it was verified through interview and document review the facility developed a process to educate staff on identification of high risk medications and developed and educated staff on a process for notification to the provider when medications were omitted for any reason. Education included a posting of some of the common high risk medications on the medications carts a long with a clear procedure for staff to follow for

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F 760	Continued From page 8 communication to management staff when medications were not available.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 15, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 8SVI11

Dear Administrator:

The above facility was surveyed on November 30, 2023 through December 4, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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, 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
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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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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 11/30/23 through 12/1/23 and 12/4/23, 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 order was issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H53977603C (MN98714) H53977602C (MN97895) The following complaints were reviewed. H53977232C (MN98622) with a licensing order issued at 1545. 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 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	2 000		

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2 000	Continued From page 2 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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication	21545		12/28/23

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21545	Continued From page 3 error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop and implement a process to ensure high risk medications were administered and failed to implement a process to report missed doses and/or lack of availability of medications to the provider for 1 of 3 residents (R1) reviewed for medication errors. Findings include: R1's undated, facility Continuity of Care Document identified a diagnosis of localization-related (focal) (partial) symptomatic epilepsy (neurological disorder that causes seizures) and epileptic syndromes (identification of specific seizure type) with simple partial seizures, not intractable (hard to control), without status epilepticus (seizure involves abnormal electrical activity in the brain affecting both the	21545	Corrected	

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mind and the body).

R1's significant change Minimum Data Set dated 9/1/23, identified R1 had intact cognition. R1's care plan updated 11/20/23, identified a potential for alteration in electrical impulse related to seizure disorder and had a self-care deficit related to hemiplegia (paralysis of one side of the body), dementia and failure to thrive.

R1's physician orders dated 11/15/23, included the following orders:
- Levetiracetam (anti-epileptic drug used to treat partial, myoclonic, and tonic-clonic seizures) 1500 milligrams (mg) twice daily in the a.m. and p.m.
- Levetiracetam 500 mg daily between 11:30 a.m. and 1:00 p.m.

R1's Medication Administration History dated 11/1/23 through 11/17/23, identified R1's 11/16/23 a.m. dose of levetiracetam was not administered, listed as "drug/item unavailable." R1's 11/16/23, midday dose of levetiracetam was not administered, listed as "drug/item unavailable." The facility investigation related to the error indicated R1's p.m. dose of levetiracetam was documented as administered on 11/15/23, however, it was determined to be documented in error as the medication had not been delivered to the facility.

An undated, Medication Error Report identified a medication error on 11/15/23. R1's levetiracetam 1500 mg was marked as given but medication was not at facility per pharmacy. The plan to correct the problem was identified as "VA [vulnerable adult] investigation, follow-up POC."

R1's progress notes identified the following:

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- 11/16/23, Staff went to R1's room to provide cares at approximately 6:35 a.m. and asked writer to check on R1 because she thought something was wrong with her. Upon entering the room R1 was tense with hands and arms constricted and her head was stiff to the right side. Upon neurological checks R1 did not follow commands such as squeezing hands and her eyes were fixed and not reactive to light. The right side of R1's face was drooping and she was verbally unresponsive. After assessment an ambulance was called for transport to the emergency department (ED). Ambulance crew arrived approximately 7:05 p.m. at which time R1 stared coming around but was very confused and kept stating her "head and right-side hurts" resident also kept stating "please help me."

- 11/17/23, Contacted Sanford ED regarding an update on R1. ED staff stated R1 had been admitted to the intensive care unit (ICU) with seizures.

R1's Hospital Admission History and Physical (H and P) dated 11/16/23, identified R1 presented to the ED with encephalopathy and concern for seizures at nursing home with several seizures in the hospital in the context of under dosing her anti-epileptic medications. The H and P indicated the physician suspected R1's presentation was related to seizures and indicated clear seizure like activity in the ED related to under-dosing of R1's levetiracetam at facility because they were not able to fill the medication. Admit to ICU given she had two witnessed seizures in the hospital.

R1's undated hospital Continuity of Care Document identified a Keppra (levetiracetam) level of 2.5. (The therapeutic index of Keppra is approximately 12.0 - 46 mg/Liter.)

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During interview on 12/1/23, at 9:00 a.m. CN stated during the medication exchange with the pharmacy staff on 11/15/23, it was identified R1's levetiracetam had not been delivered. Staff contacted the pharmacy between 2:30 p.m. and 3:30 p.m. and the pharmacy stated it would be sent with the evening medication delivery. The levetiracetam did not show up; however, that was not identified by the evening staff. CN added, the evening staff member reported she thought she had given the medication but could not have since it was not delivered. Staff contacted the pharmacy again on 11/16/23, and the medication still was not delivered so R1 missed both her a.m. and midday doses of levetiracetam. CN confirmed the physician was not notified of the missed doses because the pharmacy kept telling staff the medication would be delivered. The unit manager was aware the medication was not delivered but there was no evidence the DON was updated. The facility had been performing medication administration audits and general education on medication administration but there was no evidence of education related to how to respond or who to notify when a medication was not available other than providing staff with a 24 hour phone number for the pharmacy.

During interview on 12/1/23, at 9:29 a.m. licensed practical nurse (LPN)-A stated when the pharmacy dropped off medications staff compared the medication cards against the orders. If something was missing LPN-A made a list and normally they called the pharmacy. The day R1's medication was not delivered the unit manager (LPN-C) was there and called the pharmacy. LPN-A thought the facility was going to consider doing the medication checks differently but had not received any training or direction

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21545	Continued From page 7	21545		

related to who to notify if a medication was missing. LPN-A was not aware of a list of medications that were deemed higher importance.

During interview on 12/1/23, at 9:24 a.m. LPN-B stated usually two staff did the medication exchange from the pharmacy. If a medication was missing staff would call the pharmacy right away and if a medication was needed right away they could have someone pick it up from the pharmacy. LPN-B was not aware of the incident with R1's missing medications and had not received any education. Further, LPN-B indicated the charge nurse and the physician should have been notified on a missing anti-seizure medication.

During interview on 12/1/23 at 10:06 a.m., the DON stated there was currently no evidence staff were educated on a process that directed what to do if a medication was not available.

During interview on 12/1/23 at 10:09 a.m., registered nurse (RN)-A stated she was providing education related to medication administration and if a medication was not available staff were to notify the charge nurse and the charge nurse would get a hold of the pharmacy. The pharmacy had an after-hours phone number if the need was urgent. The medication audits were reviewed and lacked evidence staff were trained on what to do when a medication was not available.

During interview on 12/1/23, at 10:26 a.m. LPN-C (unit manager) stated when the pharmacy sent out the medications on 11/15/23, they let the pharmacy know R1's levetiracetam had not been delivered. The next day LPN-C worked until 6:00 p.m. and the medication had not arrived. LPN-C

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 8	21545		

did not follow up with pharmacy but had let the oncoming nurse know. After the incident the facility posted a number for the after-hours pharmacy.

On 12/1/23, at 12:39 p.m. the CN and DON were interviewed. The CN stated the facility did not have a policy or procedure for identification of high risk medications or a procedure for staff to follow if medications were not available. The CN did not think a lot of the TMA's knew what was considered a high risk medication. The CN stated after R1 was sent to the hospital her physician was notified and said the physician felt the missed medication resulted in R1's seizures. The DON stated she was not aware R1's medications had not been administered as ordered and there was a lack of follow through. The DON said the staff on duty had reported to the unit manager and the process was started but not completed.

During interview on 12/1/23, at 1:01 p.m. R1's physician stated, "I do think the missed medications contributed to the seizures," and ultimately the hospitalization, adding R1 had not had seizures for several months and had been very stable. If the facility was unable to obtain a medication for any reason a call should have been made to the provider or an on-call to determine next steps.

The facility General Policies in Administering Medications policy dated 7/20/22, identified errors of mission, dosage, or type of medication must be reported at once to the RN supervisor and an incident report filled out.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00017	A. BUILDING: ______ B. WING ______	12/04/2023

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21545	Continued From page 9 review and revise policies and procedures for medication errors to include omissions. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		