Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 5, 2026

Administrator
Sylvan Court
112 ST OLAF AVENUE SOUTH
CANBY, MN 56220

RE: CCN: 245433
Cycle Start Date: March 25, 2026

Dear Administrator:

On March 25, 2026, the Minnesota Department(s) of Health and Public Safety, 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
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

April 7, 2026

Administrator
Sylvan Court
112 ST OLAF AVENUE SOUTH
CANBY, MN 56220

RE: CCN:245433
Cycle Start Date: March 25, 2026

Dear Administrator:

On March 25, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

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 June 25, 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 September 25, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245433	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sylvan Court	**112 ST OLAF AVENUE SOUTH , CANBY, Minnesota, 56220**

(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
E0000	Initial Comments On 3/23/26 through 3/25/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/09/2026
F0000	INITIAL COMMENTS On 3/23/26 through 3/25/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54338141C (2797886). NO deficiencies were cited. 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 substantial compliance with the regulations has been attained.	F0000		04/09/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F0755	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared	04/10/2026

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: 245433	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

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F0755 SS = D	Continued from page 1 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 medication, Docusate Sodium, (Colace-stool softener), was not outdated prior to administration for 1 of 25 medication administration observations. Findings include: Observation and interview on 3/24/26 at 8:45 a.m., with trained medication aide (TMA)-A as she prepared to administer R42's morning medications including Docusate Sodium (Colace) 100 milligram (mg) soft gels from the stock bottle in the medication cart. TMA-A retrieved the bottle of Docusate Sodium removed 2 soft gel capsules and placed them into the medication cup with the other medications. TMA-A then delivered the medications to R42 who took the medication. Upon returning to the	F0755	Continued from page 1 and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. Health Citation F0755 | Scope & Severity: D Based on observation, interview, and document review, the facility failed to ensure that one medication—Docusate Sodium (Colace, a stool softener)—was not outdated prior to administration. This was identified in 1 of 25 medication administration observations. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? After administration of stock Docusate Sodium 100 mg to R42 by TMA-A on 03/24/2026, which was found to be expired as of February 2026, the issue was immediately reported to LPN-A. LPN-A removed the expired Docusate Sodium 100 mg from the medication cart and transported it to the medication room for proper disposal. R42's primary care provider was notified, and no new recommendations or interventions were given. The pharmacy provided a replacement bottle of 100-count Docusate Sodium 100 mg, rather than the previous 500-count bottle, to reduce the likelihood of medication expiring before use. How will other residents, having the potential to be affected by the same deficient practice, be identified? A review of residents receiving medications from the affected medication cart was completed on 03/25/2026 by the Director of Nursing. R42 was identified as the only resident prescribed and administered this medication between 03/01/2026 and 03/24/2026. Two additional medication carts containing stock Docusate Sodium 100 mg were reviewed, and it was verified that the medication on those carts was not expired. What measures will be put into place, or what	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245433	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

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Sylvan Court	**112 ST OLAF AVENUE SOUTH , CANBY, Minnesota, 56220**

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F0755 SS = D	Continued from page 2 medication cart and examining the bottle she observed the printed date of expiration of February 2026. TMA-A reported she had not checked the date of expiration prior to administering the medication and confirmed she should have checked the expiration date. Observation and interview on 3/24/26 at 9:00 a.m. with licensed Practical nurse (LPN)-A observed the expiration date of February 2026 printed on the bottle of Docusate Sodium 100 mg soft gels and identified they should have been replaced at the end of February. LPN-A retrieved the bottle of Docusate Sodium and took it to the medication room for disposal. She identified she would immediately notify the MD that R42 had received expired medication and complete the Medication Variance Communication report. Review of R42's medication administration record (MAR) identified she received Colace according to current physician orders 2 capsules (200mg) by mouth every morning. TMA-A and LPN-A confirmed the medication would have been administered from the outdated stock bottle stored in the medication cart for a total of 24 doses. Interview on 3/25/26 at 8:26 a.m. with the director of nursing (DON) identified her expectation for staff to follow the 5 rights of medication administration and not administer an outdated medication. She identified that the expired medication should have been caught and not continued to be administered. Interview on 3/25/26 at 1:30 p.m. with the facility pharmacist identified He Expected staff to follow the five rights of medication administration. The Expired medication should have been identified and replaced to avoid administration of an outdated medication. Review of the March 2026, Medication Errors Policy defined outdated medication as administration of a medication when the composition or effectiveness of the medication could be affected by the date of expiration. Medication errors were to be documented on the Medication Error Report Form. A policy for monitoring medication carts for discontinued or outdated medications was requested but not provided by the end of the survey period.	F0755	Continued from page 2 systemic changes will be made, to ensure that the deficient practice does not recur? To ensure deficient practice will not recur, staff education for RNs, LPNs, and TMAs was initiated immediately on 03/24/2026 for staff on duty and oncoming shifts, reinforcing the Medication Administration policy and procedures. Competency was validated through return demonstration of medication administration skills for all staff who administer medications, completed prior to 04/10/2026. Additionally, the facility policy "Medications: Acquisition, Receiving, Dispensing, and Storage" was reviewed and confirms that the location is responsible for routinely checking medications for expiration dates and removing expired medications as necessary. The pharmacy will continue to supply 100-count bottles of Docusate Sodium 100 mg instead of 500-count bottles during medication restocking to minimize waste and reduce the risk of expired stock medications. Facility-wide staff education and competency validation were completed for all staff administering medications, emphasizing the requirement to read medication labels, compare them with the MAR, and verify expiration dates prior to administration. During the monthly medication cart change-over process, stock medications on all three medication carts will be reviewed by DNS or designee to ensure no expired medications are present. Medications approaching expiration within the current month will be removed, properly disposed of, and replaced. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and ensure on going compliance, DNS or designee will audit medication storage areas including medication carts and medication rooms for expired or soon to be expired medications weekly x4, monthly x2. Audit results will be reviewed through the QAPI committee for trending, monitoring, and recommendations for further action if indicated. What is the date of completion? 4.10.26	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 ANNE STREET NORTHWEST , 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
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/03/2026. At the time of this survey, Neilson Place was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:A detailed description of the corrective action taken or planned to correct	K0000		04/17/2026

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: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 ANNE STREET NORTHWEST , BEMIDJI, Minnesota, 56601

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K0000	Continued from page 1 the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Neilson Place was constructed in 2004, is 2-stories, without a basement and was determined to be of a Type I (332) construction. In 2009, 3 additions were constructed, a services wing to the south and connecting links to an apartment building to the north. The two connecting links into the north assisted living building are 1-story, Type II (111) construction. The building is divided into 3 smoke zones on each floor by 1 hour fire barriers. The facility has corridor smoke detection and smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". All sleeping rooms have single station smoke detectors with annunciation in the corridor and at the nurse's station that serves that room with additional automatic fire detection in all rooms. The fire alarm is monitored for automatic fire department notification. The building is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a capacity of 78 beds and had a census of 73 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0211 SS = F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility	K0211	K-211 Means of Egress The second floor exit south stairwell and east stairwell leading outside will be assessed and repaired to meet NFPA/LSC requirements. All exits will be audited to make sure they operate within NFPA/LSC requirements. Maintenance staff will be trained by the Facilities Manager to identify situations where means of egress requirements are infringed upon. Audits of the emergency egress exits will be done by the Facilities Manager weekly x 4, monthly x 2. Results of the audits will be reviewed by the QAPI committee.	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

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K0211 SS = F	Continued from page 2 failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/03/2026 at following times, it was revealed by observation that there were egress exits that were blocked or not functioning properly which were addressed at the time of discovery. 1) at 1:01pm, second floor exit door to south stairwell did not open fully do to interference of floor surface. 2) at 1:13pm, east stairwell door leading to outside was blocked by snow and a wooden bench. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0211	Continued from page 2 Substantial completion will be achieved by 4/17/26	
K0321 SS = D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K0321	K-321 Hazardous Areas -Enclosures The hydrotherapy/storage room door will be fit with a closure. All hazardous areas will be audited to ensure they meet NFPA/LSC requirements. Training will be provided to Maintenance Staff by Facilities Manager on requirements for Hazardous Areas-Enclosures. Audits will be completed of hazardous area enclosures by the Facilities Manager weekly x 4, monthly x 2. Results of the audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 4/17/26	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 ANNE STREET NORTHWEST , BEMIDJI, Minnesota, 56601

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K0321 SS = D	Continued from page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: On 03/03/2026 at 1:15pm, it was revealed by observation that Hydrotherapy room that has been converted to a storage room did not have a self-closing device that closed and latched storage room door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and	K0345	K-345 Fire Alarm Systems-Testing and Maintenance Testing of the fire alarm system will be completed to meet NFPA requirements Documentation review will be completed to make sure all required testing for the fire alarm system is scheduled. Facilities Manager will be trained by Administrator in the requirements for Fire Alarm Systems. Audits of the documentation for the fire alarm system ITM by the Facilities Manager or designee weekly x 4, monthly x 2. Audits will be reviewed by the QAPI Committee. Substantial completion will be achieved by 4/17/26	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 ANNE STREET NORTHWEST , BEMIDJI, Minnesota, 56601

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K0345 SS = F	Continued from page 4 Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/03/2026 at 12:05pm, it was revealed by a review of available documentation the facility failed to perform the quarter alarm system testing. last report provided was dated 02/28/2025 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345		
K0346 SS = D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/03/2026 at 11:47am, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire alarm outage lasting longer than four (4) hours in a 24-hour period. Names and numbers for current AHJ is required to be listed in policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0346	K346-Fire Alarm System-Out of Service The Fire Watch Policy will be reviewed and updated to meet NFPA and AHJ requirements. The Fire Watch Policy will be audited and correted to make sure that it meets NFPA requirements. The Facilities Manager will be trained by the Administrator in the requirements of the Fire Watch Policy. Audits will be completed by the Fire Watch Plan by the Facilities Manager weekly x 4, monthly x 2. Audit results will be reviewed by the QAPI committee. Substantial completion will be achieved by 4/17/26	04/17/2026
K0353 SS = F	Sprinkler System - Maintenance and Testing	K0353	K-353 Sprinkler System-Maintenance and Testing	04/22/2026

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K0353 SS = F	Continued from page 5 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/03/2026 at 12:10pm, it was revealed by a review of available documentation the facility failed provide documentation for deficiencies in the sprinkler system. The documents indicated leaking check valves had been repaired. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K0353	Continued from page 5 The fire sprinkler documentation will be provided for the repair of leaking check valves. The vendor has been contacted; repairs are scheduled at their earliest convenience. Review of required documentation for the fire sprinkler system ITM will be completed. The Facilities Manager will be trained by the Administrator in the requirements of Sprinkler System Maintenance and Testing including the importance or reviewing reports. Audits will be completed of the Fire Sprinkler System documentation by the Facilities Manager/designee weekly x 4, monthly x 2. Audit results will be reviewed by the QAPI committee. Substantial completion will be achieved by 4/22/26	
K0354 SS = D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service	K0354	K-354 Sprinkler System out of Service The Fire Watch Plan will be reviewed and updated to meet NFPA and AHJ requirements.	04/17/2026

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K0354 SS = D	Continued from page 6 Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/03/2026 at 11:47am, it was revealed by documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. Names and numbers of current AHJ is required to be listed in policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0354	Continued from page 6 Audits of the Fire Watch Plan to ensure that it meets the NFPA requirements. The Facilities Manager will be trained by the Administrator in the requirements of the Fire Watch Plan. Audits will be completed by the Facilities Manager/designee weekly x 4, monthly x 2. Audit results will be reviewed by the QAPI committee. Substantial completion will be achieved by 4/17/26	
K0355 SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K0355	K-355 Portable Fire Extinguishers The vendor will be contacted with the request for further detailed documentation regarding extinguisher inspection. Review of the annual extinguisher inspection to ensure extinguisher maintenance is being performed and documented. The Facilities Manager will be trained by the	04/17/2026

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K0355 SS = D	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/03/2026 at 11:18am, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. Documents provided did not provide extinguisher maintenance that was provided. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0355	Continued from page 7 Administrator in the requirements of the Portable Fire Extinguishers Audits will be completed of the Portable Fire Extinguisher documentation by the Facilities Manager/designee weekly x 4, monthly x 2. Audit results will be reviewed by the QAPI committee. Substantial completion will be achieved by 4/17/26	
K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K0372	K-372 Fire Barrier Penetrations The penetration above the door going to the Huckelberry wing, Elderberry wing, elevator room on second floor will be filled with fire caulk or fixed to meet NFPA requirements. Fire barriers will be audited to make sure they are free of penetrations. Maintenance staff will be trained by the Facilities Manager/designee in the NFPA requirements for fire barriers. Audits will be completed of the fire barriers by the Facilities Manager/designee weekly x4, monthly x2. Results of the audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 4/17/26	04/17/2026

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K0372 SS = F	Continued from page 8 On 03/03/2026 at the following times, it was revealed by observation that there was a penetration running from one smoke compartment to another above following doors: 1) at 12:33pm, penetration above doors in fire wall leading to Huckleberry wing 2) at 12:37pm, penetration above doors in fire wall leading to Elderberry wing 3) at 12:44pm, penetration above doors in fire wall leading to elevator room on second floor An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0372		
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/03/2026, at 11:37am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: first quarter, first shift at 10:00am, second quarter, first shift at 10:20am. Third quarter, first shift at 1:20 and fourth quarter, first shift at 1:11. does not show varying times.	K0712	K 712 Fire Drills A schedule for fire drills will be made to ensure NFPA requirements are met. The schedule for fire drills will be reviewed to ensure fire drills are scheduled to be completed within NFPA requirements. Training will be completed with Maintenance staff by the Facilities Manager/designee on the requirements for fire drills. Audits of fire drill documentation will be completed by the Facilities Manager/designee weekly x 4, monthly x 2. Audits will be reviewed by the QAPI committee. Substantial completion will be achieved by 4/17/26	04/17/2026

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K0712 SS = F	Continued from page 9 2. On 03/03/2026, at 11:37am, it was revealed by a review of available documentation that fire drills were not completed:second quarter, second shift An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712		
K0761 SS = F Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/03/2026 at 11:20am, it was revealed by review of available documentation the required annual door inspection documentation was the proper revision and only had 11 points of inspection, not the required 13 points. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0761	K 761 Maintenance, Inspection and Testing -Doors. The fire/smoke doors inspection will be completed using the correct 13-point form. All fire/smoke doors will be inspected using the correct form. Training will be conducted with Maintenance staff by the Facilities Manager/designee on NFPA requirements for the fire and smoke door checks. Audits will be completed of the documentation for the fire/smoke doors by the Facilities Manager/designee weekly x4, monthly x 2. Audits will be reviewed by the QUAPI committee. Substantial completion will be achieved by 4/17/26	04/17/2026