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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: AN38

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00823

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245039**

2.STATE VENDOR OR MEDICAID NO.
(L2) **106240900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEILSON PLACE**
(L4) **1000 ANNE STREET NORTHWEST**
(L5) **BEMIDJI, MN** (L6) **56601**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/01/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
11/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Debra Vincent,HFE NEII — 10/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 10/18/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7006 2150 0001 4308 0410

September 16, 2016

Ms. Linda Barkley, Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, Minnesota 56601

RE: Project Number S5039027

Dear Ms. Barkley:

On September 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 11, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 11, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by December 1, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 March 1, 2017 (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.

INFORMAL DISPUTE RESOLUTION

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST 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 The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to document the identification of a non-pressure related skin injury and failed to complete a comprehensive assessment of the injury in order to determine appropriate care plan interventions and goals for 1 of 1 residents (R26) reviewed for non-pressure related skin conditions. Additionally, the facility failed to ensure dialysis medications had been provided according to the manufacturer's recommendations for 1 of 1 residents (R123) reviewed for dialysis.	F 309	See attached PoC approved 9-29-16 J.B.	10/11/16

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

Linda M Barkley — Administrator — 09.26.2016

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

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F 309	Continued From page 1 Findings included: R26's facility face sheet included diagnoses of: end stage renal disease with dialysis, peripheral vascular disease, severe protein-calorie malnutrition, diabetes, and legally blind. On 8/29/16, at 3:33 p.m. nursing assistant (NA)-A and NA-B entered R26's room with the shower chair. They removed R26's incontinent garment. On the left lower outer edge of R26's buttock there were 3 areas with dark brown/black scabs varying in size. The areas were not over bony prominences, were dry with no drainage, and no surrounding areas of redness. NA-A indicated the areas were not new and had been there since sometime the previous week but could not remember the exact date. R26's current electronic physician orders for wound care did not reflect orders to care for the impaired skin integrity on the left buttock. The physician's orders did include, "Turn every 2 hours to prevent skin break down." R26's current care plan for 8/29/16 did not reflect the impaired skin integrity on the left buttock. The care plan was revised on 8/31/16. The revision included, "lesions on left outer lower buttock-appearance of dried blood blisters," and "keep lesions on left buttock dry and clean. Monitor brief edges for curling." The care plan informed staff R26 had a potential for alteration in skin integrity related to history of incontinence, impaired mobility, and history of pressure ulcers; and directed staff to "monitor skin for redness/breakdown daily." The most recent weekly skin progress note was dated 8/22/16, at 6:10 p.m.; the note indicated presence of small bruises on both arms and did not reflect the presence of lesions on the left buttock. There was no documentation of R26's impaired skin integrity on the left buttock.	F 309		

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F 309	Continued From page 2 R26's nurse progress note dated 8/29/16, at 8:42 p.m. included, "L [left] lower buttock has blood blister as if pinched in hoyer [mechanical lift] sling, 3.25 cm [centimeters] x [by] 0.25 cm strip followed by 0.5 cm strip followed by 1.25 cm strip all in a row, dark blue, res [resident] denies pain, will continue to monitor." R26's nurse progress note dated 8/30/16, at 3:59 p.m. reported buttocks were examined by registered nurse (RN) and included, "left lower outer buttock has three black areas which have the appearance of dried blood blisters. Largest is 3 cm x 0.25 cm, another is 0.9 cm by 0.2 cm, the third is 0.3 cm x 0.2 cm, these lie in area where edge of brief crosses skin. Area palpated by this nurse and [name of nurse] area is not directly over a bony prominence but is lateral to the bone. Sling examined and resident observed while sitting in sling from Neilson Place and from dialysis. No straps cross in the area of the lesions. No tenderness upon palpation. No redness surrounding lesions. No drainage. Roho [pressure relieving cushion to prevent or reduce the risk of pressure ulcers] examined and is inflated properly and was present in his wheelchair when he was sitting on it just prior to exam. Lesions do not appear to be from pressure." On 8/29/16, at 3:41 p.m. licensed practical nurse (LPN)-B observed the areas on R26's left buttock. LPN-B stated she was not aware of the lesions on the left buttock and explained the areas appeared as if the skin was pinched in the hoyer sling. LPN-B explained R26 was prone to skin tears. LPN-B explained nurses complete skin documentation weekly on bath days, nursing assistants were supposed to report any skin concerns to the nurse. The nurse then goes in, takes care of the wound, documents the	F 309		

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F 309	Continued From page 3 information, and follow-up evaluations are completed on bath/shower days. LPN-B explained RN's assess and investigate areas that are caused from an unknown source. During an interview on 8/30/16, at 3:54 p.m. RN-A and RN-B stated R26's lesions were now comprehensively assessed and reported the lesions appeared to be superficial dried blood blisters. The lesions were not over bony prominences. The RN's concluded the lesions were more in the area of the incontinent garment line and not related to pressure. RN-B stated the nursing assistants should have reported the area right away. Nursing assistants should report anything they see if they don't know the resident and have not previously seen the skin. On 8/31/16, at 7:42 a.m. the director of nursing (DON) explained nursing assistants were to report any skin issues to a licensed staff member. R26's areas should have been reported. In a subsequent interview at 9:17 a.m., DON reported after contacting staff that worked over the weekend, one of the staff nurses had worked a five day stretch and knew the lesions had showed up the morning of 8/27/16 because the nurse had helped get R26 out of bed. The DON stated the second nurse contacted also was aware of the lesions, had put cream on them and watched them all weekend. The DON indicated the nurse took accountability, and had no excuses other than being really busy and was aware no documentation was completed. During an interview on 8/31/16, at 9:46 a.m. RN-A reported she had updated the care plan with the lesion this morning at 7:00 a.m. The facility policy dated 12/15, Skin Assessment And Documentation included, "Any change in skin condition during Activities of Daily Living will be reported immediately to a licensed nurse for	F 309		

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F 309	Continued From page 4 evaluation." R123 was provided the medication Renvela (binds phosphorous in food used to control phosphorus levels in people with chronic kidney disease on dialysis), along with R123's other scheduled morning medications. However, Renvela can decrease the bioavailability of other medications when administered together. R123's undated Face Sheet identified the resident was admitted to the facility with diagnoses that included, but were not limited to end stage renal disease (ESRD) and type II diabetes. R123's admission Minimum Data Set (MDS) dated 7/14/16, identified R123 had no memory, behavior or cognitive impairment, was able to independently ambulate and eat, and received dialysis. On 8/31/16, at 7:52 a.m. licensed practical nurse (LPN)-C gave R123 his morning medication's which included: Renvela 800 mg, aspirin 81 mg, docusate sodium (stool softener) 100 mg, folic acid (vitamin B) 1 mg, metoprolol tartrate (for angina) 6.25 mg, Nephrocaps (dietary supplement for people in kidney failure) 1 mg, Prilosec (decrease stomach acid) 20 mg, senna 8.6 mg, Zoloft (anti-depressant) 100 mg, and sodium bicarbonate (antacid) 650 mg. Review of the Renvela medication instructions for use, provided by the facility, revealed: "Avoid taking any medications within 1 hour before or 3 hours after you take Renvela. [Renvela] can bind to other medications and make them less effective." Medical record review revealed there was no physician's order authorizing	F 309		

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F 309	Continued From page 5 administration techniques contrary to the manufacturers recommendation. On 8/31/16, at 9:51 a.m. LPN-C was interviewed and stated she was not aware that the medication Renvela should not be administered with other medications. On 8/31/16, at 3:00 p.m. the director of nursing (DON) stated she had spoken to the pharmacy consultant who stated that it was acceptable to give R123 all morning medications together including Renvela. The DON stated the pharmacy consultant had not provided an explanation for the reason or reasons not to follow the manufacturer's directions for use.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	See attached PoC	10/11/16

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F 329	Continued From page 6 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the physician justified the ongoing use of antipsychotic and antidepressant medications without a documented failed attempt of a gradual dose reduction/taper and lack of documented ongoing depressive signs and symptoms for 1 of 5 residents (R96) reviewed for unnecessary medications. Findings included: R96 was admitted to the facility on 5/5/14 with diagnoses that included depression with anxiety according to the facility face sheet. R96's quarterly Minimum Data Sets (MDS) dated 5/2/16 and 7/29/16 indicated no cognitive impairment with a Brief Interview for Mental Status score of 15. The MDS indicated no delirium, behaviors, or rejection/refusal of care. The 5/2/16 MDS reported no depressive symptoms with a PHQ-9 (Patient Health Questionnaire - assessment tool for identifying depressive symptoms) score of 0. The 7/29/16 MDS indicated minimal depression with a PHQ-9 score of 2. R96's current electronic physician's orders included: -Abilify (atypical anti-psychotic medication recommended to treat schizophrenia, bipolar disorder, also used in conjunction with an antidepressant to treat depressive and mood	F 329		

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	245039	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 7 disorders) 10 milligrams daily. Physician orders indicated a start date of 5/27/14. -Venlafaxine (antidepressant) 150 mg twice daily. Physician orders indicated a start date of 8/27/14. R96's current electronic care plan identified R96 had an alteration in mood as evidenced by depression/anxiety with a goal of reduction of target behaviors of crying, statements of sadness, and withdrawn. The care plan instructed staff to monitor for effectiveness of the program with periodic review by the pharmacist. The care plan also indicated R96 had a history of refusing to reposition, do self-cares, and get out of bed. R96's 2016 Yearly Data Summary for tracking target behaviors of: statements of sadness/withdrawal/crying, decreased appetite, and withdrawal identified the following: January - no recorded target behaviors February - no recorded target behaviors March - no recorded target behaviors April - reported 0.02 incidences of statements of sadness/withdrawal/crying and 0.32 incidences of withdrawal. May - 0.56 incidences of withdrawal June - 0.22 incidences of withdrawal July - 0.03 incidences of statements of sadness/withdrawal/crying R96's physician visit noted dated 9/1/15, reported, "Depression in remission. Continue medications". A visit note dated 11/25/15, included "depression is in remission with Venlafaxine [Effexor]." R96's physician visit note dated 3/30/16, included, "She has had depression. Will continue her Effexor and Abilify and her mood has been good." R96's physician visit notes dated 4/28/16 included, "Depression, doing well. Continue Effexor [Venlafaxine] and	F 329		

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F 329	Continued From page 8 Abilify." R96's physician visit note dated 7/27/16 included, "Major depressive disorder with single episode, in full remission." The note indicated treatment with Venlafaxine and Abilify. R96's physician visit note dated 7/31/16 identified a diagnosis of depression treated with Venlafaxine and Abilify. R96's 10/15, (not otherwise dated) consultant pharmacist medication review included, "Periodic reassessment of psychotropic medications is required by CMS. Resident's last PHQ-9 was 1 indicating minimal depression symptoms. Resident is also on Abilify for major depression. IDT [interdisciplinary team] noted that a trial reduction might not have been attempted yet in this SNF [skilled nursing facility] and the team is comfortable attempting a reduction at this point". The pharmacist recommended "Please consider a modest reduction to Effexor 125 mg twice daily - continue to have nursing monitor s/s [signs/symptoms] of depression. If appropriate, please provide a risk vs benefit statement to support continued use." The physician responded by rejecting the recommendation and wrote, "She is doing well, no depression (PHQ-9 one). I hate to decrease it and have a relapse." R96's 1/16, (not otherwise dated) consultant pharmacist medication review included, "Periodic reassessment of psychotropic medications is required by CMS. Resident's last PHQ-9 was 1 indicating minimal depression symptoms. Resident is also on Abilify for major depression. IDT [interdisciplinary team] noted that a trial reduction might not have been attempted yet in this SNF [skilled nursing facility] and the team is comfortable attempting a reduction at this point". The pharmacist recommended "Please consider a modest reduction to Effexor 125 mg twice daily-continue to have nursing monitor s/s of	F 329		

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F 329	Continued From page 9	F 329		

depression. If medication is to continue, clinical documentation of how it improves [R96's] quality of life is recommended by CMS." The form and record did not reflect a physician response, signature, or that a dose reduction was attempted.
A pharmacy report created on 8/31/16 indicated the physician opted not to change the dose of Effexor on 6/1/16. A copy of June's recommendation was requested and not provided from the facility.
On 8/29/16, at 5:26 p.m. R96 was in her room watching television. R96 was pleasant and conversational. No display of behaviors, depressive statements, or indicators of depression noted.

On 8/31/16, at 1:49 p.m. registered nurse (RN)-B indicated R96 had no dose reductions of either Abilify or Effexor since admission to the facility on 5/5/14. RN-B reported nursing staff has tried to encourage the physician to document the need for continued use of psychotropic medications. RN-B stated R96 is in a much better place mentally now because her health and mobility have greatly improved following surgery.
On 9/1/16, at 11:00 a.m. the director of nursing (DON) indicated the physician did not think a dose reduction was indicated because R96's mood was stabilized. R96 had improved over the past year. The DON indicated the physician was resistant to providing a complete risk vs benefit statement that would justify the ongoing use of the medications without historical failed attempts.
The facility Antipsychotic Medication Reduction Policy dated 12/15, included, "residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to

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F 329	Continued From page 10 discontinue these drugs." Additionally, "Neilson Place will emphasize the importance of seeking an appropriate dose and duration for each medication thus minimizing the risk of adverse consequences. The purpose of tapering a medication is to find an optimal dose or to determine weather continued use of the medication is benefiting the resident." The policy also included "tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms."	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	See attached PoC	10/11/16

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F 431	Continued From page 11 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure two of two multi dose vials of tuberculin testing solution identified an open date to ensure non-use after thrity days as recommended by the manufacturer. This had the potential to affect new resident admissions to the facility. Findings included: During medication storage review and observation on 9/1/16, at 1:26 p.m. the first floor medication refrigerator contained two open multi-dose vials of Tubersol (tuberculosis (TB) skin testing solution) that did not have open dates. Both vials had multiple doses remaining. The two opened vials and the two unopened vials did not contain a pharmacy label. The two open vials contained the same lot number; C5022ba and both vials expired on October 14, 2018. On 9/1/16, at 1:26 p.m. registered nurse (RN)-B stated the vials were supposed to be dated when opened. The director of nursing (DON) indicated after a vial was opened the testing solution was only good for 30 days. The DON stated if there	F 431		

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F 431	Continued From page 12 was not an open date identified on the testing solution, then the solution was no good and staff should discard and not use. During a subsequent interview at 2:52 p.m. RN-B stated the testing solution had been sent from the hospital pharmacy on 8/2/2016, and 8/23/2016. However, it could not be determined which vials were sent on which dates. Tubersol package insert included, "A vial of Tubersol [Tuberculin Purified Protein Derivative (Mantoux)] which has been entered and in use for 30 days should be discarded because of oxidation and degradation may have reduced potency. Failure to store and handle Tubersol as recommended will result in loss of potency and inaccurate test results." Facility policy, Tuberculosis Testing last reviewed 12/2015 did not reference storage instructions or instruction to staff to date the multi-dose vials after opening or how long the solution was good for after opening.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	See attached PoC	10/11/16

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F 441	Continued From page 13 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed ensure cleaning and storage of inhalation accessories for breathing treatments to reduce or prevent the risk of infection for 2 of 2 residents (R2, R14) observed to have nebulizer treatments during the initial tour of the Huckleberry unit. Findings included: On 8/29/16, at 5:32 p.m. R2's nebulizer mask and reservoir was hanging on the wall oxygen supply. The reservoir contained 1-2 cubic centimeters (cc's) of clear fluid. The tubing was dated 6/16/16. At 5:42 p.m. licensed practical nurse (LPN)-B verified the nebulizer accessories had not been	F 441		

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F 441	Continued From page 14 cleaned and stated they should have been cleaned. LPN-B reported R2 received nebulizer treatments as needed. LPN-B then rinsed the reservoir out in R2's sink and placed the accessories on a paper towel to dry. R2's current electronic physician orders included albuterol sulfate solution 2.5 milligrams (mg)/3 milliliters (ml) for nebulization every 6 hours as needed. R2's medication administration record (MAR) indicated the last administered dose of albuterol sulfate was 8/2/16, at 8:43 a.m. On 8/29/16, at 6:29 p.m. and again on 8/30/16, at 10:27 a.m. R14's nebulizer mask and reservoir was hanging on the wall oxygen supply. The mask had smudges and was soiled. The tubing was not dated. At 10:49 a.m. registered nurse (RN)-A verified the nebulizer accessories had not been cleaned and stated she would need to check the policy for cleaning and storage. R14's current electronic physician's orders included Ipratropium-bromide solution 0.2%; one 3 ml vial for nebulization inhalation every 4 hours as needed. R14's MAR indicated the last administered dose of Ipratropium-bromide was 8/25/16, at 11:39 a.m. On 8/31/16, at 7:40 a.m. the director of nursing (DON) stated the reservoir chambers do not have to be rinsed, they are supposed to shake out as much liquid as possible, dry, then store in a bag. The DON further stated the accessories were supposed to be changed weekly or when visibly soiled. The facility policy dated 9/16, Nebulizer Cleaning included: "Replace nebulizers when soiling cannot be removed, when not functioning properly, and at a minimum of every 7 days," and "after each treatment empty the nebulizer cup by	F 441		

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F 441	Continued From page 15 shaking out as much liquid as possible and dry with flow through the nebulizer. If there is visible organic matter use sterile water to rinse the nebulizer cup, mouthpiece, mask or tubing. NEVER [capitalized] use tap water" and "Following cleaning store supplies in the bag."	F 441		

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
F 309	On 8/30/16, licensed staff were re-educated by the DON and RN Neighborhood Manager on the policies and procedures related to skin assessments and documentation. R26's care plan was updated to address the comprehensive skin assessment and interventions to prevent further skin breakdown. All residents that have skin alterations will have care plans updated to reflect a comprehensive skin assessment and interventions as appropriate On 8/31/16 licensed staff was educated by the DON on proper administration of certain dialysis medications as per manufacturer recommendation. Electronic Medication Record was updated with the manufacturer recommendation. Education will be provided to all Licensed Staff and Personal Care Associates by the DON and RN Neighborhood Manager on October 5, 2016 on the need to follow Neilson Place policies and procedures on skin assessments, skin documentation, and monitoring skin for changes. Medications needing to have specific guidelines will be reviewed with Licensed Staff. Through the Quality Assurance Performance Improvement process (QAPI) weekly audits will be completed by DON or designee x 4 weeks to ensure compliance with skin assessments and documentation. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations. (See attachment #1)	8/30/2016 8/30/2016 10/5/2016 8/31/2016 10/11/2016

Attachment # 1

QAPI

Major aspect of care or function: Date: Year:

Timely comprehensive skin assessments and documentation

Sample size and time frame:

Weekly audits x4 weeks -Comprehensive Assessments and Care Plans- then reviewed by QAPI Committee for further recommendations

Neighborhood: Mulberry, Strawberry, Huckleberry, Elderberry

Data Collection:

Admission Date										
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
1. Comprehensive Skin Assessments completed within the appropriate timeframe										
2. Timely Care Plan development and update										

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
F 329	On 8/31/16, R 96's physician was notified and educated on the routine of reviewing medications and pharmacist recommendations and providing appropriate reductions and/or risk versus benefit statements. All residents who have the potential for unnecessary medications will be reviewed by pharmacist, DON, and Neighborhood RN Manager. Education will be provided to all Licensed Staff by the DON and RN Neighborhood Manager on 10/05/2016, on the need to routinely review medications and pharmacist recommendations and providing appropriate reductions and/or risk versus benefit statements. Through the Quality Assurance Performance Improvement process (QAPI) monthly audits will be completed by DON or designee x 4 months to ensure compliance with routinely reviewing medications and pharmacist recommendations and providing appropriate reductions and/or risk versus benefit statements. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations. (See attachment #2)	8/31/16 10/5/16 10/11/16

Attachment # 2

QAPI

Major aspect of care or function: Date: Year:

Review of medications, pharmacist recommendations and providing appropriate reductions and/or risk versus benefit statements.

Sample size and time frame:

Monthly audits x 4 months- of all residents on psychotropic medications-then reviewed by QAPI committee for further recommendations

Neighborhood: Mulberry, Strawberry, Huckleberry, Elderberry

Data Collection:

Admission Date										
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
1. All resident medications reviewed by pharmacist										
2. Pharmacy Recommendations addressed by physician										
3. Appropriate reductions and/or risk versus benefit statements										

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
F 431	On 9/1/2016, Licensed staff were re-educated on the policy and procedure for dating tuberculin testing solutions when opened and length of time for use after opening tuberculin testing solution. Procedure for recording on medical record tuberculin testing was updated to include the brand name of the tuberculin solution, lot number, manufacturer, and expiration date on vial. Education will be provided to all Licensed Staff by the DON and RN Neighborhood Manager on 10/05/2016, on the policy and procedure for dating tuberculin testing solutions and recording of the brand name of the tuberculin solution, lot number, manufacturer, and expiration date on vial. Through the Quality Assurance Performance Improvement process (QAPI) weekly audits will be completed by DON or designee x 4 weeks to ensure compliance with for dating tuberculin testing solutions and recording of the brand name of the tuberculin solution, lot number, manufacturer, and expiration date on vial. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations. (See attachment #3)	9/1/2016 10/5/2016 10/11/2016

Attachment # 3

QAPI

Major aspect of care or function: Date: Year:

Dating tuberculin testing solutions-recording all pertinent information from tuberculin testing solution on medical record

Sample size and time frame:

Weekly audits x 4 weeks- all tuberculin testing solutions and residents who received a tuberculin test- then reviewed by QAPI committee for further recommendations

Neighborhood: Mulberry, Strawberry, Huckleberry, Elderberry

Data Collection:

Admission Date										
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
1. All tuberculin testing solutions dated when open										
2. All pertinent information recorded on resident medical record who received a tuberculin test										
3. Destruction of tuberculin testing solutions destroyed 30 days after opening										

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
F 441	On 8/31/16 licensed staff were re-educated by the DON and RN Neighborhood Manager on the procedure for cleaning and storing nebulizer equipment in resident's rooms. R2 and R14's medication administration records were updated to reflect cleaning, dating, and storage of nebulizer equipment after use. All residents who routinely use nebulizer equipment will have medication administration records updated to reflect cleaning, dating, and storage of nebulizer equipment. Education will be provided to all Licensed Staff and Trained Medication Aides by the DON and RN Neighborhood Manager on 10/05/2016, on the on the procedure for proper cleaning, storage, and infection control measures related to nebulizer equipment in resident's rooms. Through the Quality Assurance Performance Improvement process (QAPI) weekly audits will be completed by DON or designee x4 weeks to ensure compliance with proper cleaning, storage, and infection control measures related to nebulizer equipment in resident's rooms. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations. (See attachment #4)	8/31/2016 8/31/2016 10/5/2016 10/11/2016

Attachment # 4

QAPI

Major aspect of care or function: Date: Year:

Infection Control measures related to cleaning and storage of nebulizer equipment

Sample size and time frame:

Weekly audits x 4 weeks- all residents utilizing nebulizer equipment-then reviewed by QAPI committee for further recommendations

Neighborhood: Mulberry, Strawberry, Huckleberry, Elderberry

Data Collection:

Admission Date										
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
1. Nebulizer equipment clean and stored in bag										
2. Nebulizer equipment dated when changed out for new										
3. Medication Administration record reflect cleaning, dating, storage of nebulizer equipment										

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

F5039025

PRINTED: 09/16/2016
FORM APPROVED
OMB NO. 0938-0391

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	245039	A. BUILDING 02 - BUILDING 1 B. WING	08/30/2016

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Neilson Place 02 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	APPROVED By Tom Linhoff at 2:11 pm, Oct 14, 2016 RECEIVED SEP 27 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Administrator 09-26-2016

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING _____	08/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST 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
K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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" 1999 edition. All sleeping rooms have single station smoke detectors with annunciation in the corridor and at the nurse's station that serves that room with	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING	08/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 additional automatic fire detection in all rooms required by the Minnesota State Fire Code 2007 edition. 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 1999 edition. The facility has a capacity of 78 beds and had a census of 71 at the time of the survey. The facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain one smoke barrier wall in accordance with NFPA 101-2000 edition, Sections 18.3.7.1, 18.3.7.3. This deficient practice could allow the products of combustion to spread throughout the smoke compartment in the event of a fire which could affect 19 of the 71 residents,and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 12:15 pm	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 025	Continued From page 3 on 08/31//2016 observations and staff interview revealed a penetration in the Huckleberry wing smoke barrier above the ceiling at the cross corridor doors. This deficient condition was verified by the Maintenance Supervisor.	K 025		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 18.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This	K 051		

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K 051	Continued From page 4 deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 12:15 pm on 08/31//2016 observations and staff interview revealed a smoke detector within 36 inches of a diffuser in the first floor gift shop storage room. This deficient condition was verified by the Maintenance Supervisor.	K 051		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire and could negatively affect, all of the 71 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 12:15 pm	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING _____	08/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062	Continued From page 5 on 08/31//2016 observations and staff interview revealed one missing ceiling tile in the 2nd floor neighborhood kitchen in the Strawberry wing and two missing ceiling tiles in the 1st floor kitchen in the Huckleberry wing. This deficient condition was verified by the Maintenance Supervisor.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 71 residents, and an undetermined amount of staff, and visitors. Findings include: On the facility tour between 8:15 am to 12:15 pm on 08/31//2016 record review and staff interview revealed the 5 minute generator cool down cycle was not being logged on the monthly test report. This deficient condition was verified by the Maintenance Supervisor.	K 144		

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
K 025 SS = E	Fire caulk will be used to seal the penetration noted. A Smoke Barrier Penetration procedure has been developed and will be presented to all contractors when work is required in the area of a smoke barrier. The General Services Manager or designee will present this form to the person doing the work. The person doing the work will be made to understand their responsibilities for the repair of any penetrations. Upon the conclusion of the work, the General Services Manager or designee will visually inspect the work area to verify compliance and that all penetrations are correctly sealed. See Attachment #1	09-01-2016 09-01-2016

Attachment #1

Neilson Place General Services

Sign-off Sheet for Smoke Barrier Penetration And Protection of Sprinkler Piping Agreement

Purpose: to maintain compliance with NFPA 101, the Life Safety Code

Neilson Place adheres to the National Fire Protection Association's Life Safety Code, NFPA 101. As such, any penetration of a smoke barrier must be sealed in accordance with the steps outlined in Section 8.3.6 of NFPA 101.

Contractors and their staff, Neilson Place staff, and anyone else doing work that may penetrate a smoke barrier are required to repair the barrier before their work is considered completed. The repair must satisfy the requirements of NFPA 101.

Nothing may be attached to or supported by fire sprinkler piping.

Responsibilities: It is the responsibility of the General Services Manager or designee to verify that the contractor is aware of this requirement and to then verify that any penetration has been sealed per the requirements and that nothing has been attached to or supported from any fire sprinkler piping.

It is the responsibility of the contractor or person doing work to ensure that all penetrations are sealed per the requirements and that nothing has been attached to or supported from any fire sprinkler piping.

Procedure: When work is required in the area of a smoke barrier, the General Services Manager or designee will present this form to the person doing the work. The person doing the work will be made to understand their responsibilities for the repair of any penetrations. Upon the conclusion of the work, the General Services Manager or designee will visually inspect the work area to verify compliance and that all penetrations are correctly sealed and that nothing has been attached to or supported from any fire sprinkler piping.

Signatures:
I agree to the terms of this form and have successfully completed the work required in this area. All penetrations have been sealed and nothing has been attached to or supported from any fire sprinkler piping according to the requirements of NFPA 101.

By: _____
(Contractor and company name)

Verified by: _____ Date: _____

(General Services Manager or designee) Reviewed: 08/01/2016

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
K 051 SS = D	Ceiling diffuser and smoke detector will be moved to meet the separation distance requirement. Through the Quality Assurance Performance Improvement process (QAPI) a facility wide audit will be completed by the General Services Manager or designee to ensure compliance with the ceiling diffuser/smoke detector separation requirement. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations. (See attachment #2)	09-03-2016 ~~10-11-2016~~

Attachment #2

Checklist for Verification of Smoke Detector Location in Relation to Ceiling Diffusers

Smoke Detector Must Be a Minimum of Three (3) Feet from Any Diffuser

Room Name or Room Number	All Detectors Meet Requirement (Y/N)	Detector Does Not Meet Requirement	Location In Room of Detector Not Meeting Requirement	Corrective Action Taken DATE/STAFF INITIALS

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
K 062 SS= F	The ceiling tile in the areas noted will be replaced. Aluminum plates will be installed in four kitchen dish room locations to prevent the movement of the ceiling tiles. Through the Quality Assurance Performance Improvement process (QAPI) monthly audits will be completed by the General Services Manager or designee x 4 weeks to ensure compliance with requirements. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations. (See attachment #3)	09-01-2016 ~~10-11-2016~~

Attachment #3

QAPI

Major aspect of care or function: Month: Year: 2016

Ceilings in the four neighborhood kitchen dish rooms will be monitored to ensure there are no missing ceiling tile or openings in the fire barrier/ceiling.

Sample size and time frame:

Four neighborhood dish rooms' ceilings will be audited weekly x four weeks. Audit results will be brought to QAPI for review.

Neighborhood:

All

Data Collection by:

Date	Mulberry Date:		Huckleberry Date:		Strawberry Date:		Elderberry Date:			
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
Ceilings in dish room area are intact and penetration free										

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
K 144 SS=F	The monthly test log for the emergency generator testing has been amended to include documentation of the cool down period and will be used for all tests after this date. Through the Quality Assurance Performance Improvement process (QAPI) monthly audits will be completed by the General Services Manager or designee x 4 months to ensure compliance with the cool down documentation requirement. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations. (See attachment #4)	09-12-2016

Attachment #4

Neilson Place Gen Set
Emergency Generator – Bi-Monthly Test Log

Generator Model: Caterpillar Engine Model:D150P1 Date installed: July, 2004

Standby kW nameplate rating: 163 kW 30% of standby rating = 49 kW Fuel type: Diesel Normal operating temp: 180° to 200° F
Exhaust Temperature at Rated kW (dry exhaust): 1024 degrees

Month	Test Date	Time Meter Reading		Transfer Switch		Battery Specific Gravity	Oil Pressure	Operating Temp.	Load kW	Cool Down Time in Minutes	Tested By	Comments
		Start	End	Inspection	Test							
January												
January												
February												
February												
March												
March												
April												
April												
May												
May												
June												
June												

Neilson Place Gen Set
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Exhaust Temperature at Rated kW (dry exhaust): 1024 degrees

Month	Test Date	Time Meter Reading		Transfer Switch		Battery Specific Gravity	Oil Pressure	Operating Temp.	Load kW	Cool Down Time in Minutes	Tested By	Comments
		Start	End	Inspection	Test							
July												
July												
August												
August												
September												
September												
October												
October												
November												
November												
December												
December												

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7006 2150 0001 4308 0410

September 16, 2016

Ms. Linda Barkley, Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, Minnesota 56601

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5039027

Dear Ms. Barkley:

The above facility was surveyed on August 29, 2016 through September 1, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

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 Lyla Burkman at the email or phone number detailed above.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00823	A. BUILDING: _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST 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
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 August 29, 30, 31, and September 1, 2016, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 signature." Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health Lyla Burkman, Unit Supervisor 705 5th St. N.W., Suite A Bemidji, MN 56601-2933	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to document the identification of a non-pressure related skin injury and failed to complete a comprehensive assessment of the injury in order to determine appropriate care plan interventions and goals for 1 of 1 residents (R26) reviewed for non-pressure related skin conditions. Additionally, the facility failed to ensure dialysis medications had been provided according to the manufacturer's recommendations for 1 of 1 residents (R123) reviewed for dialysis. Findings included: R26's facility face sheet included diagnoses of: end stage renal disease with dialysis, peripheral vascular disease, severe protein-calorie malnutrition, diabetes, and legally blind. On 8/29/16, at 3:33 p.m. nursing assistant (NA)-A and NA-B entered R26's room with the shower chair. They removed R26's incontinent garment. On the left lower outer edge of R26's buttock there were 3 areas with dark brown/black scabs varying in size. The areas were not over bony prominences, were dry with no drainage, and no surrounding areas of redness. NA-A indicated the areas were not new and had been there since sometime the previous week but could not remember the exact date. R26's current electronic physician orders for wound care did not reflect orders to care for the impaired skin integrity on the left buttock. The	2 830		

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2 830	Continued From page 3 physician's orders did include, "Turn every 2 hours to prevent skin break down." R26's current care plan for 8/29/16 did not reflect the impaired skin integrity on the left buttock. The care plan was revised on 8/31/16. The revision included, "lesions on left outer lower buttock-appearance of dried blood blisters," and "keep lesions on left buttock dry and clean. Monitor brief edges for curling." The care plan informed staff R26 had a potential for alteration in skin integrity related to history of incontinence, impaired mobility, and history of pressure ulcers; and directed staff to "monitor skin for redness/breakdown daily." The most recent weekly skin progress note was dated 8/22/16, at 6:10 p.m.; the note indicated presence of small bruises on both arms and did not reflect the presence of lesions on the left buttock. There was no documentation of R26's impaired skin integrity on the left buttock. R26's nurse progress note dated 8/29/16, at 8:42 p.m. included, "L [left] lower buttock has blood blister as if pinched in hoyer [mechanical lift] sling, 3.25 cm [centimeters] x [by] 0.25 cm strip followed by 0.5 cm strip followed by 1.25 cm strip all in a row, dark blue, res [resident] denies pain, will continue to monitor." R26's nurse progress note dated 8/30/16, at 3:59 p.m. reported buttocks were examined by registered nurse (RN) and included, "left lower outer buttock has three black areas which have the appearance of dried blood blisters. Largest is 3 cm x 0.25 cm, another is 0.9 cm by 0.2 cm, the third is 0.3 cm x 0.2 cm, these lie in area where edge of brief crosses skin. Area palpated by this nurse and [name of nurse] area is not directly over a bony prominence but is lateral to the bone. Sling examined and resident observed while sitting in sling from Neilson Place and from dialysis. No straps cross in the area of the	2 830		

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2 830	Continued From page 4 lesions. No tenderness upon palpation. No redness surrounding lesions. No drainage. Roho [pressure relieving cushion to prevent or reduce the risk of pressure ulcers] examined and is inflated properly and was present in his wheelchair when he was sitting on it just prior to exam. Lesions do not appear to be from pressure." On 8/29/16, at 3:41 p.m. licensed practical nurse (LPN)-B observed the areas on R26's left buttock. LPN-B stated she was not aware of the lesions on the left buttock and explained the areas appeared as if the skin was pinched in the hoyer sling. LPN-B explained R26 was prone to skin tears. LPN-B explained nurses complete skin documentation weekly on bath days, nursing assistants were supposed to report any skin concerns to the nurse. The nurse then goes in, takes care of the wound, documents the information, and follow-up evaluations are completed on bath/shower days. LPN-B explained RN's assess and investigate areas that are caused from an unknown source. During an interview on 8/30/16, at 3:54 p.m. RN-A and RN-B stated R26's lesions were now comprehensively assessed and reported the lesions appeared to be superficial dried blood blisters. The lesions were not over bony prominences. The RN's concluded the lesions were more in the area of the incontinent garment line and not related to pressure. RN-B stated the nursing assistants should have reported the area right away. Nursing assistants should report anything they see if they don't know the resident and have not previously seen the skin. On 8/31/16, at 7:42 a.m. the director of nursing (DON) explained nursing assistants were to report any skin issues to a licensed staff member. R26's areas should have been reported. In a subsequent interview at 9:17 a.m., DON reported	2 830		

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2 830	Continued From page 5 after contacting staff that worked over the weekend, one of the staff nurses had worked a five day stretch and knew the lesions had showed up the morning of 8/27/16 because the nurse had helped get R26 out of bed. The DON stated the second nurse contacted also was aware of the lesions, had put cream on them and watched them all weekend. The DON indicated the nurse took accountability, and had no excuses other than being really busy and was aware no documentation was completed. During an interview on 8/31/16, at 9:46 a.m. RN-A reported she had updated the care plan with the lesion this morning at 7:00 a.m. The facility policy dated 12/15, Skin Assessment And Documentation included, "Any change in skin condition during Activities of Daily Living will be reported immediately to a licensed nurse for evaluation." R123 was provided the medication Renvela (binds phosphorous in food used to control phosphorus levels in people with chronic kidney disease on dialysis), along with R123's other scheduled morning medications. However, Renvela can decrease the bioavailability of other medications when administered together. R123's undated Face Sheet identified the resident was admitted to the facility with diagnoses that included, but were not limited to end stage renal disease (ESRD) and type II diabetes. R123's admission Minimum Data Set (MDS) dated 7/14/16, identified R123 had no memory, behavior or cognitive impairment, was able to independently ambulate and eat, and received dialysis. On 8/31/16, at 7:52 a.m. licensed practical nurse	2 830		

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2 830	Continued From page 6 (LPN)-C gave R123 his morning medication's which included: Renvela 800 mg, aspirin 81 mg, docusate sodium (stool softener) 100 mg, folic acid (vitamin B) 1 mg, metoprolol tartrate (for angina) 6.25 mg, Nephrocaps (dietary supplement for people in kidney failure) 1 mg, Prilosec (decrease stomach acid) 20 mg, senna 8.6 mg, Zoloft (anti-depressant) 100 mg, and sodium bicarbonate (antacid) 650 mg. Review of the Renvela medication instructions for use, provided by the facility, revealed: "Avoid taking any medications within 1 hour before or 3 hours after you take Renvela. [Renvela] can bind to other medications and make them less effective." Medical record review revealed there was no physician's order authorizing administration techniques contrary to the manufacturers recommendation. On 8/31/16, at 9:51 a.m. LPN-C was interviewed and stated she was not aware that the medication Renvela should not be administered with other medications. On 8/31/16, at 3:00 p.m. the director of nursing (DON) stated she had spoken to the pharmacy consultant who stated that it was acceptable to give R123 all morning medications together including Renvela. The DON stated the pharmacy consultant had not provided an explanation for the reason or reasons not to follow the manufacturer's directions for use. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to dialysis skin assessment and monitoring. The DON or designee, could provide training for all appropriate staff. The DON or	2 830		

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2 830	Continued From page 7 designee could develop an auditing system to ensure ongoing compliance and provide those results to the quality improvement team. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed ensure cleaning and storage of inhalation accessories for breathing treatments to reduce or prevent the risk of infection for 2 of 2 residents (R2, R14) observed to have nebulizer treatments during the initial tour of the Huckleberry unit. Findings included: On 8/29/16, at 5:32 p.m. R2's nebulizer mask and reservoir was hanging on the wall oxygen supply. The reservoir contained 1-2 cubic centimeters (cc's) of clear fluid. The tubing was dated 6/16/16. At 5:42 p.m. licensed practical nurse (LPN)-B verified the nebulizer accessories had not been cleaned and stated they should have been cleaned. LPN-B reported R2 received nebulizer treatments as needed. LPN-B then rinsed the reservoir out in R2's sink and placed the accessories on a paper towel to dry. R2's current electronic physician orders included albuterol sulfate solution 2.5 milligrams (mg)/3	21375		

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21375	Continued From page 8 milliliters (ml) for nebulization every 6 hours as needed. R2's medication administration record (MAR) indicated the last administered dose of albuterol sulfate was 8/2/16, at 8:43 a.m. On 8/29/16, at 6:29 p.m. and again on 8/30/16, at 10:27 a.m. R14's nebulizer mask and reservoir was hanging on the wall oxygen supply. The mask had smudges and was soiled. The tubing was not dated. At 10:49 a.m. registered nurse (RN)-A verified the nebulizer accessories had not been cleaned and stated she would need to check the policy for cleaning and storage. R14's current electronic physician's orders included Ipratropium-bromide solution 0.2%; one 3 ml vial for nebulization inhalation every 4 hours as needed. R14's MAR indicated the last administered dose of Ipratropium-bromide was 8/25/16, at 11:39 a.m. On 8/31/16, at 7:40 a.m. the director of nursing (DON) stated the reservoir chambers do not have to be rinsed, they are supposed to shake out as much liquid as possible, dry, then store in a bag. The DON further stated the accessories were supposed to be changed weekly or when visibly soiled. The facility policy dated 9/16, Nebulizer Cleaning included: "Replace nebulizers when soiling cannot be removed, when not functioning properly, and at a minimum of every 7 days," and "after each treatment empty the nebulizer cup by shaking out as much liquid as possible and dry with flow through the nebulizer. If there is visible organic matter use sterile water to rinse the nebulizer cup, mouthpiece, mask or tubing. NEVER [capitalized] use tap water" and "Following cleaning store supplies in the bag." SUGGESTED METHOD OF CORRECTION:	21375		

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21375	Continued From page 9 The director of nursing (DON) or designee, could review the policies and procedures for infection control measures and provide education/training to staff for the proper cleaning, storage and infection control measures related to residents nebulizer equipment. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality improvement committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to record lot numbers, the manufacturer, and expiration dates of tuberculin testing solution in resident records per MN state and Center for Disease Control (CDC) recommendations. Findings include: During medication storage review on 9/1/16, at 1:26 p.m. 2 open vials of Tubersol (tuberculosis testing solution) did not have opened dates. The facility was asked to provide a list of residents who were administered the serum from the undated vials. The facility did not provide the list. During an interview on 9/1/16, at 1:30 p.m. director of nursing (DON) reported the facility did not record lot numbers into the medical record. During an interview on 9/1/16, at 2:52 p.m. registered nurse (RN)-B stated staff didn't record the lot number, manufacturer or expiration date in the resident record. The facility policy Tuberculosis Testing dated as reviewed 12/15, did not reflect current MN State or CDC guidelines for recording and documentation. The Regulations for Tuberculosis Control in Minnesota Healthcare Settings dated 7/13, requires the manufacturer's name, lot number and expiration date of the Tuberculin to be recorded at the time of administration. In their Latent Tuberculosis Infection: A Guide for Primary Health Care Providers, last reviewed	21426		

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21426	Continued From page 11 4/3/13, the CDC directed "Record the brand name of the PPD solution, lot number, manufacturer, and expiration date on the patient record " SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review systems for tuberculin skin testing including documentation requirements. The DON or designee could educate all appropriate staff. The DON could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance team. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21535		

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21535	Continued From page 12 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the physician justified the ongoing use of antipsychotic and antidepressant medications without a documented failed attempt of a gradual dose reduction/taper and lack of documented ongoing depressive signs and symptoms for 1 of 5 residents (R96) reviewed for unnecessary medications. Findings included: R96 was admitted to the facility on 5/5/14 with diagnoses that included depression with anxiety according to the facility face sheet. R96's quarterly Minimum Data Sets (MDS) dated 5/2/16 and 7/29/16 indicated no cognitive impairment with a Brief Interview for Mental Status score of 15. The MDS indicated no delirium, behaviors, or rejection/refusal of care. The 5/2/16 MDS reported no depressive symptoms with a PHQ-9 (Patient Health Questionnaire - assessment tool for identifying depressive symptoms) score of 0. The 7/29/16 MDS indicated minimal depression with a PHQ-9 score of 2. R96's current electronic physician's orders included: -Abilify (atypical anti-psychotic medication recommended to treat schizophrenia, bipolar disorder, also used in conjunction with an antidepressant to treat depressive and mood disorders) 10 milligrams daily. Physician orders indicated a start date of 5/27/14.	21535		

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21535	Continued From page 13 -Venlafaxine (antidepressant) 150 mg twice daily. Physician orders indicated a start date of 8/27/14. R96's current electronic care plan identified R96 had an alteration in mood as evidenced by depression/anxiety with a goal of reduction of target behaviors of crying, statements of sadness, and withdrawn. The care plan instructed staff to monitor for effectiveness of the program with periodic review by the pharmacist. The care plan also indicated R96 had a history of refusing to reposition, do self-cares, and get out of bed. R96's 2016 Yearly Data Summary for tracking target behaviors of: statements of sadness/withdrawal/crying, decreased appetite, and withdrawal identified the following: January - no recorded target behaviors February - no recorded target behaviors March - no recorded target behaviors April - reported 0.02 incidences of statements of sadness/withdrawal/crying and 0.32 incidences of withdrawal. May - 0.56 incidences of withdrawal June - 0.22 incidences of withdrawal July - 0.03 incidences of statements of sadness/withdrawal/crying R96's physician visit noted dated 9/1/15, reported, "Depression in remission. Continue medications". A visit note dated 11/25/15, included "depression is in remission with Venlafaxine [Effexor]." R96's physician visit note dated 3/30/16, included, "She has had depression. Will continue her Effexor and Abilify and her mood has been good." R96's physician visit notes dated 4/28/16 included, "Depression, doing well. Continue Effexor [Venlafaxine] and Abilify." R96's physician visit note dated 7/27/16 included, "Major depressive disorder with single episode, in full remission." The note indicated	21535		

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21535	Continued From page 14 treatment with Venlafaxine and Abilify. R96's physician visit note dated 7/31/16 identified a diagnosis of depression treated with Venlafaxine and Abilify. R96's 10/15, (not otherwise dated) consultant pharmacist medication review included, "Periodic reassessment of psychotropic medications is required by CMS. Resident's last PHQ-9 was 1 indicating minimal depression symptoms. Resident is also on Abilify for major depression. IDT [interdisciplinary team] noted that a trial reduction might not have been attempted yet in this SNF [skilled nursing facility] and the team is comfortable attempting a reduction at this point". The pharmacist recommended "Please consider a modest reduction to Effexor 125 mg twice daily - continue to have nursing monitor s/s [signs/symptoms] of depression. If appropriate, please provide a risk vs benefit statement to support continued use." The physician responded by rejecting the recommendation and wrote, "She is doing well, no depression (PHQ-9 one). I hate to decrease it and have a relapse." R96's 1/16, (not otherwise dated) consultant pharmacist medication review included, "Periodic reassessment of psychotropic medications is required by CMS. Resident's last PHQ-9 was 1 indicating minimal depression symptoms. Resident is also on Abilify for major depression. IDT [interdisciplinary team] noted that a trial reduction might not have been attempted yet in this SNF [skilled nursing facility] and the team is comfortable attempting a reduction at this point". The pharmacist recommended "Please consider a modest reduction to Effexor 125 mg twice daily-continue to have nursing monitor s/s of depression. If medication is to continue, clinical documentation of how it improves [R96's] quality of life is recommended by CMS." The form and record did not reflect a physician response,	21535		

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21535	Continued From page 15 signature, or that a dose reduction was attempted. A pharmacy report created on 8/31/16 indicated the physician opted not to change the dose of Effexor on 6/1/16. A copy of June's recommendation was requested and not provided from the facility. On 8/29/16, at 5:26 p.m. R96 was in her room watching television. R96 was pleasant and conversational. No display of behaviors, depressive statements, or indicators of depression noted. On 8/31/16, at 1:49 p.m. registered nurse (RN)-B indicated R96 had no dose reductions of either Abilify or Effexor since admission to the facility on 5/5/14. RN-B reported nursing staff has tried to encourage the physician to document the need for continued use of psychotropic medications. RN-B stated R96 is in a much better place mentally now because her health and mobility have greatly improved following surgery. On 9/1/16, at 11:00 a.m. the director of nursing (DON) indicated the physician did not think a dose reduction was indicated because R96's mood was stabilized. R96 had improved over the past year. The DON indicated the physician was resistant to providing a complete risk vs benefit statement that would justify the ongoing use of the medications without historical failed attempts. The facility Antipsychotic Medication Reduction Policy dated 12/15, included, "residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." Additionally, "Neilson Place will emphasize the importance of seeking an appropriate dose and duration for each medication thus minimizing the risk of adverse consequences. The purpose of tapering a	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00823	A. BUILDING: _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

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21535	Continued From page 16 medication is to find an optimal dose or to determine weather continued use of the medication is benefiting the resident." The policy also included "tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop systems to ensure no unnecessary medications are provided to residents. This could include a system to ensure physician's are routinely reviewing the medications and pharmacist recommendations and providing appropriate reductions and/or risk/benefit statements. The DON or designee could work with the medical director to assist physician's as needed. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality improvement team. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		