

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2021

Administrator Neilson Place 1000 Anne Street Northwest Bemidji, MN 56601

RE: CCN: 245039

Cycle Start Date: August 6, 2021

Dear Administrator:

On August 25, 2021, we informed you that we may impose enforcement remedies.

On August 18, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

#### **REMEDIES**

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 23, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 23, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 23, 2021.

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

Neilson Place September 8, 2021 Page 2 payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

### NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 23, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Neilson Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 23, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

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- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

#### **DEPARTMENT CONTACT**

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

Susie Haben, Rapid Response Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 6, 2022 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

Neilson Place September 8, 2021 Page 4 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

### Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 09/15/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245039	B. WING			C / <b>18/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601	1 00.	110/2021	
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F 000	survey was conduct was found to be NO requirements of 42	TS  21, a standard abbreviated ted at your facility. Your facility DT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.	F 0	00			
	SUBSTANTIATED.  H5039051C (MN75 at F603 and F686.  The facility's plan or as your allegation of Departments accept enrolled in ePOC, you at the bottom of the form. Your electron be used as verificated Upon receipt of an onsite revisit of your validate that substate regulations has been been free from Involuntated CFR(s): 483.12(a)(S483.12)  The resident has the neglect, misappropiand exploitation as includes but is not lacorporal punishmentany physical or cheen.	acceptable electronic POC, an r facility may be conducted to intial compliance with the en attained.  ary Seclusion  1)  The right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from the involuntary seclusion and mical restraint not required to medical symptoms.	F 6	03		9/21/21	
ARODATOD\	/ DIRECTOR'S OR PPOV/I	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

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

Electronically Signed 09/14/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 603	physical abuse, cor involuntary seclusic This REQUIREMEN by: Based on observat review, the facility for	use verbal, mental, sexual, or poral punishment, or on; NT is not met as evidenced tion, interview and document ailed to provided clinical	F 603	On 8/20/21 R1 was assessed for giustification for the use of wander g		
	justification for the of 1 of 1 residents (R1 Findings include:  R1's quarterly Minimal (R1 Findings include:  R1's quarterly Minimal (R1 Findings include:  R1's quarterly Minimal (R1 Findings)  displayed no behave behaviors. R1's distincted he did not finding (R1's care plan date elopement due to solive in the street. The resident to accompor building. The care use of a Wandergu (P1 Findings)  During observation (P1 Findings)  During observation (P1 Findings)  R1 was was wearing a wan wrist. R1 stated he facility and said he	mum Data Set (MDS) dated ne was moderately cognitively set up for locomotion and iors including no wandering charge MDS dated 6/10/21, it wander.  In the description of the was moderately cognitively set up for locomotion and iors including no wandering charge MDS dated 6/10/21, it wander.  In the description of the waste of the care plan directed staff or any R1 when leaving the unit is plan further identified the		On 8/20/21 the wander guard was removed from R1's care based on assessment results. On 8/25/21 and 8/26/21 all residen wander guards were reviewed to e there was clinical justification for the of the wander guard system. On 9/24/21 the DON drafted a polir regarding the use of wandering ala nursing staff will be educated by 9/on the policy and ensuring there is justification for placement and ong use of the wander guard system. Beginning 9/27/21 the DON/design audit all residents using the wander system weekly for 6 weeks to ensuclinical justification for use. Results forwarded to the QAPI committee of further recommendation.	the ts with nsure le use cy lrms. All 21/21 clinical oing lee will r guard lire s will be	
	registered nurse (R lady he wanted to g buy a truck to put a was planning to go following day after I	N)-A and told her and another to to the Ford dealership and lift in. R1 said he told RN-A he the next day. R1 said the ne got dressed he called a taxialership. R1 said RN-A claimed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 603	he was lost and ser to pick him up. R1 s facility "rigged" all them and if he tried couldn't go anywhe R1 said he had told planned to go and R1 stated the even. R1's Resident Progindicated at 2:35 prupdated by nursing the Ford dealership assistant went to the been consulting wit to the facility with sit. An elopement Risk indicated modified making and indicate situations only. The was independent wunit and did not requomments about leattempts to elope. The use of a Wandergum During interview on director of nursing Wanderguard on R comments about with stated R1 had gone DON stated the corhis money because afford the vehicle. Think R1 was an elohe was safe to be considered to the corhismoney because afford the vehicle. The was safe to be considered to the was safe to the was sa	of the social worker in the buse stated he came back and the ne doors so he couldn't open an alarm went off. R1 said he re and he couldn't do anything. I them the day before that he was now being punished for it. It occurred 2-3 months ago.  The social worker (SW)-A was that R1 had left and went to it. SW-A and a nursing e dealership where R1 had he a salesperson. R1 returned staff.  Assessment dated 6/4/21, independence with decision ed he had difficulty in new assessment indicated R1 ith locomotion on and off the uire supervision, had made aving but had made no The assessment identified the	F 60	3		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION	COM	E SURVEY IPLETED
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	At 1:48 p.m. SW-A Ford dealership and SW-A stated R1 ha he wanted to buy a actually went. SW-A placed at that time. who was also prese he made statement She stated the War because R1 was so At 2:31 p.m. the adi aware R1 had gone told staff he made a dealership. The adr conscious effort to The administrator s that R1 wore a War Treatment/Svcs to I CFR(s): 483.25(b)( \$483.25(b) Skin Inte §483.25(b)(1) Prese Based on the comp resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by:	stated R1 had gone to the d wanted to buy a vehicle. In told her the day before that truck and the next day he was as a said the Wanderguard was the social service director and said when visiting with R1 as about feeling like a prisoner. Inderguard was placed of impulsive.  Inderguard was alleave and not an elopement. Inderguard.  Inderguard.  Inderguard.  Inderguard.  Inderguard was "vaguely" familiar inderguard.  Inderguard was placed of the the car inderguard was "vaguely" familiar inderguard.  Inderguard was placed of the car inderguard was a leave and not an elopement.  Inderguard was a placed of the car inderguard was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopement.  Inderguard was placed of the was a leave and not an elopemen	F 6	86	On 7/23/21 R1's physician ordered		9/21/21
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F 686	facility failed to imp	F 6	886	interventions were implemented to			
	interventions to prevent pressure ulcers for 1 of 1 residents (R1) reviewed for pressure ulcers. This resulted in actual harm for R1 who acquired three unstageable pressure ulcers that were caused by a device.				prevent pressure ulcers. By 9/21/21 all residents at risk for pressure ulcers as well as resident wear a splinting device will be revie ensure their physician ordered interventions are implemented to p	ewed to	
	Findings include:  and treat pressure ulcers unlication demonstrate				and treat pressure ulcers unless the clinical condition demonstrates that	eir	
	R1's entry Minimum Data Set (MDS) dated 6/15/21, indicated he did not have a pressure ulcer. A discharge MDS dated 7/30/21, identified three stage III (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed) pressure ulcers.  However, the MDS was not coded correctly as the pressure ulcers were covered in slough (soft, moist avascular, devitatlized [dead] tissue) or eschar (thick leathery black or brown devitalized tissue).  R1's care plan dated 8/4/21, identified a self care deficit and risk for pressure ulcers related to impaired mobility, below knee amputation and amputation of left toes. The care plan directed staff to monitor R1 for redness and breakdown daily.				were unavoidable. On 9/14/21 the DON/designee reviand revised as necessary the facili policy on pressure ulcers and skin assessment interventions. All nurs will be educated by 9/21/21 on the policies, including checking skin wiresidents wear splinting devices ar role in preventing and treating pres	ties risk ing staff se nen nd their	
					ulcers consistent with professional standards of practice and to ensur- physician ordered interventions are implemented to prevent and treat pressure ulcers unless their clinica condition demonstrates that they w	e :	
					unavoidable. Beginning 9/27/21 the DON/design audit 3 resident charts with pressurulcers and 3 residents with splinting devices for 6 weeks to ensure physordered interventions are impleme	ee will e g sician nted to	
	A facility Event Report dated 7/6/21, indicated R1 hit his foot on the bathroom door, said he heard a crack and had pain.  An Emergency Department Visit note dated 7/12/21, indicated R1 was seen due to his leg injury following running into the door. The visit note identified a closed, non-displaced fracture of				prevent and treat pressure ulcers untheir clinical condition demonstrate they were unavoidable. Results will forwarded to the QAPI committee further recommendation.	s that I be	
		d a splint applied to his leg.					

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F 686	A Sanford Bemidji (Medicine progress R1 was fit for a cus note indicated, "it is 3 times a day at the problems return improblems return im	Orthopedic and Sports note dated 7/14/21, indicated tom brace for his left leg. The imperative to check the skin the care center and any mediately."  Ininistration History dated dicated weekly skin check, y. The treatment record lacked was monitored three times per he physician on 7/14/21.  Is Note dated 7/22/21, at 9:20 ag cares the nursing assistants I had a large indentation and ack of his left leg and his left green. The NAs noted when sock the area "peeled off" and was noted. A note dated in indicated a nurse assessed led the following: R1's gripper with drainage and adhered to R1's left heel was greenish in inkled skin and a "moldy" et o remove greenish matter et. Foot had a pressure area to of calf and a deep tissue injury ted, "Oh, that hurts" but was The note indicated R1 had of thopedic physician and no open identified, however, R1's firmed that the physician had ace to assess the skin during		86			
		s note written by the wound rse (RN) on 7/26/21, indicated					

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F 686	R1 was referred baclinic for skin break that was issued on "It was clearly state therapy] visit note the assessed several tibreakdown." R1 state for three days prior checked. R1 arrived a foam dressing co 3+ pitting edema and due to the edema. On the left heel, left calf that were "clea not wear the brace breakdown due to R1's wounds were .2 cm x .2 cm, 1000 heel3 cm x .3 cm (yellow devitalized thick and adherent posterior calf2 cm slough.  During interview on who was the nurse she had not seen F sounded like it look she had looked at F did not have any pr R1's appointment corder in R1's treatmestin checks three tillooked for it she co 7/22/21, when she moldy skin she made be seen at the would state the would skin she made to seen at the would state the seen at the seen at the would state the seen at the se	ck to the outpatient wound down secondary to a brace 7/14/21. The note indicated, d in the OT [occupational nat the skin should be mes a day for skin ated the splint was on his leg to it being removed and d for the visit with no sock and vering his foot/ankle. R1 had not the brace was tight fitting The skin injuries were located lateral ankle and left posterior rly device related." R1 could as he would have continued known vascular compromise. Identified as: left lateral ankle would have continued to the string or on the tissue bed), and left in 100% yellow, dry slough itsue, that can be stringy or on the tissue bed), and left in x 3 cm 100% dry yellow  8/16/21, at 2:19 p.m. RN-A manager on the unit, stated the green." RN-A stated when R1's leg "not long before" he oblems. RN-A stated after in 7/14/21, she had put the nent administration record for mes a day but when she uld not find it. RN-A said on saw the note about the green, de an appointment for R1 to	F 68	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245039	B. WING_			C / <b>18/2021</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601		110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	he was being taken that's questionable. wounds R1 stated shis foot and said "the At 12:57 p.m. the distated she asked or worked with R1 reglet staff look at his I was no documented his skin assessed.  A policy related to in	yhen asked how he was and if a care of R1 said, "you know," When asked about his staff had not been looking at ney didn't do nothing really." irector of nursing (DON) ne of the staff members that ularly and said R1 would not eg. The DON confirmed there devidence R1 refused to have mplementation of physicians ed but not received.	F 68			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 8, 2021

Administrator Neilson Place 1000 Anne Street Northwest Bemidji, MN 56601

Re: State Nursing Home Licensing Orders

Event ID: WFQJ11

### Dear Administrator:

The above facility was surveyed on August 17, 2021 through August 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Neilson Place September 8, 2021 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 09/15/2021 FORM APPROVED

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00823	B. WING		08/1	) 8/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	<u> </u>
NEILSO	N PLACE		E STREET N MN 56601	NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	2 000 Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall limit a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with notice of assessme  INITIAL COMMENT On 8/17/21 - 8/18/2 conducted at your familiation of the facility was found N State Licensure. Ple plan of correction years	hearing on any assessments in non-compliance with these it a written request is made to nin 15 days of receipt of a nit for non-compliance.  TS:  1, a complaint survey was acility by surveyors from the itent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders it when they will be completed.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/14/21 **Electronically Signed** 

STATE FORM 6899 WFQJ11 If continuation sheet 1 of 7

TITLE

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			_
		00823	B. WING		08/1	) 8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEILSO	N PLACE		NE STREET N MN 56601	IORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: a licensing order is:  Minnesota Department the State Licensing Federal software. The state state of the state of the findings of the correction order the findings which a state after the state of the findings which a state of the Suggested of the Minnesota Department of State lice the Minnesota Department of Heavyou electronically, is necessary for State lice of the word "CO available for text. Ye electronic State lice the Minnesota Department of the you electronic State lice the word "CO available for text. Ye electronic State lice the Minnesota Department of the word "CO available for text. Ye electronic State lice the Minnesota Department of the word "CO available for text. Ye electronic State lice the Minnesota Department of Department of the Minnesota Dep	nent of Health is documenting Correction Orders using Tag numbers have been sota state statutes/rules for the assigned tag number eft column entitled "ID Prefix attute/rule out of compliance is the "To Comply" portion of the state tement, "This Rule is not met tollowing the surveyor's findings Method of Correction and trection. To participate in the electronic insure orders consistent with				

Minnesota Department of Health

STATE FORM WFQJ11 If continuation sheet 2 of 7

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
,	o. oo.uo		A. BUILDING:			
		00823	B. WING		C 08/18/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NEILSON	I PLACE		IE STREET I MN 56601	NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 000	Continued From page 2		2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers		2 900			9/21/21
	Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:					
	A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and					
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	by: Based on interview facility failed to imp interventions to pre residents (R1) revie resulted in actual ha	and document review, the lement physician ordered vent pressure ulcers for 1 of 1 ewed for pressure ulcers. This arm for R1 who acquired three are ulcers that were caused by		corrected		

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00823	B. WING			C <b>18/2021</b>	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
NEILSOI	N PLACE		NE STREET N MN 56601	IORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 3	2 900				
	6/15/21, indicated hulcer. A discharge Marker stage III (full to Subcutaneous fat marker tendon or muscle aulcers.  However, the MDS the pressure ulcers moist avascular, de	n Data Set (MDS) dated the did not have a pressure MDS dated 7/30/21, identified hickness tissue loss. The pressure have be visible but bone, and the exposed pressure was not coded correctly as were covered in slough (soft, evitatlized [dead] tissue) or any black or brown devitalized					
	R1's care plan dated 8/4/21, identified a self care deficit and risk for pressure ulcers related to impaired mobility, below knee amputation and amputation of left toes. The care plan directed staff to monitor R1 for redness and breakdown daily.						
		ort dated 7/6/21, indicated R1 athroom door, said he heard a					
	7/12/21, indicated F injury following runr note identified a clo	partment Visit note dated R1 was seen due to his leg ning into the door. The visit sed, non-displaced fracture of d a splint applied to his leg.					
	Medicine progress R1 was fit for a cus note indicated, "it is	Orthopedic and Sports note dated 7/14/21, indicated tom brace for his left leg. The imperative to check the skin at the care center and any mediately."					
	R1's Treatment Adr	ministration History dated					

Minnesota Department of Health STATE FORM

TATE FORM WFQJ11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7. Bolebino.		C	
		00823	B. WING		<b>I</b>	18/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEILSO	NEILSON PLACE 1000 ANI BEMIDJI,			NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	7/1/21 - 7/31/21, inconce daily on Frida evidence R1's skin day as ordered by the A Resident Progressa.m. indicated durin (NA)s noted that Ropen area on the bheel was black and they removed R1's a "very strong odor 7/22/21, at 9:48 a.n R1's leg and identification sock was soaked with back of his calficolor, moist with wrodor. Staff were abwith wound cleanse back of heel, back on the heel. R1 state unable to rate pain. been seen by the oskin concerns had family member connot removed the brown the visit.  An untitled progres clinic registered nurely was referred back on "It was clearly state therapy] visit note the assessed several tip breakdown." R1 state for three days prior checked. R1 arriversides in the side of the state of the classes of the	dicated weekly skin check, y. The treatment record lacked was monitored three times per the physician on 7/14/21.  It is so Note dated 7/22/21, at 9:20 ag cares the nursing assistants 1 had a large indentation and ack of his left leg and his left leg and his left green. The NAs noted when sock the area "peeled off" and " was noted. A note dated in indicated a nurse assessed ied the following: R1's gripper with drainage and adhered to R1's left heel was greenish in rinkled skin and a "moldy" let to remove greenish matter er. Foot had a pressure area to of calf and a deep tissue injury ted, "Oh, that hurts" but was The note indicated R1 had inthopedic physician and no been identified, however, R1's firmed that the physician had ace to assess the skin during so note written by the wound acce to assess the skin during the skin should be skin should be	2 900			

Minnesota Department of Health

STATE FORM WFQJ11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		С	
	00823	B. WING			18/2021
NAME OF PROVIDER OR SUPPLI	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEILSON PLACE		IE STREET N MN 56601	IORTHWEST		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
due to the edem on the left heel, I calf that were "cl not wear the brack breakdown due to R1's wounds we .2 cm x .2 cm, 10 heel3 cm x .3 (yellow devitalize thick and adhere posterior calf2 slough.  During interview who was the nur she had not seel sounded like it loshe had looked adid not have any R1's appointmer order in R1's treaskin checks three looked for it she 7/22/21, when she moldy skin she not be seen at the wears being take that's questional wounds R1 states his foot and said.  At 12:57 p.m. the stated she asked worked with R1 in the stated she asked worked with R1 in the was being take that the stated she asked worked with R1 in the was being take that the stated she asked worked with R1 in the was being take that the stated she asked worked with R1 in the was being take that the was being take the was	and the brace was tight fitting a. The skin injuries were located eft lateral ankle and left posterior early device related." R1 could be as he would have continued to known vascular compromise. The identified as: left lateral ankle - 100% eschar (dead tissue), left cm 100% yellow, dry slough down tissue, that can be stringy or not on the tissue bed), and left cm x 3 cm 100% dry yellow and left cm x 3 cm 100% dry yellow and left cm x 3 cm 100% dry yellow and left cm x 3 cm 100% before the problems. RN-A stated when the R1's leg "not long before" he problems. RN-A stated after the on 7/14/21, she had put the lateral administration record for the times a day but when she could not find it. RN-A said on the saw the note about the green, made an appointment for R1 to	2 900			

Minnesota Department of Health

STATE FORM WFQJ11 If continuation sheet 6 of 7

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00823	B. WING			C <b>08/18/2021</b>	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		10/2021	
NEILSO	N PLACE		IE STREET N MN 56601	IORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 6	2 900				
	his skin assessed.						
		mplementation of physicians ed but not received.					
	The director of nurs all residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could condelivery of care; to deservices are implent pressure ulcer devel	to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for					

Minnesota Department of Health

STATE FORM 6899 WFQJ11 If continuation sheet 7 of 7

PRINTED: 09/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245039	B. WING		C 08/18/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 ANNE STREET NORTHWEST  BEMIDJI, MN 56601	1 00	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000		21, a standard abbreviated	F 000			
	was found to be NC requirements of 42 Requirements for L	ted at your facility. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.				
	SUBSTANTIATED.	laints were found to be				
	at F603 and F686.	274), with a deficiencies cited				
	as your allegation on Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the plance. Because you are your signature is not required it first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 603 SS=D	onsite revisit of you validate that substa regulations has been	ry Seclusion	F 600	3		
	neglect, misapprop and exploitation as includes but is not I corporal punishmer	e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from ht, involuntary seclusion and mical restraint not required to medical symptoms.				
	§483.12(a) The fac	ility must-				

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

· , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COMPLETED	
		245039	B. WING			C / <b>18/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601		10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 603	physical abuse, cor involuntary seclusic This REQUIREMEN by: Based on observat review, the facility fi justification for the of 1 of 1 residents (R1 Findings include: R1's quarterly Mining 3/18/21, indicated himpaired, required signly displayed no behave behaviors. R1's distincted he did not R1's care plan date elopement due to slive in the street. The resident to accompor building. The car use of a Wandergu During observation 12:33 p.m. R1 was was wearing a wan wrist. R1 stated he facility and said he anywhere. R1 state registered nurse (R lady he wanted to go buy a truck to put a was planning to go following day after him service.	use verbal, mental, sexual, or poral punishment, or on; NT is not met as evidenced ion, interview and document ailed to provided clinical use of a wandering device for ) reviewed for restraint use.  The mum Data Set (MDS) dated use was moderately cognitively set up for locomotion and iors including no wandering charge MDS dated 6/10/21, it wander.  If 6/4/21, identified a risk for tatements about leaving to go use care plan directed staff or any R1 when leaving the unit e plan further identified the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245039	B. WING _			18/2021
	NAME OF PROVIDER OR SUPPLIER  NEILSON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 ANNE STREET NORTHWEST  BEMIDJI, MN 56601	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 603	to pick him up. R1 s facility "rigged" all them and if he tried couldn't go anywher R1 said he had told planned to go and will stated the event R1's Resident Progindicated at 2:35 prupdated by nursing the Ford dealership assistant went to the been consulting with to the facility with stated modified in making and indicated in making and indicated situations only. The was independent where was independent where the comments about leattempts to elope. The use of a Wandergum During interview on director of nursing (Wanderguard on Romments about whe stated R1 had gone DON stated the corn his money because afford the vehicle. Think R1 was an elohe was safe to be continued to the state of the was safe to be continued to the state of the was safe to be continued to the state of the was safe to be continued to the state of the state of the was safe to be continued to the state of the	the social worker in the bus stated he came back and the ne doors so he couldn't open an alarm went off. R1 said he re and he couldn't do anything. I them the day before that he was now being punished for it. It occurred 2-3 months ago.  Tress Note date 6/4/21, m. social worker (SW)-A was that R1 had left and went to b. SW-A and a nursing e dealership where R1 had h a salesperson. R1 returned taff.  Assessment dated 6/4/21, independence with decision ed he had difficulty in new assessment indicated R1 ith locomotion on and off the uire supervision, had made aving but had made no The assessment identified the	F 60	3		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  ING	(X	COMPLETED		
		245039	B. WING	B. WING		C <b>08/18/2021</b>	
NAME OF PROVIDER OR SUPPLIER  NEILSON PLACE				STREET ADDRESS, CITY, STATE, ZIP CO 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601	ODE	33, 13, 202 1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		SHOULD BE		
	At 1:48 p.m. SW-A Ford dealership and SW-A stated R1 ha he wanted to buy a actually went. SW-A placed at that time. who was also prese he made statement She stated the War because R1 was so At 2:31 p.m. the adraware R1 had gone told staff he made a dealership. The adraconscious effort to I The administrator sthat R1 wore a War Treatment/Svcs to I CFR(s): 483.25(b)(1) Prese Based on the compresident, the facility (i) A resident receiv professional standar pressure ulcers and ulcers unless the in demonstrates that the (ii) A resident with professional standar promote healing, promote healing, promote healing, promote healing, promote healing, promote REQUIREMENTS.	stated R1 had gone to the d wanted to buy a vehicle. d told her the day before that truck and the next day he a said the Wanderguard was. The social service director ent said when visiting with R1 is about feeling like a prisoner. Inderguard was placed of impulsive.  Indicate the facility after he had arrangements to go the the carministrator said he felt it was a leave and not an elopement. Inderguard.  Prevent/Heal Pressure Ulcer (1)(i)(ii)  Begrity  Sure ulcers.  Inderguard was essessment of a must ensure thates care, consistent with ands of practice, to prevent dividual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent andards of practice, to revent infection and prevent	F 6				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245039	B. WING				C 18/2021	
NAME OF F	PROVIDER OR SUPPLIER			1000	EET ADDRESS, CITY, STATE, ZIP CODE  ANNE STREET NORTHWEST  MIDJI, MN 56601	1 00/	10/2021	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	facility failed to impinterventions to presidents (R1) reviewed residents (R1) reviewed resulted in actual hunstageable pressuratevice.  Findings include:  R1's entry Minimum 6/15/21, indicated hulcer. A discharge had three stage III (full subcutaneous fat residents to present the stage of	age 4 element physician ordered event pressure ulcers for 1 of 1 ewed for pressure ulcers. This arm for R1 who acquired three ure ulcers that were caused by  n Data Set (MDS) dated ne did not have a pressure MDS dated 7/30/21, identified thickness tissue loss. may be visible but bone, are not exposed) pressure	F 6	86				
	However, the MDS the pressure ulcers moist avascular, de	was not coded correctly as swere covered in slough (soft, evitatlized [dead] tissue) or ery black or brown devitalized						
	deficit and risk for p impaired mobility, b amputation of left to	ed 8/4/21, identified a self care pressure ulcers related to pelow knee amputation and poes. The care plan directed for redness and breakdown						
		port dated 7/6/21, indicated R1 pathroom door, said he heard a						
	7/12/21, indicated finjury following runinote identified a clo	partment Visit note dated R1 was seen due to his leg ning into the door. The visit psed, non-displaced fracture of d a splint applied to his leg.						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245039	B. WING		08	C / <b>18/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 686	Medicine progress R1 was fit for a cus note indicated, "it is 3 times a day at the problems return imit R1's Treatment Adr 7/1/21 - 7/31/21, inconce daily on Fridate vidence R1's skin day as ordered by the A Resident Progress a.m. indicated durin (NA)s noted that Riopen area on the back and they removed R1's a "very strong odor 7/22/21, at 9:48 a.n R1's leg and identificated was soaked with a back of his calficolor, moist with wrodor. Staff were ab with wound cleanse back of heel, back on the heel. R1 statunable to rate pain. been seen by the oskin concerns had family member con not removed the brothe visit.	Orthopedic and Sports note dated 7/14/21, indicated tom brace for his left leg. The imperative to check the skin the care center and any	F 6	86			

AND DUAN OF CORRECTION INFRIENCES		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245039	B. WING _			C / <b>18/2021</b>
	NAME OF PROVIDER OR SUPPLIER  NEILSON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	clinic for skin break that was issued on "It was clearly state therapy] visit note that was essed several tibreakdown." R1 state for three days prior checked. R1 arrived a foam dressing co 3+ pitting edema ardue to the edema. on the left heel, left calf that were "clean not wear the brace breakdown due to kR1's wounds were in 2 cm x .2 cm, 1009 heel3 cm x .3 cm (yellow devitalized the thick and adherent posterior calf2 cm slough.  During interview on who was the nurse she had not seen R sounded like it look she had looked at F did not have any proper R1's appointment of order in R1's treatment skin checks three tillooked for it she cot 7/22/21, when she	ck to the outpatient wound down secondary to a brace 7/14/21. The note indicated, d in the OT [occupational hat the skin should be mes a day for skin ated the splint was on his leg to it being removed and d for the visit with no sock and vering his foot/ankle. R1 had not the brace was tight fitting The skin injuries were located lateral ankle and left posterior rly device related." R1 could as he would have continued known vascular compromise. Identified as: left lateral ankle - 666 eschar (dead tissue), left in 100% yellow, dry slough tissue, that can be stringy or on the tissue bed), and left in x 3 cm 100% dry yellow  8/16/21, at 2:19 p.m. RN-A manager on the unit, stated end green." RN-A stated when R1's leg "not long before" he oblems. RN-A stated after in 7/14/21, she had put the nent administration record for mes a day but when she uld not find it. RN-A said on saw the note about the green, de an appointment for R1 to	F 68	86		
	On 8/17/21, at 12:3	3 p.m. R1 was sitting up in				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245039	B. WING			C <b>08/18/2021</b>	
	NAME OF PROVIDER OR SUPPLIER  NEILSON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESPONDED TO THE APPLICATION OF THE APPLICATION	OULD BE	(X5) COMPLETION DATE	
F 686	bed eating lunch. Whe was being taken that's questionable wounds R1 stated shis foot and said "the At 12:57 p.m. the distated she asked of worked with R1 reglet staff look at his look at	When asked how he was and if a care of R1 said, "you know, " When asked about his staff had not been looking at ney didn't do nothing really." irector of nursing (DON) ne of the staff members that jularly and said R1 would not leg. The DON confirmed there did evidence R1 refused to have implementation of physicians and but not received.	F6	886			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. BOILBING.		С	
		00823	B. WING		08/1	8/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEILSON	N PLACE		MN 56601	IORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Plan of correction y	rs: at a complaint survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders when they will be completed.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 t. BOILBII 10.		C	:
		00823	B. WING		08/18/202	
NAME OF PROVIDER OR SUPPLIER STREET ADI			DRESS, CITY, S	STATE, ZIP CODE		
NEILSO	N PLACE			IORTHWEST		
		<u> </u>	MN 56601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	The following comp SUBSTANTIATED: a licensing order is: Minnesota Department the State Licensing Federal software. The state Licensing Federal software. The state state is the far-letter of the findings which a state of the correction order the findings which a state after the state of the Suggested of the Suggested of the Minnesota Department of State licenthe Minnesota Department of Headyou electronically, is necessary for State licenthe word "CO available for text. You electronic State licenthe Minnesota Department of Headyou electronically, is necessary for State licenthe word "CO available for text. You electronic State licenthe Minnesota Department of Headyou electronic State licenthe Minnesota De	plaint was found to be H5039051C (MN75274) with sued at 0900.  The ent of Health is documenting. Correction Orders using ag numbers have been not a state statutes/rules for the assigned tag number efft column entitled "ID Prefix attute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the state are in violation of the state tement, "This Rule is not met following the surveyor's findings the Method of Correction and the rection.  To participate in the electronic insure orders consistent with				

Minnesota Department of Health

STATE FORM WFQJ11 If continuation sheet 2 of 7

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
					C	
		00823	b. WING		08/1	8/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEILSON	I PLACE		MN 56601	IORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 900	0 MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers		2 900			
	Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:					
	A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and					
	receives necessary	ho has pressure sores y treatment and services to event infection, and prevent yeloping.				
	by: Based on interview facility failed to impliinterventions to pre residents (R1) revieresulted in actual ha	and document review, the lement physician ordered vent pressure ulcers for 1 of 1 ewed for pressure ulcers. This arm for R1 who acquired three are ulcers that were caused by				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00823	B. WING			C <b>18/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
NEILSOI	NEILSON PLACE 1000 ANN BEMIDJI,			IORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPL DATE		
2 900	Continued From pa	ge 3	2 900			
	6/15/21, indicated hulcer. A discharge Marker stage III (full to Subcutaneous fat natendon or muscle aulcers.  However, the MDS the pressure ulcers moist avascular, de	n Data Set (MDS) dated he did not have a pressure MDS dated 7/30/21, identified hickness tissue loss. hay be visible but bone, re not exposed) pressure was not coded correctly as were covered in slough (soft, evitatlized [dead] tissue) or ery black or brown devitalized				
	deficit and risk for p impaired mobility, b amputation of left to	d 8/4/21, identified a self care pressure ulcers related to elow knee amputation and pes. The care plan directed for redness and breakdown				
		ort dated 7/6/21, indicated R1 athroom door, said he heard a				
	7/12/21, indicated F injury following runr note identified a clo	partment Visit note dated R1 was seen due to his leg ning into the door. The visit sed, non-displaced fracture of d a splint applied to his leg.				
	Medicine progress R1 was fit for a cus note indicated, "it is 3 times a day at the problems return imi	•				
	R1's Treatment Adr	ninistration History dated				

Minnesota Department of Health STATE FORM

STATE FORM WFQJ11 If continuation sheet 4 of 7

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY	
741212741	or contraction	ISEITH 10, THOTH HOMBELL.	A. BUILDING:			С	
		00823	B. WING			8/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
NEILSO	N PLACE		E STREET N MN 56601	IORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 4	2 900				
	once daily on Friday evidence R1's skin day as ordered by the A Resident Progressia. An indicated during (NA)s noted that R2 open area on the basel was black and they removed R1's a "very strong odor" 7/22/21, at 9:48 a.m R1's leg and identification sock was soaked with back of his calficolor, moist with worder. Staff were ablied with wound cleansed back of heel, back on the heel. R1 staff unable to rate pain. been seen by the or skin concerns had be family member controlled.	dicated weekly skin check, y. The treatment record lacked was monitored three times per he physician on 7/14/21.  Is Note dated 7/22/21, at 9:20 ag cares the nursing assistants I had a large indentation and ack of his left leg and his left green. The NAs noted when sock the area "peeled off" and was noted. A note dated in indicated a nurse assessed led the following: R1's gripper with drainage and adhered to R1's left heel was greenish in inkled skin and a "moldy" le to remove greenish matter er. Foot had a pressure area to of calf and a deep tissue injury led, "Oh, that hurts" but was The note indicated R1 had rethopedic physician and no been identified, however, R1's firmed that the physician had acce to assess the skin during					
	clinic registered nur R1 was referred ba clinic for skin break that was issued on "It was clearly state therapy] visit note th assessed several ti breakdown." R1 sta for three days prior checked. R1 arrived	s note written by the wound rse (RN) on 7/26/21, indicated ck to the outpatient wound down secondary to a brace 7/14/21. The note indicated, d in the OT [occupational nat the skin should be mes a day for skin sted the splint was on his leg to it being removed and d for the visit with no sock and vering his foot/ankle. R1 had					

Minnesota Department of Health

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER.   A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00823 B. WING 08/18/202	021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
NEILSON PLACE  1000 ANNE STREET NORTHWEST  BEMIDJI, MN 56601		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) OMPLETE DATE	
2 900  3 + pitting edema and the brace was tight fitting due to the edema. The skin injuries were located on the left heel, left lateral ankle and left posterior calf that were "clearly device related." R1 could not wear the brace as he would have continued breakdown due to known vascular compromise. R1's wounds were identified as: left lateral ankle - 2 cm x 2 cm, 100% eschar (dead tissue), left heel3 cm x .3 cm 100% yellow, dry slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed), and left posterior calf2 cm x 3 cm 100% dry yellow slough.  During interview on 8/16/21, at 2:19 p.m. RN-A who was the nurse manager on the unit, stated she had not seen R1's wounds but said "It sounded like it looked green." RN-A stated when she had looked at R1's leg "not long before" he did not have any problems. RN-A stated after R1's appointment on 77/4/21, she had put the order in R1's treatment administration record for skin checks three times a day but when she looked for it she could not find it. RN-A said on 7/22/21, when she saw the note about the green, moldy skin she made an appointment for R1 to be seen at the wound care clinic.  On 8/17/21, at 12:33 p.m. R1 was sitting up in bed eating lunch. When asked how he was and if he was being taken care of R1 said, "you know, that's questionable." When asked shout his wounds R1 stated staff had not been looking at his foot and said "they didn't do nothing really."  At 12:67 p.m. the director of nursing (DON) stated she asked one of the staff members that worked with R1 regularly and said R1 would not let staff look at his leg. The DON confirmed there was no documented evidence R1 refused to have		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
	00823	B. WING		<b>08/1</b>	8/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
NEILSON PLACE		E STREET N MN 56601	NORTHWEST			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 900 Continued From page	је 6	2 900				
his skin assessed.						
A policy related to in orders was requested	nplementation of physicians ed but not received.					
The director of nursi all residents at risk f they are receiving the treatment/services to from developing and pressure ulcers. The designee, could condelivery of care; to eservices are implement pressure ulcer development.	o prevent pressure ulcers d to promote healing of the director of nursing or reduct random audits of the tensure appropriate care and thented; to reduce the risk for					

Minnesota Department of Health

STATE FORM 6899 WFQJ11 If continuation sheet 7 of 7