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

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.

- 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

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:

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	C 08/18/2021

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 On 8/17/21 - 8/18/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED. H5039051C (MN75274), with a deficiencies cited at F603 and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 603		9/21/21

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

Electronically Signed | 09/14/2021

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F 603	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provided clinical justification for the use of a wandering device for 1 of 1 residents (R1) reviewed for restraint use. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/18/21, indicated he was moderately cognitively impaired, required set up for locomotion and displayed no behaviors including no wandering behaviors. R1's discharge MDS dated 6/10/21, indicated he did not wander. R1's care plan dated 6/4/21, identified a risk for elopement due to statements about leaving to go live in the street. The care plan directed staff or resident to accompany R1 when leaving the unit or building. The care plan further identified the use of a Wanderguard bracelet. During observation and interview on 8/17/21, at 12:33 p.m. R1 was laying in bed eating lunch. R1 was wearing a wander guard bracelet on his right wrist. R1 stated he was being punished by the facility and said he was not allowed to go anywhere. R1 stated one day he was talking with registered nurse (RN)-A and told her and another lady he wanted to go to the Ford dealership and buy a truck to put a lift in. R1 said he told RN-A he was planning to go the next day. R1 said the following day after he got dressed he called a taxi and went to the dealership. R1 said RN-A claimed	F 603	On 8/20/21 R1 was assessed for clinical justification for the use of wander guard. On 8/20/21 the wander guard was removed from R1's care based on the assessment results. On 8/25/21 and 8/26/21 all residents with wander guards were reviewed to ensure there was clinical justification for the use of the wander guard system. On 9/24/21 the DON drafted a policy regarding the use of wandering alarms. All nursing staff will be educated by 9/21/21 on the policy and ensuring there is clinical justification for placement and ongoing use of the wander guard system. Beginning 9/27/21 the DON/designee will audit all residents using the wander guard system weekly for 6 weeks to ensure clinical justification for use. Results will be forwarded to the QAPI committee for further recommendation.	

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F 603	Continued From page 2	F 603		

he was lost and sent the social worker in the bus to pick him up. R1 stated he came back and the facility "rigged" all the doors so he couldn't open them and if he tried an alarm went off. R1 said he couldn't go anywhere and he couldn't do anything. R1 said he had told them the day before that he planned to go and was now being punished for it. R1 stated the event occurred 2-3 months ago.

R1's Resident Progress Note date 6/4/21, indicated at 2:35 pm. social worker (SW)-A was updated by nursing that R1 had left and went to the Ford dealership. SW-A and a nursing assistant went to the dealership where R1 had been consulting with a salesperson. R1 returned to the facility with staff.

An elopement Risk Assessment dated 6/4/21, indicated modified independence with decision making and indicated he had difficulty in new situations only. The assessment indicated R1 was independent with locomotion on and off the unit and did not require supervision, had made comments about leaving but had made no attempts to elope. The assessment identified the use of a Wanderguard.

During interview on 8/17/21, at 12:57 p.m. the director of nursing (DON) stated RN-A placed the Wanderguard on R1 because he made comments about wanting to buy a vehicle and stated R1 had gone the the Ford dealership. The DON stated the concern was about R1 spending his money because R1 had money and could afford the vehicle. The DON stated she did not think R1 was an elopement risk and said she felt he was safe to be out in the community and she would not worry about him going out alone.

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F 603	Continued From page 3 At 1:48 p.m. SW-A stated R1 had gone to the Ford dealership and wanted to buy a vehicle. SW-A stated R1 had told her the day before that he wanted to buy a truck and the next day he actually went. SW-A said the Wanderguard was placed at that time. The social service director who was also present said when visiting with R1 he made statements about feeling like a prisoner. She stated the Wanderguard was placed because R1 was so impulsive. At 2:31 p.m. the administrator stated he was aware R1 had gone out of the facility after he had told staff he made arrangements to go the the car dealership. The administrator said he felt it was a conscious effort to leave and not an elopement. The administrator said he was "vaguely" familiar that R1 wore a Wanderguard.	F 603		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 686	On 7/23/21 R1's physician ordered	9/21/21

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F 686	Continued From page 4 facility failed to implement physician ordered 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. Findings include: 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. 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 the left tibia. R1 had a splint applied to his leg.	F 686	interventions were implemented to prevent pressure ulcers. By 9/21/21 all residents at risk for pressure ulcers as well as residents who wear a splinting device will be reviewed to ensure their physician ordered interventions are implemented to prevent and treat pressure ulcers unless their clinical condition demonstrates that they were unavoidable. On 9/14/21 the DON/designee reviewed and revised as necessary the facilities policy on pressure ulcers and skin risk assessment interventions. All nursing staff will be educated by 9/21/21 on these policies, including checking skin when residents wear splinting devices and their role in preventing and treating pressure ulcers consistent with professional standards of practice and to ensure physician ordered interventions are implemented to prevent and treat pressure ulcers unless their clinical condition demonstrates that they were unavoidable. Beginning 9/27/21 the DON/designee will audit 3 resident charts with pressure ulcers and 3 residents with splinting devices for 6 weeks to ensure physician ordered interventions are implemented to prevent and treat pressure ulcers unless their clinical condition demonstrates that they were unavoidable. Results will be forwarded to the QAPI committee for further recommendation.	

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F 686	Continued From page 5	F 686		

A Sanford Bemidji Orthopedic and Sports Medicine progress note dated 7/14/21, indicated R1 was fit for a custom brace for his left leg. The note indicated, "it is imperative to check the skin 3 times a day at the the care center and any problems return immediately."

R1's Treatment Administration History dated 7/1/21 - 7/31/21, indicated weekly skin check, once daily on Friday. The treatment record lacked evidence R1's skin was monitored three times per day as ordered by the physician on 7/14/21.

A Resident Progress Note dated 7/22/21, at 9:20 a.m. indicated during cares the nursing assistants (NA)s noted that R1 had a large indentation and open area on the back of his left leg and his left heel was black and green. The NAs noted when they removed R1's sock the area "peeled off" and a "very strong odor" was noted. A note dated 7/22/21, at 9:48 a.m. indicated a nurse assessed R1's leg and identified the following: R1's gripper sock was soaked with drainage and adhered to the back of his calf. R1's left heel was greenish in color, moist with wrinkled skin and a "moldy" odor. Staff were able to remove greenish matter with wound cleanser. Foot had a pressure area to back of heel, back of calf and a deep tissue injury on the heel. R1 stated, "Oh, that hurts" but was unable to rate pain. The note indicated R1 had been seen by the orthopedic physician and no skin concerns had been identified, however, R1's family member confirmed that the physician had not removed the brace to assess the skin during the visit.

An untitled progress note written by the wound clinic registered nurse (RN) on 7/26/21, indicated

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F 686	Continued From page 6	F 686		

R1 was referred back to the outpatient wound clinic for skin breakdown secondary to a brace that was issued on 7/14/21. The note indicated, "It was clearly stated in the OT [occupational therapy] visit note that the skin should be assessed several times a day for skin breakdown." R1 stated the splint was on his leg for three days prior to it being removed and checked. R1 arrived for the visit with no sock and a foam dressing covering his foot/ankle. R1 had 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 heel - .3 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 calf - .2 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 7/14/21, 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

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F 686	Continued From page 7 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 about his wounds R1 stated staff had not been looking at his foot and said "they didn't do nothing really." At 12:57 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 his skin assessed. A policy related to implementation of physicians orders was requested but not received.	F 686		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susie Haben, 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

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 _____	C 08/18/2021

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 8/17/21 - 8/18/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5039051C (MN75274) with a licensing order issued at 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From 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.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 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 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement physician ordered 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. Findings include:	2 900	corrected	9/21/21

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2 900	Continued From page 3 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. 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 the left tibia. R1 had a splint applied to his leg. A Sanford Bemidji Orthopedic and Sports Medicine progress note dated 7/14/21, indicated R1 was fit for a custom brace for his left leg. The note indicated, "it is imperative to check the skin 3 times a day at the the care center and any problems return immediately." R1's Treatment Administration History dated	2 900		

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2 900	Continued From page 4 7/1/21 - 7/31/21, indicated weekly skin check, once daily on Friday. The treatment record lacked evidence R1's skin was monitored three times per day as ordered by the physician on 7/14/21. A Resident Progress Note dated 7/22/21, at 9:20 a.m. indicated during cares the nursing assistants (NA)s noted that R1 had a large indentation and open area on the back of his left leg and his left heel was black and green. The NAs noted when they removed R1's sock the area "peeled off" and a "very strong odor" was noted. A note dated 7/22/21, at 9:48 a.m. indicated a nurse assessed R1's leg and identified the following: R1's gripper sock was soaked with drainage and adhered to the back of his calf. R1's left heel was greenish in color, moist with wrinkled skin and a "moldy" odor. Staff were able to remove greenish matter with wound cleanser. Foot had a pressure area to back of heel, back of calf and a deep tissue injury on the heel. R1 stated, "Oh, that hurts" but was unable to rate pain. The note indicated R1 had been seen by the orthopedic physician and no skin concerns had been identified, however, R1's family member confirmed that the physician had not removed the brace to assess the skin during the visit. An untitled progress note written by the wound clinic registered nurse (RN) on 7/26/21, indicated R1 was referred back to the outpatient wound clinic for skin breakdown secondary to a brace that was issued on 7/14/21. The note indicated, "It was clearly stated in the OT [occupational therapy] visit note that the skin should be assessed several times a day for skin breakdown." R1 stated the splint was on his leg for three days prior to it being removed and checked. R1 arrived for the visit with no sock and a foam dressing covering his foot/ankle. R1 had	2 900		

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2 900	Continued From page 5 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 heel - .3 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 calf - .2 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 7/14/21, 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 about his wounds R1 stated staff had not been looking at his foot and said "they didn't do nothing really." At 12:57 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	2 900		

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2 900	Continued From page 6 his skin assessed. A policy related to implementation of physicians orders was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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	245039	A. BUILDING _____ B. WING _____	C 08/18/2021

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F 000	INITIAL COMMENTS On 8/17/21 - 8/18/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED. H5039051C (MN75274), with a deficiencies cited at F603 and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 603		

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

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 603	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provided clinical justification for the use of a wandering device for 1 of 1 residents (R1) reviewed for restraint use. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/18/21, indicated he was moderately cognitively impaired, required set up for locomotion and displayed no behaviors including no wandering behaviors. R1's discharge MDS dated 6/10/21, indicated he did not wander. R1's care plan dated 6/4/21, identified a risk for elopement due to statements about leaving to go live in the street. The care plan directed staff or resident to accompany R1 when leaving the unit or building. The care plan further identified the use of a Wanderguard bracelet. During observation and interview on 8/17/21, at 12:33 p.m. R1 was laying in bed eating lunch. R1 was wearing a wander guard bracelet on his right wrist. R1 stated he was being punished by the facility and said he was not allowed to go anywhere. R1 stated one day he was talking with registered nurse (RN)-A and told her and another lady he wanted to go to the Ford dealership and buy a truck to put a lift in. R1 said he told RN-A he was planning to go the next day. R1 said the following day after he got dressed he called a taxi and went to the dealership. R1 said RN-A claimed	F 603		

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F 603	Continued From page 2	F 603		

he was lost and sent the social worker in the bus to pick him up. R1 stated he came back and the facility "rigged" all the doors so he couldn't open them and if he tried an alarm went off. R1 said he couldn't go anywhere and he couldn't do anything. R1 said he had told them the day before that he planned to go and was now being punished for it. R1 stated the event occurred 2-3 months ago.

R1's Resident Progress Note date 6/4/21, indicated at 2:35 pm. social worker (SW)-A was updated by nursing that R1 had left and went to the Ford dealership. SW-A and a nursing assistant went to the dealership where R1 had been consulting with a salesperson. R1 returned to the facility with staff.

An elopement Risk Assessment dated 6/4/21, indicated modified independence with decision making and indicated he had difficulty in new situations only. The assessment indicated R1 was independent with locomotion on and off the unit and did not require supervision, had made comments about leaving but had made no attempts to elope. The assessment identified the use of a Wanderguard.

During interview on 8/17/21, at 12:57 p.m. the director of nursing (DON) stated RN-A placed the Wanderguard on R1 because he made comments about wanting to buy a vehicle and stated R1 had gone the the Ford dealership. The DON stated the concern was about R1 spending his money because R1 had money and could afford the vehicle. The DON stated she did not think R1 was an elopement risk and said she felt he was safe to be out in the community and she would not worry about him going out alone.

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F 603	Continued From page 3 At 1:48 p.m. SW-A stated R1 had gone to the Ford dealership and wanted to buy a vehicle. SW-A stated R1 had told her the day before that he wanted to buy a truck and the next day he actually went. SW-A said the Wanderguard was placed at that time. The social service director who was also present said when visiting with R1 he made statements about feeling like a prisoner. She stated the Wanderguard was placed because R1 was so impulsive. At 2:31 p.m. the administrator stated he was aware R1 had gone out of the facility after he had told staff he made arrangements to go the the car dealership. The administrator said he felt it was a conscious effort to leave and not an elopement. The administrator said he was "vaguely" familiar that R1 wore a Wanderguard.	F 603		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 686		

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F 686	Continued From page 4	F 686		

facility failed to implement physician ordered 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.

Findings include:

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.

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 the left tibia. R1 had a splint applied to his leg.

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	245039	A. BUILDING _____ B. WING _____	C 08/18/2021

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 686	Continued From page 5 A Sanford Bemidji Orthopedic and Sports Medicine progress note dated 7/14/21, indicated R1 was fit for a custom brace for his left leg. The note indicated, "it is imperative to check the skin 3 times a day at the the care center and any problems return immediately." R1's Treatment Administration History dated 7/1/21 - 7/31/21, indicated weekly skin check, once daily on Friday. The treatment record lacked evidence R1's skin was monitored three times per day as ordered by the physician on 7/14/21. A Resident Progress Note dated 7/22/21, at 9:20 a.m. indicated during cares the nursing assistants (NA)s noted that R1 had a large indentation and open area on the back of his left leg and his left heel was black and green. The NAs noted when they removed R1's sock the area "peeled off" and a "very strong odor" was noted. A note dated 7/22/21, at 9:48 a.m. indicated a nurse assessed R1's leg and identified the following: R1's gripper sock was soaked with drainage and adhered to the back of his calf. R1's left heel was greenish in color, moist with wrinkled skin and a "moldy" odor. Staff were able to remove greenish matter with wound cleanser. Foot had a pressure area to back of heel, back of calf and a deep tissue injury on the heel. R1 stated, "Oh, that hurts" but was unable to rate pain. The note indicated R1 had been seen by the orthopedic physician and no skin concerns had been identified, however, R1's family member confirmed that the physician had not removed the brace to assess the skin during the visit. An untitled progress note written by the wound clinic registered nurse (RN) on 7/26/21, indicated	F 686		

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F 686	Continued From page 6	F 686		

R1 was referred back to the outpatient wound clinic for skin breakdown secondary to a brace that was issued on 7/14/21. The note indicated, "It was clearly stated in the OT [occupational therapy] visit note that the skin should be assessed several times a day for skin breakdown." R1 stated the splint was on his leg for three days prior to it being removed and checked. R1 arrived for the visit with no sock and a foam dressing covering his foot/ankle. R1 had 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 heel - .3 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 calf - .2 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 7/14/21, 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

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F 686	Continued From page 7 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 about his wounds R1 stated staff had not been looking at his foot and said "they didn't do nothing really." At 12:57 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 his skin assessed. A policy related to implementation of physicians orders was requested but not received.	F 686		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/17/21 - 8/18/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5039051C (MN75274) with a licensing order issued at 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From 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.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 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 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement physician ordered 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. Findings include:	2 900		

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2 900	Continued From page 3 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. 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 the left tibia. R1 had a splint applied to his leg. A Sanford Bemidji Orthopedic and Sports Medicine progress note dated 7/14/21, indicated R1 was fit for a custom brace for his left leg. The note indicated, "it is imperative to check the skin 3 times a day at the the care center and any problems return immediately." R1's Treatment Administration History dated	2 900		

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2 900	Continued From page 4 7/1/21 - 7/31/21, indicated weekly skin check, once daily on Friday. The treatment record lacked evidence R1's skin was monitored three times per day as ordered by the physician on 7/14/21. A Resident Progress Note dated 7/22/21, at 9:20 a.m. indicated during cares the nursing assistants (NA)s noted that R1 had a large indentation and open area on the back of his left leg and his left heel was black and green. The NAs noted when they removed R1's sock the area "peeled off" and a "very strong odor" was noted. A note dated 7/22/21, at 9:48 a.m. indicated a nurse assessed R1's leg and identified the following: R1's gripper sock was soaked with drainage and adhered to the back of his calf. R1's left heel was greenish in color, moist with wrinkled skin and a "moldy" odor. Staff were able to remove greenish matter with wound cleanser. Foot had a pressure area to back of heel, back of calf and a deep tissue injury on the heel. R1 stated, "Oh, that hurts" but was unable to rate pain. The note indicated R1 had been seen by the orthopedic physician and no skin concerns had been identified, however, R1's family member confirmed that the physician had not removed the brace to assess the skin during the visit. An untitled progress note written by the wound clinic registered nurse (RN) on 7/26/21, indicated R1 was referred back to the outpatient wound clinic for skin breakdown secondary to a brace that was issued on 7/14/21. The note indicated, "It was clearly stated in the OT [occupational therapy] visit note that the skin should be assessed several times a day for skin breakdown." R1 stated the splint was on his leg for three days prior to it being removed and checked. R1 arrived for the visit with no sock and a foam dressing covering his foot/ankle. R1 had	2 900		

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2 900	Continued From page 5 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 heel - .3 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 calf - .2 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 7/14/21, 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 about his wounds R1 stated staff had not been looking at his foot and said "they didn't do nothing really." At 12:57 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	2 900		

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2 900	Continued From page 6 his skin assessed. A policy related to implementation of physicians orders was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		