Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H50391760M
Compliance #: H50397487C

Date Concluded: June 8, 2026

Name, Address, and County of Licensee Investigated:
Neilson Place
1000 Anne Street Northwest
Bemidji, MN, 56601
Beltrami County

Facility Type: Nursing Home

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) neglected the resident when the AP failed to follow the resident's plan of care. The resident fell and sustained a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident fell out of her wheelchair and sustained a hip fracture. The AP failed to put hip protectors on as directed in a care plan; however, during a previous Minnesota department of health (MDH) complaint survey, a medical provider stated he did not have a strong opinion on hip protector use. Prior to the fall, the resident's care plan did not indicate wheelchair footrests were to be removed while the resident was not actively being transported. However, it could not be determined if the footrests caused the resident's fall. The fall was unwitnessed and there was no video footage. In addition, the resident also had a blanket over her and was seated next to a temporary wall described as a flexible hard plastic type of material.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident report, a personnel file, staff schedules, related facility policy and procedures.

The resident resided in a nursing home. The residents' diagnoses included Alzheimer disease, dementia, history of sacral fracture, failure to thrive, and osteoporosis. The resident was at high-risk of falls, had a history of falls with balance and cognitive deficits. The resident's plan of care for fall prevention and safety interventions included keeping the bed at transfer height, frequent and purposeful rounding, supervision while walking, hip protectors on at all times, and to watch for anxious/restless behavior to offer toileting. The resident's assessment indicated the resident was independent with bed mobility, sit to stand, and required supervision with walking.

The staff schedule indicated on the resident's unit the AP worked from 7:00 p.m. to 7:30 a.m., unlicensed personnel (ULP) #1 worked 7:00 a.m. to 3:30 p.m., ULP #2 worked 7:00 a.m. to 3:30 p.m., and nurse #1 worked 7:00 a.m. to 3:30 p.m.

The resident's fall report indicated one day at 7:30 a.m., the resident had an unwitnessed fall in hallway and was found on the floor. Prior to the fall the resident was sleepy. The resident had a blanket on, and footrests were on the wheelchair. The fall report indicated the resident "may" have tripped on the wheelchair or barrier wall.

Hospital Records indicated the resident was admitted and underwent right hip nailing (surgical procedure used to repair a broken hip (femur). The resident discharged back to the facility two days later.

During facility internal investigation interviews, the AP stated she got the resident ready for the morning and did not put the resident hip protector's on because the AP did not know where to find them. The AP forgot to tell ULP #1 the resident did not have them on. ULP #1 and ULP #2 had not provided any care to the resident yet. Nurse #1 stated the resident was in her wheelchair, had a blanket on and wheelchair footrests on that the overnight staff placed. Nurse #1 was in the dining area administering medications when the resident fell. Both ULP #1 and ULP #2 were in a different resident room getting them up for the day. They heard "a yell and a crash." Nurse #1, ULP #1, and ULP #2 arrived to find the resident lying on the floor in the plastic barrier. The resident was sent to the emergency room for evaluation.

During the facility internal investigation, the facility identified the resident's hip protectors on the day of the incident were not available in the resident's room, they were in the laundry to be washed. However, the facility had hip protectors available in a storage room.

MDH survey notes indicated a medical provider stated he did not have a strong opinion on hip protector use. The notes also indicated the resident had not had a previous fall within in the last 3 months.

After the incident, records indicated the resident's hip protectors were removed from the resident's care plan. The facility also added to the resident's care plan removing footrests from the resident's wheelchair when the resident was not being transported and indicated this may cause a tripping hazard.

During an interview, the AP stated the day the resident fell she had provided the resident morning cares. She washed the resident up, brought her to the toilet to void, and got her dressed. The AP said the resident was care planned for hip protectors however she could not find them in the resident's room nor was she told where to find them in the facility prior to the incident. The AP said she had put the resident's hip protector's previously, and this was the only occasion she could not find them. The AP wheeled the resident in her wheelchair out to the nurse's station so she could keep an eye on her. The resident's wheelchair footrests were on. There was nothing different going on with the resident. The resident did not say anything. She was quiet, which was normal for her and had just woken up for the day. The AP said it slipped her mind during shift change report to relay to the oncoming dayshift the resident did not have her hip protectors on. The AP stated she did not place a blanket on the resident.

During an interview, nurse #1 stated the resident was confused, was unable to communicate, and used word salad (words that lack coherent meaning). The resident had a history of getting up and down and getting up to walk at will. The resident had a fall history. When nurse #1 arrived on shift the resident was seated in her wheelchair near the nurse's station. The resident's wheelchair was located next to a plastic barrier which was a temporary makeshift wall that was put up because they were doing work/construction. This temporary wall was described by nurse #1 as a barrier, hard plastic, clear, plexiglass type material, and was flexible. Nurse #1 said she was in dining room when she heard the fall/commotion and ran over to the resident. Nurse #1 said it looked as if the resident may have fallen into the temporary wall. The resident's wheelchair was right next to her. There were no recent changes going on with the resident.

During an interview, ULP #1 stated when she arrived on shift the resident had a blanket resting over her shoulders, chest area, and resting on the top of her legs to keep her warm. The resident was sleeping/resting in her wheelchair with footrests on. ULP #1 went to get other residents up and ready for breakfast. While in a nearby room, ULP #1 heard nurse #1 holler out for help. ULP #1 responded. When ULP #1 arrived, the resident was leaning up against the temporary wall/barrier. ULP #1 stated it looked as if the resident stood up and either slid down, fell into, or fell next to the temporary wall. The wheelchair was not tipped over. ULP #1 said there was no distance between the resident and the wheelchair like the resident took steps and walked. It was common for the resident to be near the nurse station area. The resident would be there so staff could keep an eye on her and would not be alone in her room due to her fall

risk. After hospitalization, the resident got back to where she was prior to the fall, standing, getting up and down, and walking.

During an interview, ULP # 2 stated it was like 30 minutes into dayshift when the resident fell. Upon arrival to shift, when ULP #2 seen the resident, the resident was calm, was not actively trying to stand up, was not reaching out, nor calling out. The resident was sleepy. At times, prior to the resident's fall, the resident would get up and walk. Staff provided reminders for the resident to sit back down. ULP #2 stated sometimes the resident would listen, other times the resident would get up and walk. The resident held onto walls and rails in the building when she walked. Staff would follow behind her with a wheelchair until she was ready to sit back down. ULP #2 stated the resident would sit in the wheelchair more often than she would get up and walk. When ULP #2 responded to the resident's fall, the resident was next to her wheelchair. ULP #2 stated there was no distance between the resident and the wheelchair requiring them to retrieve it when they got her up off the floor.

During an interview, nurse #2, stated the facility had some flooding so they had a temporary wall up to redo the drywall. Nurse #2 stated hip protectors were underwear with pads on the hip area. They go over an incontinent product. After the incident, they decided not to continue to use hip protectors because they were tight and this could be more of a hazard when the resident or other residents would get up and toilet themselves. Nurse #2 stated there was no video footage of the incident.

During an interview, a family member stated the resident had severe Alzheimer's and cannot remember one minute to the next. The resident did not have hip protectors on at the time of the fall and the family member said the resident's feet got tangled up in the blanket she had on her. The family member stated resident had a blanket on her routinely.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The facility reeducated the AP and other staff regarding the incident, importance of following care plans, where to find equipment and the expectation of asking for help if unable to find equipment. All resident care plans were reviewed to ensure interventions were in place and consistent.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H50391760M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the	20000		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Continued from page 1 electronic documents.	20000		