Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 11, 2024

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: July 2, 2024

Dear Administrator:

On July 2, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 2, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 2, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 07/02/2024

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

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F 000	INITIAL COMMENTS On 6/27/24, 6/28/24, and 7/2/24, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H50395082C (MN00104395) with a deficiency issued at F740 and F760. 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 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not	F 740		8/2/24

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

Electronically Signed | 07/19/2024

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 740	Continued From page 1 limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan with person centered interventions for food seeking behaviors for 1 of 3 residents (R1) reviewed for behavioral health needs. Findings include: R1's annual Minimal Data Set (MDS) dated 6/7/24, indicated R1 had diagnoses which included dementia, and type 2 diabetes mellitus with hyperglycemia. Further, MDS revealed R1 had moderately impaired cognition and did not exhibit any behaviors. R1's Progress Notes revealed the following: -On 6/25/24, R1 was seen by staff taking half gallon of milk from the kitchen. Staff spoke with R1 and R1 returned the gallon while saying "this is bullshit". -On 6/21/24, R1 had been restless all night and had been out to nursing station numerous times looking for and requesting food. R1 had also made attempts to enter kitchen to sneak food. R1 was offered snacks and redirected when attempts were made to enter kitchen. -On 6/19/24, R1's care plan was reviewed and updated with completed of the MDS. -On 6/17/24, R1 was walking from his room to the kitchen area in his briefs, staff declined to give him snacks. R1 got mad at staff. -On 6/16/24 at 10:17 p.m., R1 went inside the kitchen for the 3rd time, took 2 Boosts, staff spoke with resident and reminded R1 he was not	F 740	The following disclaimer should be written in the “Provider’s Plan of Correction” column prior to responding to the first survey citation: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center’s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 7/2/2024, R1’s care plan was updated to reflect appropriate interventions to mediate food seeking behaviors. On 6/28/2024 the dining room cupboards were locked and kitchen was secured. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the	

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F 740	Continued From page 2 allowed in the kitchen area. R1 ignored staff. -On 6/16/24 at 8:23 p.m., R1 was seen walking out of the kitchen door with 2 chocolate Boosts. -On 6/15/24 at 10:25 p.m., R1 was awake and kept asking staff for snacks. -On 6/14/24 at 9:07 p.m., R1 was observed by staff walk inside the kitchen door and took 3 cups of ice cream. When staff approached R1 he stated he was hungry and needed some snacks. R1's care plan dated 6/27/24, indicated R1 had diabetes mellitus and the goal was identified as R1 will have blood glucose ranging between 80-180 and absence of signs of hypoglycemia and hyperglycemia. Interventions included to monitor blood glucose as ordered and monitor for signs of hyperglycemia which included increased appetite. Further, R1's care plan indicated R1 had an alteration in behavioral state which was exhibited by yelling at staff or other residents and making comments about wanting to die. R1's care plan lacked evidence of identifying R1 had behaviors related to food which included eating and drinking excessive amounts, and lacked interventions directing staff what to implement to minimize these behaviors as R1 was at risk due to diagnosis of diabetes. R1's Emergency Department (ED) Provider Notes dated 6/21/24, indicated R1 was evaluated due to hyperkalemia and has had potassium of around 5.8 for a few weeks and was now up to 6.2 and glucose was elevated on morning labs also. R1 was given insulin prior to arrival at the ED. Further, labs revealed normal renal functioning and was noted R1's elevated potassium was "almost certainly" due to Spironolactone, which R1 takes for history of congestive heart failure. R1 was also noted to be drinking several cans of	F 740	potential to be affected by the deficient practice. Specifically, all residents with behavioral concerns or those prescribed psychotropic medications have the potential to be affected by this same deficiency. The facility will review all current resident charts for those with identified behavioral concerns and currently prescribed psychotropic medications. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, DNS will review and re-educate staff on the facilities policy on Behavioral Causes and Interventions was reviewed by Director of Nursing on 7/8/2024. All staff will be educated on Behavioral Causes and Interventions policy. The facility will review the care plans for all residents with behavioral concerns and prescribed psychotropic medications routinely at the IDT meetings to evaluate that appropriate interventions are in place and current on the behavior tracking logs, Care Plan and Electronic record. Current interventions are being added to the electronic record so staff are able to see them and be aware of current interventions to try. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The Director of Nursing or designee will audit care plans and behavior monitoring sheets weekly for 6 weeks to ensure	

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F 740	Continued From page 3 Boost, which does have a small amount of potassium. Further, history provided by patient and family, who reported R1 had taken 6 protein shakes that morning. Family would take steps to see that R1 does not have access to Boost. On 6/27/24 at 12:08 p.m., family member (FM)-A stated R1 had short term memory deficits and no safety awareness. FM-A stated R1 would "break into" the cabinets and drink Boosts, syrup, or whatever he could get his hands on. Further, FM-A stated she has spoke with registered nurse (RN)-A multiple times regarding this concern and the impact this behavior had on R1's blood sugars and potassium levels, the concerns were brought up a couple weeks ago at R1's care conference and family requested another care conference on that day, 6/27/24. On 6/27/24 at 12:43 p.m., during an observation an unidentified female nursing staff uses a key to unlock a cabinet in the dining room area, grabs a Boost shake from the cabinet, closes and locks the door again. The unidentified staff then grabs a cup and pours the Boost into the cup with a straw for another resident in the dining room. On 6/27/24 at 3:37p.m, during an observation of the dining room, there was a large metal pull down door to close off the kitchen and all the cabinets appeared to have a lock already installed on the outside of them. There was no visible food, beverages, or fridge visible. On 6/27/24 at 3:42 p.m., nursing assistant (NA)-A stated R1 had impaired cognition and was able to independently ambulate through out the unit without any assistive devices. NA-A stated R1 had exhibited behaviors of stealing food or	F 740	issues are being addressed timely and follow-up is being completed. The results of these audits will be reported to the QAPI committee for review and recommendations. The QAPI committee will determine if further auditing needs are necessary.	

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F 740	Continued From page 4 beverages from the kitchen when staff were not around, and for approximately two months the cabinets had been locked and the kitchen door had just had a keypad installed on that day, 6/27/24, due to R1's behaviors. NA-A stated staff would redirect R1 if they observed R1 in the kitchen but there were no other interventions for R1's behavior at that time. On 6/27/24 at 4:15 p.m., FM-B stated there was a Rice Krispy Treat wrapper and an empty Boost container in his garbage can just a little while ago. FM-B was frustrated and stated she was not sure where R1 was getting the extra snacks. On 6/27/24 at 4:58 p.m., RN-B stated R1 was alert and exhibited behaviors of sneaking into the kitchen and taking all the snacks such as a half-gallon of chocolate milk or 6 bottles of Boosts. Further, RN-B stated she would educate R1 related to his blood sugars and potassium levels, visual checks on R1 frequently, as well as staff locked the cabinets and the pull-down kitchen door to help decrease R1 from sneaking snacks. However, RN-B stated R1 will forcefully open the cabinets, and go through the back door of the kitchen, and still have access to the snacks and boosts. Further, RN-B stated RN-A and the director of nursing were aware of R1's behaviors. RN-B stated as of 6/27/24, the back door to the kitchen was now locked with a keypad. On 6/28/24 at 9:55 a.m., licensed practical nurse (LPN)-A stated she noticed R1 does not eat much of his meals but prefers to have snacks and will often ask staff multiple times for different snacks such as chocolate milk or Rice Krispy Treats. LPN-A stated she was not sure what the kitchen has for healthy snack choices for residents who	F 740		

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F 740	Continued From page 5	F 740		

are diabetic and stated as of the last two days the kitchen had been locked in attempt to prevent R1 from obtaining snacks.

On 6/28/24 at 10:04 a.m, NA-B stated R1 was independent with activities of daily living (ADLs) and was often forgetful. NA-B stated since admission, R1 had a history of going into the kitchen and taking multiple snacks, and NA-B stated recently R1's behaviors have "got worse". NA-B stated staff would attempt to redirect R1 back to his room and staff had moved the snacks and closed the big pulldown door to the kitchen, but R1 figured out to use the back door to obtain the snacks now. Further, NA-B stated depending on the dietary staff working there are different healthier snack options to offer R1.

On 6/28/24 at 10:23 a.m., NA-C stated R1 was independent and would often be up in the middle of the night wanting snacks and would go into the kitchen without staff's knowledge and grab cookies Boosts, pop, and unlimited coffee. NA-C stated staff started locking some of the cabinets in the kitchen but now R1 was going through the back kitchen door to obtain the snacks. Further, NA-C stated as of 6/27/24, the back kitchen door was now locked. NA-C stated R1's family was upset regarding R1's behaviors and being able to obtain the snacks without staff's knowledge and have now brought it healthier snack options for R1 to keep in his room.

On 6/28/24 at 11:12 a.m., RN-C stated R1 had impaired cognition and was often forgetful. RN-C stated R1 had been going into the kitchen and taking Boosts and was taking a "ton" of them and his blood sugars were "ridiculous". RN-C stated R1 had a history of alcoholism and now was bit

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F 740	Continued From page 6 into eating sweets. RN-C stated R1 has had these behaviors since admission but over the last three months had increased and staff were directed to lock the main pull-down door to the kitchen but R1 now had been using the back door to the kitchen to obtain the snacks. On 6/28/24 at 11:45 a.m., nurse practitioner (NP)-A stated R1 had cognitive impairments and would exhibit behaviors such as the certain food he was choosing to eat as well as the quantity. Further, NP stated the facility staff were lacking monitoring or restricting R1 to those types of food, especially Boosts, and had been an ongoing issue for 6 or more months. NP-A stated these concerns have been brought to administration "multiple times" and had not been addressed. NP-A expressed frustration and "puts a wrench" in treating some of R1's medical concerns he had been experiencing when R1 had access to Boosts and would consume 6 bottles in a quick manner. NP-A stated conversations related to R1's behaviors had been an ongoing discussing with facility management every time NP-A was onsite and had been aware of R1's behaviors months ago and were discussed at interdisciplinary team (IDT) meetings. On 6/28/24 at 12:59 p.m., RN-D stated she was "furious" with management related to R1's behaviors as staff have reported multiple times R1 was going into the kitchen and taking packs of oatmeal cookies, cartons of milk, 12 cups of ice crema at a time, and multiple Boosts. RN-D stated R1 has had a history of this since the day he admitted to the facility approximately a year ago and there had been no other interventions attempted until 6/27/24, when management locked the door to the kitchen.	F 740		

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F 740	Continued From page 7 On 7/2/24 at 10:51 a.m., RN-A stated R1 was admitted to the facility following a hospitalization related to a stroke and R1 had cognitive impairment and complications with short term memory. Further, RN-A stated R1 had a history of helping himself to anything in the kitchen that he could find to eat or drink, and staff would close the pull-down kitchen door and lock the cabinets but R1 was still able to get access through the back door of the kitchen. RN-A stated R1's behavior had been occurring since admitting to the facility. Further, RN-A stated as of 7/2/24, registered dietician (RD)-A was now involved and assisting with interventions to manage R1's behaviors. RN-A stated staff would be aware of these behaviors by reviewing R1's care plan and interventions for staff to implement to reduce R1's behaviors would be listed in R1's care plan or the NA's care guide sheets. RN-A confirmed she had failed to update R1's care plan with these behaviors and could not recall interventions that had been attempted to reduce R1's behaviors, as well as the behaviors were not listed on the NA's care guide sheet. RN-A denied knowing of R1's ongoing behaviors despite multiple staff interviews reporting management was aware. At 1:30 p.m., RN-A confirmed she could not locate R1's behavior monitoring sheets for the last couple months. On 7/2/24 at 12:07 p.m., RD-A stated she has been working part time at the facility since December of 2023, and does not attend resident's care conferences. RD-A stated she was first made aware of R1's behaviors related to going into the kitchen and consuming large quantities of food on the morning of 7/2/24. Further, RD-A stated she was "blindsided" and	F 740		

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F 740	Continued From page 8 was not aware of any active concerns and had been "scrambling" that morning to meet with the dietary team. RD-A then stated she did receive a report from staff related to R1 consuming 6 bottles of Boost last week and these behaviors had been an "issue for a long time". In addition, RD-A stated now the kitchen was totally locked. On 7/2/24 at 12:32 p.m., director of nursing (DON) stated she has been the interim DON at the facility since May of 2024, and recently within the last two weeks, became aware of R1's food seeking behaviors. DON reported she was informed by a dietary staff member by email related to his concerns about R1 being able to access the kitchen and helping himself to the food and beverages. DON stated a keypad was implemented on the back door to the kitchen on 6/27/24, and staff were provided a key to be able to access the kitchen when needed. Further, DON stated concerns related to resident would be expected to be discussed in IDT meetings by staff, and DON stated she did not recall R1's name ever being brought up regarding any concerns. Review of facility policy titled Behavioral Causes and Interventions revised 2/22/24, revealed the purpose of the policy was to use an IDT approach to determine probable causes of the behavior and understand the meaning behind the behavior. Further, policy indicated when a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident and it was the facility's responsibility to ensure that all staff were trained and knowledgeable in how to reach and respond appropriately to resident behavior. However, the facility lacked evidence and staff	F 740		

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	245039	A. BUILDING _____ B. WING _____	C 07/02/2024

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 740	Continued From page 9 guidance as to how the resident's would be assessed and determining appropriate interventions to prevent or decrease the behaviors, as well as how the determined interventions would be communicated to staff to implement.	F 740		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to obtain blood sugar checks and administer insulin timely, as ordered by physician, for 3 of 3 residents (R1, R2,R3) who had a diagnosis of diabetes. Findings include: R1's annual Minimal Data Set (MDS) dated 6/7/24, indicated R1 had diagnoses which included dementia, and type 2 diabetes mellitus with hyperglycemia. R1's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring four times a day which was "administered late" 5 days. Further, physician order revealed insulin aspart once a morning which was "administered late" 8 days and Novolog FlexPen per sliding scale before meals and at bedtime which was "administered late" 9 days. R2's quarterly MDS dated 6/17/24, indicated R2	F 760	The following disclaimer should be written in the “Provider’s Plan of Correction” column prior to responding to the first survey citation: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center’s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient	8/2/24

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F 760	Continued From page 10 had diagnosis of diabetes mellitus. R2's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring before meals and at bedtime which was "administered late" 11 days. Further, physician order revealed Humalog Insulin per sliding scale before meals which was "administered late" 18 days. R3's quarterly MDS dated 6/16/24, indicated R3 had diagnoses which included Alzheimer's disease and diabetes mellitus. R3's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring before meals and at bedtime which was "administered late" 11 days. Further, physician order revealed Humalog solution per sliding scale before meals and at bedtime which was "administered late" 18 days. On 6/27/24 at 12:08 p.m., family member (FM)-A stated she requested R1's medical records and noticed from March 2024-until date there were several times where R1's insulin was administered late and not according to physician orders. On 6/27/24 at 4:15 p.m., registered nurse (RN)-B and licensed practical nurse (LPN)-A knock on R1's door and check his blood sugar level which was 192 and administers 8 units of insulin per physician orders. R1 was pleasant and compliant with interaction. On 6/27/24 at 4:58 p.m., RN-B stated insulin was expected to be administered before a resident would eat.	F 760	practice? For R1,R2, R3 the medication administration records were reviewed to help determine most appropriate times to schedule insulin administration and glucose checks as ordered by their physician. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the potential to be affected by the deficient practice. Specifically, all residents who receive blood sugar checks and insulins have the potential to be impacted by this practice. The facility will review medication administration records for all residents with insulin and glucose monitoring to ensure timely blood sugar checks and administration of insulin as ordered by their physician. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, DNS will review and re-educate staff on the facilities policy titled Medication Errors 7/17/24. Also, all nursing staff who administer medications will be trained on the medication administration policy, blood glucose monitoring and insulin administration policy. This will be completed by the Director of Nursing or designee. 4. How will the corrective action be	

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F 760	Continued From page 11 On 6/28/24 at 7:58 a.m., LPN-A knocked on R1's door and entered room. LPN-A stated she had obtained R1's blood sugar reading at 7:45 a.m., and it was 133 so R1 did not require the sliding scale insulin. LPN-A stated R1 ate his breakfast at 6:30 a.m. that morning. At 9:55 a.m., LPN-A stated blood sugars were expected to be obtained before meals however, she was a little late administering R1's insulin on that day due to computer issues. On 6/28/24 at 11:12 a.m., RN-C stated blood sugars were expected to be obtained 30 minutes prior to a resident eating and then administer the insulin once they are eating. On 6/28/24 at 11:45 a.m., nurse practitioner (NP)-A stated blood sugars were expected to be obtained prior to any oral consumption and if the blood sugars were not obtained prior to the resident eating then the nursing staff would not be treating them appropriate as the blood sugar would not be accurate, and the insulin would not be accurate. Further, NP-A stated staff had reported that R1's insulin was administered late in the mornings and NP-A would ask staff what was planned for the noon meal because R1's blood sugar reading was now inaccurate for the noon meal check due to the morning insulin being administered late. NP-A expressed frustration as now the inaccurate blood sugar reading "falls on my plate" and NP-A had to gauge how much R1 would eat for the noon meal to ensure enough insulin would be given to cover him because the staff unfortunately did not follow physician orders for timely administration of insulin. Further, NP-A stated RN-A approached her at the facility and stated, "just so you know it looks like [R1]'s blood	F 760	monitored to ensure the deficient practice is being corrected and will not recur? The Director of Nursing or designee will audit medication administration for those residents receiving glucose monitoring and insulin administration weekly for 6 weeks to ensure these are being administered timely. The results of these audits will be reported to the QAPI committee for review and recommendations. The QAPI committee will determine if further auditing needs are necessary.	

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F 760	Continued From page 12 sugar was taken late" and NP-A stated RN-A "laughs about it". In addition, NP-A stated, "we are failing him". On 6/28/24 at 12:59 p.m., RN-D stated she would check resident's blood sugars as soon as possible, first thing in the morning however, if an emergency occurs then RN-A may get to them later than usual. RN-A stated to be honest there had been times I don't get to the blood sugar and insulin administration until 10:00 a.m. Further when asked what the process was for late administration, RN-D stated she had never completed a medication error and was not sure if there was a process to follow. On 7/2/24 at 10:51 a.m., RN-A stated staff were expected to obtain blood sugar readings prior to the resident eating and administering the insulin shortly after. RN-A stated she was aware of times where the blood sugar readings "slip through the cracks" insulin was administered later than it should have been. RN-A stated staff had not been completing medication errors when that occurs but "we should be" as completing the medication error would assist the management with tracking and trending. RN-A confirmed she was not aware R1, R2, and R3 had late administrations of insulin per their administration records. On 7/2/24 at 12:32 p.m. director of nursing (DON) stated staff were expected to obtain a blood sugar reading prior to a resident eating and administer the insulin prior to the meal or within 15 minutes of starting to eat the meal. Further, DON stated staff were expected to complete a medication error if the insulin was "administered late" as well as notifying the resident's physician.	F 760		

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F 760	Continued From page 13 DON stated completing a medication error was important for resident's safety especially for insulin as there was a risk for hypoglycemia and hyperglycemia, as well as obtaining guidance from the resident's physician and leadership would be able to identify patterns and trends. Review of facility policy titled Medication Errors revised 3/29/24, indicated if a medication error occurs it would be reported promptly to the attending physician, resident and or responsible party and documented. The policy defines medication error as the observed or identifier preparation or administration of medications which was not in accordance with the prescriber's order, manufactures specifications regarding the preparation and administration of the medication. Further, policy identifies wrong time, the failure to administer a medication to a resident within a predefined interval from its scheduled administration time (before meal or after meal), as a type of medication error.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 11, 2024

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: X2PZ11

Dear Administrator:

The above facility was surveyed on June 27, 2024 through July 2, 2024 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, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	07/02/2024

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

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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 6/27/24, 6/28/24 and 7/2/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have	2 000		

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2 000	Continued From page 1 reviewed these orders and identify the date when they will be completed. The following complaint was reviewed. H50395082C (MN00104395) with a licensing order issued at 1545. 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		8/2/24

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21545	Continued From page 3 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to obtain blood sugar checks and administer insulin timely, as ordered by physician, for 3 of 3 residents (R1, R2,R3) who had a diagnosis of diabetes. Findings include: R1's annual Minimal Data Set (MDS) dated 6/7/24, indicated R1 had diagnoses which included dementia, and type 2 diabetes mellitus with hyperglycemia. R1's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring four times a day which was "administered late" 5 days. Further, physician order revealed insulin aspart once a morning which was "administered late" 8 days and Novolog FlexPen per sliding scale before meals and at bedtime which was	21545	Corrected.	

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21545	Continued From page 4 "administered late" 9 days. R2's quarterly MDS dated 6/17/24, indicated R2 had diagnosis of diabetes mellitus. R2's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring before meals and at bedtime which was "administered late" 11 days. Further, physician order revealed Humalog Insulin per sliding scale before meals which was "administered late" 18 days. R3's quarterly MDS dated 6/16/24, indicated R3 had diagnoses which included Alzheimer's disease and diabetes mellitus. R3's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring before meals and at bedtime which was "administered late" 11 days. Further, physician order revealed Humalog solution per sliding scale before meals and at bedtime which was "administered late" 18 days. On 6/27/24 at 12:08 p.m., family member (FM)-A stated she requested R1's medical records and noticed from March 2024-until date there were several times where R1's insulin was administered late and not according to physician orders. On 6/27/24 at 4:15 p.m., registered nurse (RN)-B and licensed practical nurse (LPN)-A knock on R1's door and check his blood sugar level which was 192 and administers 8 units of insulin per physician orders. R1 was pleasant and compliant with interaction. On 6/27/24 at 4:58 p.m., RN-B stated insulin was	21545		

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21545	Continued From page 5 expected to be administered before a resident would eat. On 6/28/24 at 7:58 a.m., LPN-A knocked on R1's door and entered room. LPN-A stated she had obtained R1's blood sugar reading at 7:45 a.m., and it was 133 so R1 did not require the sliding scale insulin. LPN-A stated R1 ate his breakfast at 6:30 a.m. that morning. At 9:55 a.m., LPN-A stated blood sugars were expected to be obtained before meals however, she was a little late administering R1's insulin on that day due to computer issues. On 6/28/24 at 11:12 a.m., RN-C stated blood sugars were expected to be obtained 30 minutes prior to a resident eating and then administer the insulin once they are eating. On 6/28/24 at 11:45 a.m., nurse practitioner (NP)-A stated blood sugars were expected to be obtained prior to any oral consumption and if the blood sugars were not obtained prior to the resident eating then the nursing staff would not be treating them appropriate as the blood sugar would not be accurate, and the insulin would not be accurate. Further, NP-A stated staff had reported that R1's insulin was administered late in the mornings and NP-A would ask staff what was planned for the noon meal because R1's blood sugar reading was now inaccurate for the noon meal check due to the morning insulin being administered late. NP-A expressed frustration as now the inaccurate blood sugar reading "falls on my plate" and NP-A had to gauge how much R1 would eat for the noon meal to ensure enough insulin would be given to cover him because the staff unfortunately did not follow physician orders for timely administration of insulin. Further, NP-A stated RN-A approached her at the facility and	21545		

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 _____	07/02/2024

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

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21545	Continued From page 6 stated, "just so you know it looks like [R1]'s blood sugar was taken late" and NP-A stated RN-A "laughs about it". In addition, NP-A stated, "we are failing him". On 6/28/24 at 12:59 p.m., RN-D stated she would check resident's blood sugars as soon as possible, first thing in the morning however, if an emergency occurs then RN-A may get to them later than usual. RN-A stated to be honest there had been times I don't get to the blood sugar and insulin administration until 10:00 a.m. Further when asked what the process was for late administration, RN-D stated she had never completed a medication error and was not sure if there was a process to follow. On 7/2/24 at 10:51 a.m., RN-A stated staff were expected to obtain blood sugar readings prior to the resident eating and administering the insulin shortly after. RN-A stated she was aware of times where the blood sugar readings "slip through the cracks" insulin was administered later than it should have been. RN-A stated staff had not been completing medication errors when that occurs but "we should be" as completing the medication error would assist the management with tracking and trending. RN-A confirmed she was not aware R1, R2, and R3 had late administrations of insulin per their administration records. On 7/2/24 at 12:32 p.m. director of nursing (DON) stated staff were expected to obtain a blood sugar reading prior to a resident eating and administer the insulin prior to the meal or within 15 minutes of starting to eat the meal. Further, DON stated staff were expected to complete a medication error if the insulin was "administered late" as well as notifying the resident's physician.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21545	Continued From page 7 DON stated completing a medication error was important for resident's safety especially for insulin as there was a risk for hypoglycemia and hyperglycemia, as well as obtaining guidance from the resident's physician and leadership would be able to identify patterns and trends. Review of facility policy titled Medication Errors revised 3/29/24, indicated if a medication error occurs it would be reported promptly to the attending physician, resident and or responsible party and documented. The policy defines medication error as the observed or identifier preparation or administration of medications which was not in accordance with the prescriber's order, manufactures specifications regarding the preparation and administration of the medication. Further, policy identifies wrong time, the failure to administer a medication to a resident within a predefined interval from its scheduled administration time (before meal or after meal), as a type of medication error. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		