Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 15, 2023

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: October 19, 2023

Dear Administrator:

On November 8, 2023, we notified you a remedy was imposed. On December 13, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 6, 2023.

As authorized by CMS the remedy of:

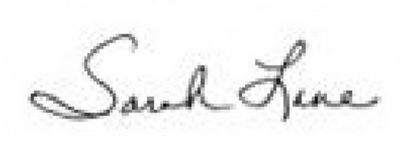
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 19, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 8, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 19, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 6, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 15, 2023

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

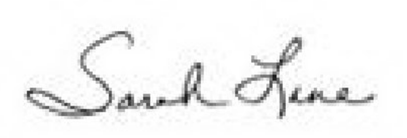
Re: Reinspection Results
Event ID: 24DR12

Dear Administrator:

On December 5, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 19, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 8, 2023

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: October 19, 2023

Dear Administrator:

On October 19, 2023, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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, 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, 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 January 19, 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 April 19, 2024 (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

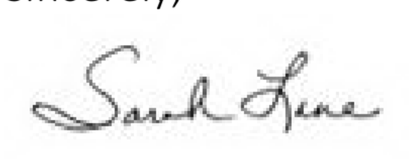
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 8, 2023

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: 24DR11

Dear Administrator:

The above facility was surveyed on October 18, 2023 through October 19, 2023 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.

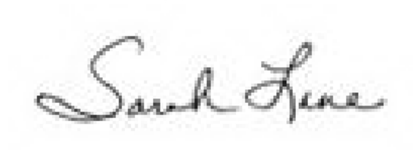
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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 feel free to call me with any questions.

Sincerely,



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Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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Email: sarah.lane@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 _____	10/19/2023

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 10/18/23 through 10/19/23, 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 orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H50396606C (MN92038) H50396491C (MN94303) H50396566C (MN95326) H50396494C (MN95596) H50396493C (MN96508) H50396477C (MN97586, MN97668) H50396483C (MN97520) Licensing orders were issued at 0830 and 1980 due to incidental findings. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to perform root cause analysis and failed to provide staff education to reduce the risk for burns after 1 of 1 residents (R9) reviewed sustained a burn from a hot plate.	2 830	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. -Nursing order put in place on 9/29 to	11/29/23

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2 830	Continued From page 3 Findings include: R9's annual Minimum Data Set (MDS) dated 9/21/23, identified intact cognition. R9's care plan dated 10/3/23, identified a Self Care deficit due to quadriplegia and indicated he had some function in upper extremities. The care plan directed staff to set up R9's food and cut up food as needed. R9's Resident Progress Note dated 9/28/23, indicated R9 was eating breakfast in his room and had placed plate on bare abdomen. When plate was removed it was found that R9 had a 4 centimeter (cm) x 5 cm red area and 1 cm x 2 cm blistered burn from the plate. Provider was notified and orders received for treatment. Dietary was talked too about this and thought that the new plaid clothing protectors would be appropriate coverage for abdomen. A supply was placed in residents room and he was told of this plan. During interview on 10/18/23, at 4:32 p.m. the DON stated R9's burn was discussed in the interdisciplinary team meeting. The DON said the facility did not have plate warmers and said there was a policy against heating food in the microwave because you never knew how hot the plate got. The DON stated they felt the burn was attributed to R9 having bare skin. The DON said the incident was not investigated further. During observation on 10/19/23, at 8:52 a.m. breakfast was being served in the Strawberry dining room. Food was on a steam table and plates were in a bin. No plate warmer was observed. During interview on 10/19/23, at 9:04 a.m.	2 830	ensure that resident has a clothing protector on while eating in bed to help prevent and minimize the risk for burns.Careplan updated on 11/13/2023 to identify the risk of burns and instructions on the process of reheating foods to prevent a reoccurrence and added to Dietary Flowsheet. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. -All resident with a with a history and preference of wanting their food reheated, residents that eat in bed and residents that have microwaves in their rooms will have their care plans reviewed and updated with the appropriate interventions to help prevent and minimize the risk for burns related to heating food in microwave. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. -All new admissions or residents will be assessed for their risk for burns related to heating food in microwave. All staff will be educated on reheating of food policy and process. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. -The DON/Designee will review all new admissions and 4 residents at risk for burns for 8 weeks to ensure residents have the appropriate interventions in place to prevent or minimize risk of burns related to heating food in microwave.	

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2 830	Continued From page 4 nursing assistant (NA)-A was asked if she knew how R9 was burned. NA-A said "they probably microwaved it," referring to R9's plate of food. Registered Nurse (RN)-A was present and said he was not present when R9 was burned but said "I know the plate was really hot." RN-A said he really did not know how the plate got that hot and said he thought the food was microwaved to heat it up as R9 usually ate a late breakfast. RN-A said R9 was paralyzed and did not have much feeling in his belly so staff now used a clothing protector to protect him from burns. RN-A further stated staff should be able to feel if a plate was steaming hot. During interview on 10/19/23, at 9:09 a.m. RN-B stated the day R9 was burned the NA came out of his room and said a nurse was needed. RN-B said she went and looked at the burn and measured it and got treatment orders. RN-B said the nurse was supposed to complete an incident report but it had not been done. RN-B stated she spoke with the dietician who recommended using a clothing protector. RN-B said "the only thing I can think of is they microwaved it." During interview on 10/19/23, at 9:18 a.m. NA-B stated she had not microwaved any food and was not sure it had ever come up whether or not they were allowed to. NA-B said she had served R9 his breakfast the day he got burned. NA-B said the plate came from the kitchen and was already on a tray so she had not noticed if the plate was hot. NA-B said when she later removed the plate she saw the redness and said R9 typically ate a late breakfast. During interview at 9:24 a.m., NA-C said said they had a resident on her unit that got up late and said they heat food in the microwave. NA-C	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 5 stated another residents family brought in food and that also got heated up. During interview at 12:54 p.m., NA-D was observed to heat a plate of food in the microwave and bring it to a room. NA-D said she heated the food for 15-20 seconds because the food was already pretty hot. NA-D said if the plate was too hot when she touched it it was too hot to serve. NA-D said soup and coffee got tempted but said she had not received any guidance on heating food in the microwave. On 10/19/23, at 1:18 p.m. the DON said there was no policy for heating food in the microwave but said it was not typically their practice. The DON said if staff were heating food she would expect them to heat in 15 second increments and temp the food in between. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize the risk for burns related to heating food in the microwave. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated,	21980		11/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21980	Continued From page 6 or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining	21980		

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	00823	A. BUILDING: _____ B. WING _____	10/19/2023

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21980	Continued From page 7 how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of neglect to the state agency (SA) which had the potential to affect all residents who resided on the Elderberry unit of the facility. Findings include: A report to the SA dated 7/17/23, indicated on 7/15/23, a nursing assistant (NA) was sent to the Elderberry unit of the facility at 1:30 a.m. to relieve licensed practical nurse (LPN)-A for a break. Upon arriving to the unit LPN-A was nowhere to be seen, the NA checked every room and bathrooms and was still unable to find LPN-A. At 3:00 a.m. LPN-A still had not returned to the unit. The on call nurse instructed staff to check the parking lot to see if LPN-A was asleep in her car. A second nurse went to the second floor to assist with the search and found LPN-A asleep in the sunroom. The report indicated there was only one staff on each unit on the overnight shift so staff were not to leave the unit unattended. During interview on 10/18/23, at 3:58 p.m. registered nurse (RN)-A stated there was only one NA on the units during the overnight shift so she sent a staff member over to give LPN-A a break and the NA could not find her. RN-A stated LPN-A left the whole unit unattended for over two	21980	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. -Contract LPN's contract was terminated after the incident occurred on 8/3/2023. All other staff members involved in the incident will be educated on the facility's policy and procedure for reporting vulnerable adult incidents by 11/278/2023. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. -All residents in the facility have potential to be affected by this practice. All location staff will be educated on our policy and procedure for reporting of vulnerable adult situations and the timelines associated with reporting by 11/28/2023 by Director of Nursing or Designee. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. -By 11/27/2023 all staff will receive education on reporting potential vulnerable adult situations and requirements for staff available on the units. Communication	

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21980	Continued From page 8 hours. RN-A said at one point she asked the NA to return to the Elderberry unit and remain until LPN-A could be located. RN-A said LPN-A was later found sleeping. RN-A stated she had reported the incident to facility management. A review of the facility's call light report indicated on 7/15/23, resident in room 405 pushed the call light at 1:44 a.m. The report indicated the call light was answered 41 minutes later. the resident in room 418 pressed the call light at 2:12 a.m. The light was answered 50 minutes later. During interview on 10/18/23, at 4:32 p.m. the director of nursing (DON) stated it was reported that LPN-A had been missing for several hours. The DON said the incident was not reported to the SA because the facility call light log did not identify any large gaps and said from the time staff last saw LPN-A to the time someone went to the unit was only 15-30 minutes. Facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 11/2/22, indicated it is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator	21980	expectations were also reviewed with all staff, so they are aware of who needs to be contacted when allegations of abuse and neglect are made and when. This will be completed by Director of Nursing or Designee. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. -All reports of a suspected vulnerable adult situations will be reviewed by location leadership during the weekly interdisciplinary team meetings, for the next 3 months, or until substantial compliance can be determined. Results will be reported to the QAPI committee.	

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21980	Continued From page 9 of the facility and to the State Agency in accordance with State law through established procedures. SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review the facility polices in regards to reporting of allegations of abuse and neglect to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIME FRAME FOR CORRECTION: Twenty-One (21) days.	21980		

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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 10/18/23 through 10/19/23, 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 orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H50396606C (MN92038) H50396491C (MN94303) H50396566C (MN95326) H50396494C (MN95596) H50396493C (MN96508) H50396477C (MN97586, MN97668) H50396483C (MN97520) Licensing orders were issued at 0830 and 1980 due to incidental findings. 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	2 000		

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2 000	Continued From page 2 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. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to perform root cause analysis and failed to provide staff education to reduce the risk for burns after 1 of 1 residents (R9) reviewed sustained a burn from a hot plate.	2 830	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. -Nursing order put in place on 9/29 to	11/29/23

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2 830	Continued From page 3 Findings include: R9's annual Minimum Data Set (MDS) dated 9/21/23, identified intact cognition. R9's care plan dated 10/3/23, identified a Self Care deficit due to quadriplegia and indicated he had some function in upper extremities. The care plan directed staff to set up R9's food and cut up food as needed. R9's Resident Progress Note dated 9/28/23, indicated R9 was eating breakfast in his room and had placed plate on bare abdomen. When plate was removed it was found that R9 had a 4 centimeter (cm) x 5 cm red area and 1 cm x 2 cm blistered burn from the plate. Provider was notified and orders received for treatment. Dietary was talked too about this and thought that the new plaid clothing protectors would be appropriate coverage for abdomen. A supply was placed in residents room and he was told of this plan. During interview on 10/18/23, at 4:32 p.m. the DON stated R9's burn was discussed in the interdisciplinary team meeting. The DON said the facility did not have plate warmers and said there was a policy against heating food in the microwave because you never knew how hot the plate got. The DON stated they felt the burn was attributed to R9 having bare skin. The DON said the incident was not investigated further. During observation on 10/19/23, at 8:52 a.m. breakfast was being served in the Strawberry dining room. Food was on a steam table and plates were in a bin. No plate warmer was observed. During interview on 10/19/23, at 9:04 a.m.	2 830	ensure that resident has a clothing protector on while eating in bed to help prevent and minimize the risk for burns.Careplan updated on 11/13/2023 to identify the risk of burns and instructions on the process of reheating foods to prevent a reoccurrence and added to Dietary Flowsheet. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. -All resident with a with a history and preference of wanting their food reheated, residents that eat in bed and residents that have microwaves in their rooms will have their care plans reviewed and updated with the appropriate interventions to help prevent and minimize the risk for burns related to heating food in microwave. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. -All new admissions or residents will be assessed for their risk for burns related to heating food in microwave. All staff will be educated on reheating of food policy and process. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. -The DON/Designee will review all new admissions and 4 residents at risk for burns for 8 weeks to ensure residents have the appropriate interventions in place to prevent or minimize risk of burns related to heating food in microwave.	

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2 830	Continued From page 4 nursing assistant (NA)-A was asked if she knew how R9 was burned. NA-A said "they probably microwaved it," referring to R9's plate of food. Registered Nurse (RN)-A was present and said he was not present when R9 was burned but said "I know the plate was really hot." RN-A said he really did not know how the plate got that hot and said he thought the food was microwaved to heat it up as R9 usually ate a late breakfast. RN-A said R9 was paralyzed and did not have much feeling in his belly so staff now used a clothing protector to protect him from burns. RN-A further stated staff should be able to feel if a plate was steaming hot. During interview on 10/19/23, at 9:09 a.m. RN-B stated the day R9 was burned the NA came out of his room and said a nurse was needed. RN-B said she went and looked at the burn and measured it and got treatment orders. RN-B said the nurse was supposed to complete an incident report but it had not been done. RN-B stated she spoke with the dietician who recommended using a clothing protector. RN-B said "the only thing I can think of is they microwaved it." During interview on 10/19/23, at 9:18 a.m. NA-B stated she had not microwaved any food and was not sure it had ever come up whether or not they were allowed to. NA-B said she had served R9 his breakfast the day he got burned. NA-B said the plate came from the kitchen and was already on a tray so she had not noticed if the plate was hot. NA-B said when she later removed the plate she saw the redness and said R9 typically ate a late breakfast. During interview at 9:24 a.m., NA-C said said they had a resident on her unit that got up late and said they heat food in the microwave. NA-C	2 830		

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2 830	Continued From page 5 stated another residents family brought in food and that also got heated up. During interview at 12:54 p.m., NA-D was observed to heat a plate of food in the microwave and bring it to a room. NA-D said she heated the food for 15-20 seconds because the food was already pretty hot. NA-D said if the plate was too hot when she touched it it was too hot to serve. NA-D said soup and coffee got tempted but said she had not received any guidance on heating food in the microwave. On 10/19/23, at 1:18 p.m. the DON said there was no policy for heating food in the microwave but said it was not typically their practice. The DON said if staff were heating food she would expect them to heat in 15 second increments and temp the food in between. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize the risk for burns related to heating food in the microwave. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated,	21980		11/29/23

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21980	Continued From page 8 hours. RN-A said at one point she asked the NA to return to the Elderberry unit and remain until LPN-A could be located. RN-A said LPN-A was later found sleeping. RN-A stated she had reported the incident to facility management. A review of the facility's call light report indicated on 7/15/23, resident in room 405 pushed the call light at 1:44 a.m. The report indicated the call light was answered 41 minutes later. the resident in room 418 pressed the call light at 2:12 a.m. The light was answered 50 minutes later. During interview on 10/18/23, at 4:32 p.m. the director of nursing (DON) stated it was reported that LPN-A had been missing for several hours. The DON said the incident was not reported to the SA because the facility call light log did not identify any large gaps and said from the time staff last saw LPN-A to the time someone went to the unit was only 15-30 minutes. Facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 11/2/22, indicated it is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator	21980	expectations were also reviewed with all staff, so they are aware of who needs to be contacted when allegations of abuse and neglect are made and when. This will be completed by Director of Nursing or Designee. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. -All reports of a suspected vulnerable adult situations will be reviewed by location leadership during the weekly interdisciplinary team meetings, for the next 3 months, or until substantial compliance can be determined. Results will be reported to the QAPI committee.	

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 _____	10/19/2023

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

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21980	Continued From page 9 of the facility and to the State Agency in accordance with State law through established procedures. SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review the facility polices in regards to reporting of allegations of abuse and neglect to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIME FRAME FOR CORRECTION: Twenty-One (21) days.	21980		