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:

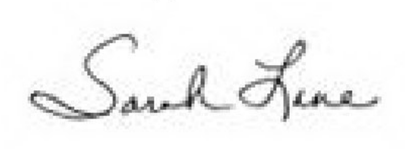
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 19, 2024 did not go into effect. (42 CFR 488.417 (b))

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 Therefore, the NATCEP prohibition is rescinded.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

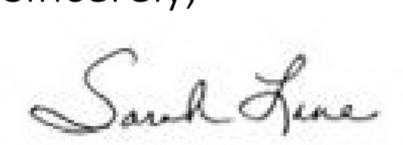
Re: Reinspection Results
Event ID: BIG012

Dear Administrator:

On December 13, 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 November 9, 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 22, 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 informed you of imposed enforcement remedies.

On November 9, 2023, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 19, 2024

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 19, 2024 They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 19, 2024

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

As we notified you in our letter of November 8, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 19, 2024

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 19, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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

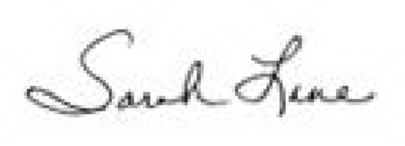
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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 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 22, 2023

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: BIG011

Dear Administrator:

The above facility was surveyed on November 8, 2023 through November 9, 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.

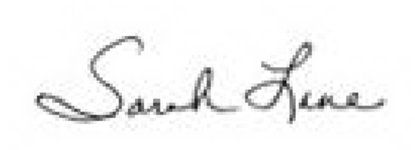
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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 11/09/2023

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) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/8/23 through 11/9/23, 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 complaints were reviewed: H50396966C (MN98218) with a deficiency cited at F600. H50397072C (MN98225) H50397012C (MN98027) Deficient practice was identified related to incidental finding with deficiencies cited at F609, F610. 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 600 SS=D	. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		12/6/23

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

Electronically Signed | 12/01/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop and implement interventions to prevent sexual abuse for 1 of 2 residents (R1) who was being sexually abused by another resident (R4). Findings include: A report to the state agency dated 11/1/23, indicated on 10/29/23, Staff reported that they saw R4 touching R1's face, legs, thighs and head then tried putting his hands down her pants. The report indicated staff stepped in and stopped R4 and told him he needed to go to his room. An undated, untitled document provided by the facility in response to request for the investigation of the allegation indicated the incident was isolated. The document indicated three residents were interviewed by the facility with no identified concerns. Summary of interviews with witnesses indicated: It was reported on 11/1/23, that on 10/29/23, staff member had seen R4 touching R1 on her legs and face and also tried to put his hands down her brief. The document however, lacked evidence of interviews with staff members. Summary of interview with R4 indicated he stated	F 600	F600 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice -R4 was initially transferred to the ER for further evaluation and review of his medications. Upon return to the facility, R4 was moved to the short stay wing, which consists of less residents and more alert residents. Also, staff has been monitoring mood and behavior of R4, and the above interventions have shown to be effective. Facility has adjusted call light system to alert staff when resident leaves his room. All interventions listed above have been care planned. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. -All residents in the facility have potential to be affected by this practice, all changes in resident behavior are reviewed by the interdisciplinary team with care plans adjusted appropriately. As a result all	

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F 600	Continued From page 2 he had not touched anyone or been near R1. R4 then sated "who reported me [R4]?, Oh, wait she can't talk." An untitled document dated 10/29/23, written 11/1/23, by (NA-B indicated R1 was sitting in her wheel chair in the living room and R4 went up to her and was rubbing her face, legs, thighs and head then proceeded to try to put his hands down R1's pants. R1's significant change Minimum Data Set (MDS) dated 8/12/23, identified severe cognitive impairment and indicated she did not ambulate. R1's care plan dated 8/11/23, identified a self care deficit and cognitive loss/dementia. The care plan indicated R1 had difficulty making her needs known due to Alzheimer's. R4's quarterly MDS identified intact cogitation and indicated he ambulated independently. R4's care plan dated 9/18/23, identified an alteration in cognition due to dementia and indicated he could be impulsive. R4's care plan indicated he ambulated independently. R4 Progress Notes identified the following: 10/24/23, R4 was making sexual comments to another resident (R1). R4 asked R1, "Do you want me to come into your room tonight?" 10/25/23, R4 was witnessed attempting to expose himself to another resident (R1) in the dining room. Report from the dietary aid was that R4 approached R1 in the dining room and looked around then stood up and began to unzip his pants. He attempted this two times and was redirected each time. R4's response to redirection	F 600	employees have been trained on immediate reporting and intervening on vulnerable adult incidents, this occurred on 11/27 and 11/28, with all other staff receiving education prior to working. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. -To ensure systemic changes are sustained, all location staff have been educated on our policy and procedure titled, Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and timelines associated with reporting on 11/27/2023 and 11/28/2023, by Administrator/Designee. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. -Social Services/designee will review all resident grievances and incidents 3 times a week for 8 weeks to ensure immediate action was taken and was appropriate, as well as any residents who had alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported according to facility policy and state/federal regulations. Results will be forwarded to the QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 3 was "I am just trying to make her happy". 10/26/23, Writer was contacted from unit staff reporting R4 may have been in R1's room. R4 had had a history of sexual inappropriateness which had been progressively getting worse. This writer contacted the director of nursing (DON) who requested this writer contact on call physician to send R4 to the emergency department (ED) for evaluation. 11/1/23, Writer was notified by nursing assistant (NA) that she had seen R4's hand down R1's pants at the table on 10/29/23. NA stated to writer that resident was rubbing R1's arm and asking if she was okay. NA stated that this was not the first incidence with R4 and R1. NA stated that there had been an incident the week prior. R1 was not able to speak for herself. NA was concerned because R4 had been seen on multiple occasions going in and coming out of R1's room. When R4 was near R1, R1 often had had a very fearful look and grimace on her face and kept shaking her head when R4 came near her. During interview on 11/8/23, at 2:46 p.m. the DON stated she had received the report that R4 had exposed himself to R1 and said he was trying to make her happy. The DON stated that was the first incident she had been aware of. The DON said she then heard that R4 had exposed himself to R1 on the 26th or had attempted to. The DON said she had spoken to R4 the next day and told him to stay away from R1. The DON said on the 26th she had received a call from the nurse who reported the NA's had gone to check on R1 and her legs were out of bed, her brief was partially undone and her gown was partway up. The DON	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 4 stated R4 was sent to the ED due to the initial report of him exposing himself and she had wanted to rule out any medical cause. The DON said after she got the phone call on 11/1/23, about R4 touching R1's face and putting his hand down her pants, she sent him out to the ED again. During interview on 11/8/23, at 3:31 p.m. registered nurse (RN)-A stated on 10/26/23, she received a call from staff saying they had gone into R1's room, found her door partway open, legs hanging off the bed and her gown pulled up. RN-A stated she called the DON who said to send R4 in to the ED. RN-A said the DON said they were not going to have R1 evaluated because there was no proof R4 had been in her room. During interview on 11/9/23, at 4:06 p.m. NA-B stated on 10/29/23, she had seen R4 come out of his room and approach R1 and was telling her she was beautiful and had his hands on her face and was rubbing her thigh. NA-B said R4 had moved his hand up R1's thigh and NA-B told him to go back to his room. Facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 11/2/22, indicated The facility leadership will assess the needs of the residents in the facility to be able to identify concerns in order to prevent potential abuse. If the resident could be at risk in the same environment (i.e.. Resident to resident altercation), evaluate the situation and consider options (i.e.. room change, assessment and care plan interventions).	F 600		
F 609 SS=D	Reporting of Alleged Violations	F 609		12/6/23

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 11/09/2023

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

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F 609	Continued From page 5 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) 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 of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to timely report an allegation of sexual abuse to the state agency for 1 of 1 residents (R1) reviewed who was allegedly being abused by another resident (R4) in the facility. Findings include:	F 609	F609 1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. -CNA that witnessed the incident has	

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F 609	Continued From page 6 A report to the state agency dated 11/1/23, indicated on 10/29/23, Staff reported that they saw R4 touching R1's face, legs, thighs and head then tried putting his hands down her pants. The report indicated staff stepped in and stopped R4 and told him he needed to go to his room R4 Progress Notes identified the following: 10/24/23, R4 was making sexual comments to another resident (R1). R4 asked R1, "Do you want me to come into your room tonight?" 10/25/23, R4 was witnessed attempting to expose himself to another resident (R1) in the dining room. Report from the dietary aid was that R4 approached R1 in the dining room and looked around then stood up and began to unzip his pants. He attempted this two times and was redirected each time. R4's response to redirection was "I am just trying to make her happy". 10/26/23, Writer was contacted from unit staff reporting R4 may have been in R1's room. R4 had had a history of sexual inappropriateness which had been progressively getting worse. This writer contacted the director of nursing (DON) who requested this writer to contact on call physician to send R4 to the emergency department (ED) for evaluation. 11/1/23, Writer was notified by nursing assistant (NA) that she had seen R4's hand down R1's pants at the table on 10/29/23. NA stated to writer that resident was rubbing R1's arm and asking if she was okay. NA stated that this was not the first incidence with R4 and R1. NA stated that there had been an incident the week prior. R1 was not	F 609	been educated on the facility□s policy and procedure for reporting vulnerable adult incidents on 11/1/2023. 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. As a result, all location staff have been educated on our policy and procedure for reporting of vulnerable adult situations and the timelines associated with reporting by 11/29/2023, by Administrator 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. -To ensure systemic changes are sustained, by 11/29/2023 all staff received education per the facility□s abuse and neglect policy and reporting of vulnerable adult situations policy. Communication 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 was completed by Administrator and Designee. Facility also reviewed their Abuse and Neglect policy to ensure it was appropriate and would ensure resident safety. 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.	

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F 609	Continued From page 7 able to speak for herself. NA was concerned because R4 had been seen on multiple occasions going in and coming out of R1's room. When R4 was near R1, R1 often had had a very fearful look and grimace on her face and kept shaking her head when R4 came near her. On 11/8/23, at 2:46 p.m. the DON stated she had received a report that R4 seemed to be talking to R1 at the table, "incident where he exposed himself" and made a comment he was trying to make her happy. The DON said that was the first report she was aware. The DON said apparently on 10/24/23, R4 had asked R1 if she wanted to go to this room and said on 10/25/23, he had exposed himself to R1. The DON said the next day she spoke with R4 and told him to stay away from R1. The DON said on 10/26/23, she received a call that staff had reason to believe R4 had been in R1's room, but said no staff seen him in there. The DON said R4 had been sent to the emergency departement (ED). The DON said she received a call again on 11/1/23, that staff had witnessed R4 touching R1's face and that he put his hands in her pants so she sent him to the ED again. The DON said they found out then the alleged incident had occurred on 10/29/23. The DON said the incident was not reported until 11/1/23 when she learned about it. When asked if the staff member who reported the incident late was educated the DON stated she had not been because because a training was planned for a later date. 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	F 609	-All reports of a suspected vulnerable adult situations will be reviewed by administrator or designee during the weekly interdisciplinary team meetings, for the next 8 weeks, or until substantial compliance can be determined. Results will be reported to the QAPI committee for further recommendations.	

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F 609	Continued From page 8 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 of the facility and to the State Agency in accordance with State law through established procedures.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		12/6/23

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F 610	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate an allegation of resident to resident sexual abuse for 1 of 1 residents (R1) who was being abused by another resident (R4). Findings include: A report to the state agency dated 11/1/23, indicated on 10/29/23, Staff reported that they saw R4 touching R1's face, legs, thighs and head then tried putting his hands down her pants. The report indicated staff stepped in and stopped R4 and told him he needed to go to his room. R4 Progress Notes identified the following: 10/24/23, R4 was making sexual comments to another resident (R1). R4 asked R1, "Do you want me to come into your room tonight?" 10/25/23, R4 was witnessed attempting to expose himself to another resident (R1) in the dining room. Report from the dietary aid was that R4 approached R1 in the dining room and looked around then stood up and began to unzip his pants. He attempted this two times and was redirected each time. R4's response to redirection was "I am just trying to make her happy". 10/26/23, Writer was contacted from unit staff reporting R4 may have been in R1's room. R4 had had a history of sexual inappropriateness which had been progressively getting worse. This writer contacted the director of nursing (DON) who requested this writer to contact on call physician to send R4 to the emergency	F 610	F610 1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. -Senior Director or designee provided training to facility leadership on 11/13/2023, regarding facility□s Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and on location□s internal vulnerable adult investigation checklist. 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 have a potential to be affected by this practice. All members of the leadership team received education by 11/29/2023, regarding facility□s Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and on location□s internal vulnerable adult investigation checklist. Education will be completed by the Administrator or Senior Director. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. -To ensure systemic changes are sustained, education was completed with all staff members regarding facility□s abuse and neglect policy, which covers	

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F 610	Continued From page 10 department (ED) for evaluation. 11/1/23, Writer was notified by nursing assistant (NA) that she had seen R4's hand down R1's pants at the table on 10/29/23. NA stated to writer that resident was rubbing R1's arm and asking if she was okay. NA stated that this was not the first incidence with R4 and R1. NA stated that there had been an incident the week prior. R1 was not able to speak for herself. NA was concerned because R4 had been seen on multiple occasions going in and coming out of R1's room. When R4 was near R1, R1 often had had a very fearful look and grimace on her face and kept shaking her head when R4 came near her. An undated, untitled document provided by the facility in response to request for the investigation of the allegation indicated the incident was isolated. The document indicated three residents were interviewed by the facility with no identified concerns. Summary of interviews with witnesses indicated: It was reported on 11/1/23, that on 10/29/23, staff member had seen R4 touching R1 on her legs and face and also tried to put his hands down her brief. The document however, lacked evidence of interviews with staff members. Summary of interview with R4 indicated he stated he had not touched anyone or been near R1. R4 then sated "who reported me [R4]?, Oh, wait she can't talk." An untitled document dated 10/29/23, written 11/1/23, by (NA-B indicated R1 was sitting in her wheel chair in the living room and R4 went up to her and was rubbing her face, legs, thighs and head then proceeded to try to put his hands down R1's pants.	F 610	investigations and reporting of these instances. All vulnerable adult checklists and investigations will be reviewed at the location□s interdisciplinary team meeting weekly. 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 vulnerable adult reports, for the next 8 weeks or until substantial compliance can be determined, will be reviewed by the Administrator or designee to ensure a proper investigation and documentation of investigation did occur. Results of the audit will be reported to the QAPI committee.	

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F 610	Continued From page 11 On 11/8/23, at 2:46 p.m. the director of nursing (DON) and licensed social worker (LSW)-A were interviewed. The DON stated she had received a report that R4 seemed to be talking to R1 at the table, "incident where he exposed himself" and made a comment he was trying to make her happy. The DON said that was the first report she was aware. The DON said apparently on 10/24/23, R4 had asked R1 if she wanted to go to this room and said on 10/25/23, he had exposed himself to R1. The DON said the next day she spoke with R4 and told him to stay away from R1. The DON said on 10/26/23, she received a call that staff had reason to believe R4 had been in R1's room, but said no staff seen him in there. The DON said R4 had been sent to the emergency departement (ED). The DON said she received a call again on 11/1/23, that staff had witnessed R4 touching R1's face and that he put his hands in her pants so she sent him to the ED again. When asked about interviews with staff who reported concerns, LSW-A stated she had not interviewed NA-B who had made the initial report. LSW-A stated the night of the report they had talked to the licensed practical nurse on the shift but had no documentation of staff interviews. LSW-A stated the written statement completed by NA-A was done when the police arrived on site following the report. Facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 11/2/22, indicated when an incident or suspected incident of "abuse" is reported, Social Services or a designee will investigate the incident with the assistance of appropriate personnel. The investigation may include but is not limited to:	F 610		

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F 610	Continued From page 12 a. Who was involved b. Residents ' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. c. Involved staff and witness statements of events d. A description of the resident ' s behavior and environment at the time of the incident e. Injuries present including a resident assessment f. Observation of resident and staff behaviors during the investigation g. Environmental considerations	F 610		

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	00823	A. BUILDING: _____ B. WING _____	C 11/09/2023

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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 11/8/23 through 11/9/23, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H50396966C (MN98218) H50397072C (MN98225) H50397012C (MN98027) As a result of the investigation a licensing order was issued at 1980. 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	2 000		

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2 000	Continued From page 2 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		
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, 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	21980		12/6/23

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21980	Continued From page 3 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 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 timely report an allegation of sexual abuse to the state agency for 1 of 1 residents (R1) reviewed who was allegedly being abused by another resident (R4) in the facility. Findings include: A report to the state agency dated 11/1/23, indicated on 10/29/23, Staff reported that they saw R4 touching R1's face, legs, thighs and head then tried putting his hands down her pants. The report indicated staff stepped in and stopped R4 and told him he needed to go to his room	21980	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00823	A. BUILDING: _____ B. WING _____	C 11/09/2023

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 4 R4 Progress Notes identified the following: 10/24/23, R4 was making sexual comments to another resident (R1). R4 asked R1, "Do you want me to come into your room tonight?" 10/25/23, R4 was witnessed attempting to expose himself to another resident (R1) in the dining room. Report from the dietary aid was that R4 approached R1 in the dining room and looked around then stood up and began to unzip his pants. He attempted this two times and was redirected each time. R4's response to redirection was "I am just trying to make her happy". 10/26/23, Writer was contacted from unit staff reporting R4 may have been in R1's room. R4 had had a history of sexual inappropriateness which had been progressively getting worse. This writer contacted the director of nursing (DON) who requested this writer to contact on call physician to send R4 to the emergency department (ED) for evaluation. 11/1/23, Writer was notified by nursing assistant (NA) that she had seen R4's hand down R1's pants at the table on 10/29/23. NA stated to writer that resident was rubbing R1's arm and asking if she was okay. NA stated that this was not the first incidence with R4 and R1. NA stated that there had been an incident the week prior. R1 was not able to speak for herself. NA was concerned because R4 had been seen on multiple occasions going in and coming out of R1's room. When R4 was near R1, R1 often had had a very fearful look and grimace on her face and kept shaking her head when R4 came near her.	21980		

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21980	Continued From page 5 On 11/8/23, at 2:46 p.m. the DON stated she had received a report that R4 seemed to be talking to R1 at the table, "incident where he exposed himself" and made a comment he was trying to make her happy. The DON said that was the first report she was aware. The DON said apparently on 10/24/23, R4 had asked R1 if she wanted to go to this room and said on 10/25/23, he had exposed himself to R1. The DON said the next day she spoke with R4 and told him to stay away from R1. The DON said on 10/26/23, she received a call that staff had reason to believe R4 had been in R1's room, but said no staff seen him in there. The DON said R4 had been sent to the emergency departement (ED). The DON said she received a call again on 11/1/23, that staff had witnessed R4 touching R1's face and that he put his hands in her pants so she sent him to the ED again. The DON said they found out then the alleged incident had occurred on 10/29/23. The DON said the incident was not reported until 11/1/23 when she learned about it. When asked if the staff member who reported the incident late was educated the DON stated she had not been because because a training was planned for a later date. 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	21980		

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21980	Continued From page 6 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 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		