DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2025

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: December 5, 2024

Dear Administrator:

On March 4, 2025, we notified you a remedy was imposed. On March 12, 2025 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 March 4, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 5, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 4, 2025, 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 March 5, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 4, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

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March 4, 2025

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: February 25, 2025

Dear Administrator:

On January 2, 2025, we informed you of imposed enforcement remedies.

On February 25, 2025, the Minnesota Department 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 March 5, 2025

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 location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 5, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 5, 2025.

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 5, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Neilson Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 June 5, 2025 (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 (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 02/25/2025

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 2/21/25 and 2/25/25, 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. H50398141C (MN00110837), H50397202C (MN00110537) with deficiencies cited at F656, F684. 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		2/28/25

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

Electronically Signed | 03/06/2025

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

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F 656	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop and implement care planned interventions to address refusal of cares for 1 of 3 residents (R1) reviewed for deteriorating	F 656	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts	

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F 656	Continued From page 2 skin condition. Findings include: R1's Resident Face Sheet indicated he admitted to the facility on 10/18/24, with diagnosis that included congestive heart failure, hypertension, cellulitis of right lower limb, Esysipelis and mild cognitive impairment. R1's Skin Risk Assessment with Braden Scale dated 11/2/24, indicated he required assistance of a mechanical lift and was frequently incontinent. The assessment identified open lesions on the foot, edema and reduced urinary output. R1's Braden evaluation for risk of skin breakdown indicate he was at risk. R1's care plan dated 11/18/24, identified a self-care deficit due to weakness. The care plan directed staff to encourage participation in grooming and indicated he required substantial assistance for grooming and toileting. The care plan identified incontinence and directed staff to keep skin dry and intact. The toileting plan indicated before and after meals and at bedtime and directed staff to check for incontinence at night with repositioning. The care plan was updated 2/5/25, to include an alteration in behavioral state as evidenced by refusal of cares, choosing to stay in soiled brief, chucks. The care plan directed staff to document refusals of care and re-approach R1 when refused care. R1's Resident Progress Note dated 12/15/24, indicated power of attorney (POA) in this evening. POA reported that R1 would refuse care and sit for days in feces. POA reported if R1 refused care, staff should call and POA would get on	F 656	alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F656 Develop/Implement Comprehensive Care Plan 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2/5/2025, Resident R1 care plan was updated to reflect refusals of care. Resident R1 has since been discharged from the facility. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by the deficient practice. Specifically, all residents who refuse cares have the potential to be affected by this deficient practice. As a result, their care plans have been reviewed and care plan interventions implemented to address refusal of cares. Also, staff have been educated on the need to complete education on risk and benefits to residents when they refuse cares.	

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F 656	Continued From page 3 phone to have him wash up. R1's Physician Progress Note dated 2/5/25, indicated pubic area rash, appears resident had been incontinent for an extended period. See attached photos. Abrasions, multiple, scattered. Erythema and rash present. Significant maceration to genitals and bilateral posterior upper thighs. The note indicated R1 was started on Amoxicillin 500 milligrams three times daily for seven days with extension if needed. R1's discharge Minimum Data Set (MDS) dated 2/7/25, identified intact cognition and indicated he displayed rejection of care behaviors 1-3 days during the assessment period. The MDS indicated R1 required substantial to maximal assistance for transfers and was dependent on staff for toileting and bathing. During interview on 2/21/25 at 10:50 a.m., POA-A said one time while R1 was at the facility he sat in the same soiled incontinent brief for at least 48 hours. POA-A said she had told staff to call if R1 was non-compliant, but no one ever called. POA-A stated a few days before they took R1 home the smell was so bad coming down the hall they decided to take R2 home out of the facility. POA-A stated there was a concern for bed sores and said R1's buttocks was purple, like leather and had multiple wounds on it. During interview on 2/21/25 at 2:18 p.m., registered nurse (RN)-B stated R1 did not like to use a urinal and would urinate in a cup. RN-B said it was "hit or miss" whether he would allow treatments to be done or not. RN-B said when R1 was incontinent, staff tried to change him, but he would say no. RN-B said staff should have	F 656	3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, all residents with a documented history of refusing cares were identified and care planned with appropriate interventions. Staff were educated by the DON/designee regarding, care plan development, following the care plan, refusal of treatment (residents choice, documentation, escalation) and activities of daily living. Also staff have been educated on our policy on Activities of Daily Living. Staff education completed on 2/28/2025. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, DON/designee will audit 8 residents charts for 6 weeks to ensure residents refusing care are care planned with appropriate interventions. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease discontinue audits. 5. What is the date of completion? 2/28/2025	

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F 656	Continued From page 4	F 656		

re-approached R1 or let a nurse know if he refused and said, part of the time they did. Regarding calling the POA for assistance, RN-B stated, "I honestly can't say we did," but was not sure why. RN-B stated the care plan was updated on 2/5/25, because she had not realized the refusal of cares were not on the care plan.

During interview on 2/21/25 at 3:52 p.m., Nursing assistant (NA)-A stated she would offer cares to R1 but said he did not want her to provide care. NA-A stated she helped with R1's care here and there. NA-A said almost every time she arrived to work her shift, R1 was wet and/or soiled and said there was a very strong odor in the hall that bothered other residents. NA-A stated staff never received any interventions related to refusals until R1 was scheduled to discharge.

During interview on 2/21/24 at 4:00 p.m. RN-A stated R1 had been very hard to deal with at times and stated he had behaviors in which he would yell and scream and kick staff out of his room. RN-A stated she had only worked with R1 a couple times and said he could be very nice. RN-A said only certain staff were able to get R1 to stand up and get cleaned up. RN-A said if R1 had been refusing cares staff would get her but said it did not work. RN-A stated she was unaware R1's POA's could be called if he refused cares.

During interview on 2/25/25 at approximately 2:00 p.m. the interim director of nursing (as of 2/25/25) stated the facility tried to acknowledge resident preferences but said if refusals put a resident at risk, interventions should have been implemented along with physician notification.

Facility policy Care Plan dated 12/2/24, indicated

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F 656	Continued From page 5 each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident ' s optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician ' s orders.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure toileting and hygiene tasks were performed for 1 of 3 (R1) residents reviewed resulting in worsening skin condition that required physician ordered treatment. Findings include: R1's Resident Face Sheet indicated he admitted to the facility on 10/18/24, with diagnosis that included congestive heart failure, hypertension, cellulitis of right lower limb, Esysipelis and mild cognitive impairment.	F 684	F684 Quality of Care 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2/5/2025, Resident R1 care plan was updated to reflect refusals of care. Resident R1 has since been discharged from the facility. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be	2/28/25

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F 684	Continued From page 6 R1's Skin Risk Assessment with Braden Scale dated 11/2/24, indicated he required assistance of a mechanical lift and was frequently incontinent. The assessment identified open lesions on the foot, edema and reduced urinary output. R1's Braden evaluation for risk of skin breakdown indicate he was at risk. R1's care plan dated 11/18/24, identified a self-care deficit due to weakness. the care plan directed staff to encourage participation in grooming and indicated he required substantial assistance for grooming and toileting. The care plan identified incontinence and directed staff to keep skin dry and intact. The toileting plan indicated before and after meals and at bedtime and directed staff to check for incontinence at night with repositioning. Alteration in behavioral state as evidenced by refusal of cares and choosing to stay in soiled brief, chucks was added 2/5/25. R1's Point of Care History dated 1/5/25 through 2/5/25, identified rejection of care behavior four times over a period of 30 days/ 90 shifts: 1/27/25, 1/29/25, 2/1/25 and 2/5/25. R1's Physician Progress Note dated 2/5/25, indicated pubic area rash, appears resident had been incontinent for an extended period. See attached photos. Abrasions, multiple, scattered. Erythema and rash present. Significant maceration to genitals and bilateral posterior upper thighs. The note indicated R1 was started on Amoxicillin 500 milligrams three times daily for seven days with extension if needed. R1's discharge Minimum Data Set (MDS) dated	F 684	affected by the deficient practice. Specifically residents requiring assistance with ADLs have the potential to be affected by this deficient practice. As a result, staff have been educated to report refusal of cares to supervisor immediately. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, staff were educated by the DON/designee regarding following the care plan, refusal of treatment (residents' choice, documentation, escalation) and activities of daily living. Staff education completed on 2/28/2025. Also staff have been educated on our policy on Activities of Daily Living 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, DON/designee will audit ADL cares, including timely toileting for 8 residents weekly, for 6 weeks. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease discontinue audits. 5. What is the date of completion? 2/28/2025	

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	245039	A. BUILDING _____ B. WING _____	C 02/25/2025

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F 684	Continued From page 7 2/7/25, identified intact cognition and indicated he displayed rejection of care behaviors 1-3 days during the assessment period. The MDS indicated R1 required substantial to maximal assistance for transfers and was dependent on staff for toileting and bathing. During interview on 2/21/25 at 10:50 a.m., power of attorney (POA)-A stated R1 had a number of visitors, and a few times had received complaints from his friends. POA-A said one-time R1 sat in the same soiled incontinent brief for at least 48 hours. POA-A said she had told staff to call if R1 was non-compliant, but no one ever called. POA-A stated a few days before they took R1 home the smell was so bad coming down the hall they decided to take home out of the facility. POA-A stated there was a concern for bed sores and said R1's buttocks was purple, like leather and had multiple wounds on it. POA-A stated she brought R1 a planner to write things down every day because staff contradicted everything, he told them and was getting paranoid. During Interview on 2/21/25 at 11:17 a.m., POA-B stated R1 was known to be non-complaint with care but said "I do believe some staff didn't care." POA-B stated R1's room stunk like body odor and yeast and said R1 would urinate in a plastic cup and put it into a urinal. POA-B said R1 was not always the most helpful patient. POA-B said when R1 discharged, most of his groin and thighs were a red, irritated mess, "really red and irritated." POA-B said when R1 was at the facility, if the door to his room was open, he could smell him coming down the hall and said it was not out of the ordinary to find R1 sitting in an incontinent brief in his own feces. POA-B further said he told	F 684		

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F 684	Continued From page 8 staff if R1 was not compliant to call. During interview on 2/21/25 at 1:36 p.m., an anonymous staff member stated had never had a problem with R1 refusing cares and stated had a hard time believing R1 would adamantly refuse care. Anonymous staff member stated instead of completing cares and treatment staff would just mark that he refused. The staff member stated there were nursing assistant (NA)'s that would not go check on R1 and said one day R1 sat in a wet brief and chair until approximately 10:00 p.m. and a second time R1 was still sitting in a urine soaked brief at 3:30 p.m., even though staff had been asked to provide care at 1:30 p.m. During interview on 2/21/25 at 2:18 p.m., registered nurse (RN)-B stated R1 did not like to use a urinal and would urinate in a cup. RN-B said it was "hit or miss" whether he would allow treatments to be done or not. RN-B said when R1 was incontinent, staff tried to change him, but he would say no. RN-B said staff should have re-approached R1 or let a nurse know if he refused and said, part of the time they did. Regarding calling the POA for assistance, RN-B stated, "I honestly can't say we did," but was not sure why. RN-B stated she had observed the odor coming from R1's room when the door was open but said, "he was okay with the door being closed." RN-B stated on 2/5/25, the provider told her she need to come to R1's room and after getting him up, the provider took photos and left the room. RN-B stated R1 had redness in his groin and on his upper thighs and had stool between his butt cheeks. RN-B said the brief was definitely wet along with the chucks and the chair underneath. RN- B stated she had not seen R1's skin prior to that. RN-B further stated the provider	F 684		

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F 684	Continued From page 9 seemed upset. During interview on 2/21/25 at 3:08 p.m., nursing assistant (NA)-C stated she had never had any trouble getting R1 to wash up. NA-C stated R1 would holler and was cantankerous but said she would re-approach him and explain she needed to provide cares he would allow it. NA-C stated frequently when she started her shift, she would find R1 "saturated" and said "you could wring out his brief." NA-C stated some of the staff just did not go in an offer to help him because they did not want to deal with him. NA-C stated before R1 discharged she saw his skin and said, "oh my word." During interview on 2/21/25 at 3:52 p.m., NA-A stated R1 required a stand lift to do cares and never wanted to get up and go to the dining room. NA-A stated she would offer cares to R1 but said he was not a fan of her. NA-A said she stayed away from R1 after an incident when she brought him disposable cups because he would urinate in them and R1 grabbed onto her shirt and yelled at her. NA-A stated she helped with R1's care here and there and said R1 was "kind of icky." NA-A said R1 hardly ever kept a brief on and sat with a sheet over him. NA-A said staff would come in and find R1 wet and soiled and while cleaning him, he would start urinating. NA-A said she "fully believed" R1 had some control and thought maybe it was done on purpose. NA-A said almost every time she arrived to work her shift, R1 was wet and/or soiled and said there was a very strong odor in the hall that bothered other residents. NA-A stated staff never received any interventions related to refusals until R1 was scheduled to discharge.	F 684		

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F 684	Continued From page 10 During interview on 2/21/24 at 4:00 p.m. RN-A stated R1 had been very hard to deal with at times and stated he had behaviors in which he would yell and scream and kick staff out of his room. RN-A said R1 had been sexually inappropriate and said NAs told her he was looking at their butts and down their shirts and would masturbate while they were in the room. RN-A stated she had only worked with R1 a couple times and said he could be very nice. RN-A said only certain staff were able to get R1 to stand up and get cleaned up. RN-A said if R1 had been refusing cares staff would get her but said it did not work. RN-A stated she was unaware R1's POA's could be called if needed. RN-A further stated other residents were complaining of the smell in the hallway and said it was "horrendous." During interview on 2/25/25 at 11:19 a.m., R1 stated he felt his care at the facility had been satisfactory but said when it came to keeping him clean, he did not get the help he needed. R1 said he needed the assistance of a machine to stand and when he asked staff for assistance, by the time they came back he had already soiled himself. R1 stated he did not refuse care and said when staff came to assist him, he said yes, but said they took 2-3 hours to come back. R1 said regarding bathing, staff would ask him after supper and he would agree, then no one would return until around 10:00 p.m. R1 said staff did not offer or provide cares every two hours as directed by the plan of care. During interview on 2/25/25 at 11:52 a.m., anonymous resident (AR)- A stated "oof-dah, the smell coming down the hallway." AR- A stated it went on for weeks and said it smelled like R1 was rotting. AR said staff told him R1 was the cause	F 684		

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F 684	Continued From page 11 of the smell and told him R1 did not shower. AR-A sated the smell was offensive. During interview on 2/25/25 at 11:57 a.m., AR-B stated there used to be a resident at the end of the hall who lived in his recliner, pooped in it, and said the stink coming out of the room was unbearable. AR-B said his room was next door. AR-B stated he told R1 to keep his door shut and said the smell was so bad he would almost gag. AR-B said the NA's told him what had been happening. During interview on 2/25/25 at 1:10 p.m., NA-B said R1 never asked for anything other than breakfast and lunch. NA-B stated right before R1 discharged she took care of him and said she asked two other staff to assist her and said that was the only time she had ever seen staff change R1. NA-B said she had never heard R1 tell staff no and said staff just had not gone in and checked on him. During interview on 2/25/25 at 1:17 p.m., photos of R1's skin dated 2/25/25, were observed with RN-B. RN-B described R1's skin as follows: Lower abdomen, groin and inner thigh were red from moisture. Buttocks impacted stool in rectum, redness from moisture and pressure of sitting covering both buttocks from upper thighs to just above his knees. RN-B stated staff had not reported the condition of R1's skin to her. During interview on 2/25/25 at approximately 2:00 p.m. the interim director of nursing (as of 2/25/25) stated the facility tried to acknowledge resident preferences but said if refusals put a resident at risk, interventions should have been implemented along with physician notification.	F 684		

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F 684	Continued From page 12 Facility policy Refusal of Treatment, Right to Choose dated 10/15/24, indicated refusal of treatment will be documented consistently in the medical record and will be countered by discussion with the resident regarding the health and safety consequences of the refusal and the availability of any therapeutic alternatives that may exist. When a resident chooses not to follow treatment which is prescribed by the physician or a member of the healthcare team, appropriate employees should attempt to determine why the resident is making this choice. Inform the resident about the health risk/benefit and safety consequences, as well as the availability of other existing therapeutic alternatives. Inform the resident ' s physician of the resident ' s choice. If the physician changes an order to align with the resident ' s desire, employees are to comply with the new order. However, if the physician is not able to change the order to align with the resident ' s wishes, employees should continue to offer the treatment as ordered and document all attempts.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 4, 2025

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: Event ID: BWMG11

Dear Administrator:

The above facility survey was completed on February 25, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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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 2/21/25 and 2/25/25, 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 have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H50398141C (MN00110837) H50397202C (MN00110537) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		