Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2025

Administrator
Neilson Place

1000 ANNE STREET NORTHWEST
BEMIDJI, MN 56601

RE: CCN: 245039
Cycle Start Date: December 9, 2025

Dear Administrator:

On December 9, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **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.

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.

Therefore, your agency is maybe prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 9, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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1000 ANNE STREET NORTHWEST
BEMIDJI, MN 56601

Re: Event ID: 1DD77A-H1

Dear Administrator:

The above facility survey was completed on December 9, 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

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Compliance Analyst | Federal Enforcement
Health Regulation Division
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 12/5/25 through 12/10/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint(s) was reviewed: H50397487C (2667282) and a deficiency was issued at F689 at HARM PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, noncompliance was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned fall interventions were implemented for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm for R1 who fell and sustained a fracture requiring surgical repair. The facility implemented corrective action prior to the start of survey, and this is issued in past noncompliance.	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

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F0689 SS = G	Continued from page 1 R1's Resident Face Sheet indicated she was admitted to the facility on 5/23/23 and re-admitted, following hospitalization, on 11/13/25. R1's diagnosis included displaced fracture of right femur. Alzheimer's disease, dementia, history of sacral fracture and failure to thrive. R1's quarterly Minimum Data Set (MDS) dated 11/5/25, indicated she was independent with bed mobility, sit to stand and required supervision for ambulation. R1's significant change MDS dated 11/19/25, indicated she was dependent for bed mobility, transfers, and indicated ambulation not attempted due to medical condition. R1's care plan dated 11/3/25, identified a risk for falls related to a history of falls, balance deficit and cognitive deficits. Care planned interventions dated 6/6/23, included bed at transfer height, hourly purposeful rounding, footrests for transportation and while at dining table. The care plan further identified cognitive loss/dementia as exhibited by confusion and forgetfulness. R1's Fall Risk Observation dated 11/5/25, indicated diminished safety awareness and indicated she required the use of assistive devices. The observation identified a high risk for falls. Fall Scene Huddle Worksheet dated 11/11/25, indicated at 7:30 a.m., R1 had an unwitnessed fall in the hallway. The worksheet indicated R1 had foot pedals on the chair and indicated "possibly tripped on wheelchair or barrier from flood." R1's Hospital Admission History and Physical dated 11/11/25, indicated fall with hip fracture. Will proceed with surgery. R1 had a fall at the nursing home. Obvious hip deformity noted. Found to have right femoral fracture. R1's Resident Progress Notes identified the following: 11/11/25, Writer came on shift and R1 was in her wheelchair sitting next to the storage cove. R1 had foot pedals on her wheelchair and a blanket wrapped around her that overnight staff had placed. R1 did not have hip protectors on. Writer was in the dining room administering medications and nursing assistants (NA)'s were in other resident rooms when writer heard a "yell and a crash." Staff arrived to find R1 laying on the floor against a plastic barrier on her right side. Upon assessment R1 was very uncomfortable and would not allow writer to lift right leg. R1 was sent to the ED. 11/13/25, R1 was admitted to the hospital post fall and underwent a right hip nailing (a surgical procedure used to repair a broken hip by placing a metal rid or nail inside the center of the broken thigh bone (femur). During observation on /12/9/25 at 9:26 a.m., R1 was lying on her back in bed and appeared to be asleep. R1 did not respond to knock on her door. During interview on 12/5/25 at 3:59 p.m., licensed practical nurse (LPN)-A stated R1 had dementia and had a fall history. LPN- A stated prior to her fall, R1 was always attempting to walk independently but was not steady at	F0689		

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F0689 SS = G	Continued from page 2 all. LPN-A stated R1 was not directable and had recently been trying to get out of her chair again. During interview on 12/5/25 at 4:03 p.m., registered nurse (RN)-A stated R1 self-transferred a lot from her wheelchair, so staff frequently checked on her. RN-A stated prior to her recent fall, R1 was able to stand up and walked by herself but required staff supervision. During interview on 12/9/25 at 9:36 a.m., trained medication aide (TMA)-A stated R1 used to ambulate on her own, staff would assist R1 into a chair, then she would get antsy and would get up and start walking. TMA-A stated sometimes it meant R1 needed to use the bathroom and said if staff saw R1 ambulating they would walk with her then put her back in her wheelchair or in a recliner. When R1 fell, she had foot pedals on her wheelchair and should not have. The foot pedals should have been used only when transporting her in her wheelchair. TMA-A stated the pedals may have contributed to her fall. During interview on 12/9/25 at 10:46 a.m., nursing assistant (NA)-A stated the day R1 fell, she and another staff were in another resident room and heard the nurse call for help. NA-A said when she came out of the room, R1 was on the floor, leaning against a plastic barrier. NA-A said prior to the fall R1 had been seated in her wheelchair next to the plastic barrier because the overnight staff had gotten her out of bed and dressed for the day. NA-A stated because R1 would attempt to stand up out of her wheelchair, R1 should not have had the foot pedals on her chair. During interview on 12/9/25 at 10:15 a.m., RN-B stated the day R1 fell, she received a call from staff about the fall. When RN-B went to the unit, R1 had already been placed back into her wheelchair. RN-B said foot pedals should been removed when not transporting R1. During interview on 12/9/25 at 11:52 a.m., the director of nursing (DON) reviewed the care plan and acknowledged R1 should not have had foot pedals on the wheelchair when she was seated in a common area. Facility policy Care Plan dated 12/1/25, indicated residents will receive and be provided with the necessary care and services to /attain or maintain the highest practicable well-being in accordance with the /comprehensive assessment. The noncompliance that began on 11/11/25 was corrected prior to the start of survey when the facility implemented a corrective action plan on 11/12/25. Actions taken included education related to the importance of following the care plan and initiated care plan audits for residents at risk for falls. The education and audits were verified through interview and document review. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.	F0689		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/5/25 through 12/9/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey. H50397487C (2667282). Minnesota Department of Health is documenting the State	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 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.	20000		