Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 28, 2025

Administrator
Neilson Place
1000 ANNE STREET NORTHWEST
BEMIDJI, MN 56601

RE: CCN: 245039
Cycle Start Date: July 2, 2025

Dear Administrator:

On July 22, 2025, we notified you a remedy was imposed. On July 30, 2025 the Minnesota Department of Health 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 July 28, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 6, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 22, 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 August 6, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 28, 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 Therefore, the NATCEP prohibition is rescinded.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
Office: 651-201-4112

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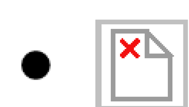
- 
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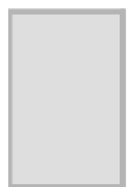
Enforcement 315121-F

- Neilson Place
- CCN 245039
- Nursing Home



Summary Bar

Enforcement Status

Open

Initial Transfer to CMS

07/22/2025

Substantial Compliance Date

(07/28/2025)

Day 23

(07/25/2025)

3 Calendar Months

(10/02/2025)

6 Calendar Months

(01/02/2026)

Enforcement Start Date

07/02/2025

Starting Survey

WFNT11 (07/02/2025)

Create attachment

Edit and preview letter.

Cancel Create attachment

ENF - NH Revisit Ordered Corrected

Print Preview

File Name*

Description

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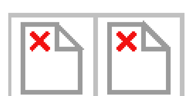

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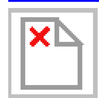

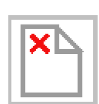

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 22, 2025

Administrator
Neilson Place

1000 ANNE STREET NORTHWEST
BEMIDJI, MN 56601

RE: CCN: 245039
Cycle Start Date: July 2, 2025

Dear Administrator:

On July 2, 2025, a survey was completed at your facility by the Minnesota Department of Health and Public Safety 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), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- **Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 6, 2025.**

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 6, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 6, 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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 August 6, 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 August 6, 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

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

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 2, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

tamika.brown@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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 22, 2025

Administrator
Neilson Place
1000 ANNE STREET NORTHWEST
BEMIDJI, MN 56601

Re: State Nursing Home Licensing Orders

Event ID: WFNT11

Dear Administrator:

The above facility was surveyed on July 1, 2025 through July 2, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division

Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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 **07/02/2025**

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 7/1/25 through 7/2/25, 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 with deficiencies cited at F557 and F603. H50398288C (MN00114218, MN00114230) H50398088C (MN00114124) H50398451C (MN0113616) 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.	F0000		07/02/2025
F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by:	F0557	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F557 Respect, Dignity/Right to have Personal Property 1. What corrective action will be accomplished for	07/28/2025

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 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

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 **07/02/2025**

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

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F0557 SS = D	Continued from page 1 Based on observation, interview and document review the facility failed to ensure respect and dignity for 1 of 3 residents (R1) reviewed when her personal power chair was removed from her room and use without her consent. Findings include: R1's Admission Record indicated she admitted to the facility on 9/19/23. Diagnosis included diabetes, arthritis, right above the knee amputation, post-traumatic stress disorder, depression and anxiety. R1's significant change Minimum Data Set (MDS) dated 4/11/25, identified intact cognition and indicated she displayed no behaviors during the assessment period. The MDS indicated R1 was independent with dressing, personal hygiene and transfers and did not ambulate. R1's care plan dated 5/9/25, indicated she had a history of utilizing her motorized wheelchair off campus. The care plan identified the following approaches: 1. R1 will notify staff when leaving facility and expected return time. 2. R1 will utilize safety features when using wheelchair: Flag, seat belt, horn , reflectors. 3. Staff to assist R1 to get in wheelchair. 4. Staff to assist R1 in charging wheelchair. 5. R1 will not leave facility without battery fully charged. 6. If Resident had a change in condition facility would reevaluate R1's ability to safely operate wheelchair. 7. R1 will operate wheelchair in low speed only. 8. If R1 utilized wheelchair in an unsafe or reckless manor or under the influence of any alcohol or non-prescription drugs the facility had ability to prohibit the use of the wheelchair in facility and campus. R1's Progress Notes indicated the following:	F0557	Continued from page 1 those residents found to have been affected by the deficient practice? Resident R1 was provided power wheelchair. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents who have or have had power wheelchair have the potential to be affected by this deficient practice. DNS/designee has ensured that they can use their power wheel chairs freely without any limitations as it relates to their rights to have property/respect and dignity. 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 current residents whose power wheelchairs have been removed will have documentation reviewed to ensure determined to be unsafe. All residents with a power wheelchair will only have power chair removed if they are determined to be unsafe. Leadership team was educated by the CLDS/designee regarding resident right to have personal property. Education completed by 7/28/2025. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS/Designee will audit all residents with power wheelchairs for 6 weeks to make sure that they've not been removed, unless determined unsafe. 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? 7/28/2025	

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 07/02/2025

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

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F0557 SS = D	Continued from page 2 -5/8/25, R1 told staff that she had a dentist appointment and she was planning on taking her wheelchair over so staff could cancel Medivan. Staff did not have appointment on the calendar for R1 and therefore no medivan had been set up. R1 was informed of this and that she had not been assessed to take her wheelchair outside of the facility. R1 went to therapy to ask about it and administrator, therapy staff and writer attempted to talk to R1 about concerns and safety of crossing a busy highway with a new chair. R1 stated that she didn't have battery issues and it was a new wheelchair so there should be no issues. She was informed that there still could be issues. Staff also brought up concerns about the lack of shoulder on the road and how she would deal with it if she got herself in a position where she tipped the wheel chair. Resident again stated she didn't think that would happen as she wasn't stupid and would not get herself in that situation. Staff attempted to explain to R1 that we had concerns for safety. She stated she had taken it to the store the previous day and didn't have issues. When asked what store she just stated, the store. R1 felt that staff was just trying to be controlling. R1 did relent to taking medivan to appointment but staff received a call from Medivan that she had not stayed for pickup. R1 was already back at the facility at that time. Therapy has now said that R1 was safe outside of building on facility grounds. 5/13/25, Writer received a call from unit nurse at 7:00 p.m. reporting that R1 had not returned from 1:00 p.m. appointment. Nurse reported R1 took medivan to appointment with her electric wheelchair and stated there was no indication or communication that she was going elsewhere after her appointment. Directed staff to attempt to reach R1 via number listed on her face sheet. Writer arrived at facility, confirmed R1 was not on the campus, confirmed location of her appointment, and called police department. A different staff member called to report resident was spotted in town south of facility and that resident reported to staff she was headed back to facility. 5/14/25, While R1 was out of the building for a procedure, management team discussed issues they were having with R1. Since receiving her electric scooter, R1 had been leaving the facility without letting staff know and had left appointment before transportation arrived to pick her up. The previous day R1 had not returned after an appointment. Staff had located her and she did return. After review it was decided to remove R1's electric scooter.	F0557		

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F0557 SS = D	Continued from page 3 During interview on 7/1/25 at 10:44 a.m., the interim DON stated he had only been at the facility for three weeks and said he was familiar with the situation. The DON said R1 was appropriate for independent living with services and the facility was actively working on it. In regard to the removal of R1's power chair, the DON said he would rather have a rights violation than have her out over dosing or getting hit by a bus. During observation and interview on 7/1/25 at 11:08 a.m., R1 was lying in bed watching television. There was a manual wheelchair next to her bed. R1 said the facility had taken her scooter away on May 15th while she was out of the facility for a medical procedure. R1 said she had gone to visit her kids and had taken the bus there and took her wheelchair back to the facility. R1 said she used the cross walks, pushed the buttons and did everything safe the way she should have. R1 said the facility told her they took her chair away because she hadn't signed out. R1 said she had not had any accidents with the scooter and said she had passed the facility driving test. During interview on 7/1/25 at 2:38 p.m., RN-B stated the previous DON, administrator and corporate staff made the decision to take R1's chair away and said R1 was not happy about it. RN-B said the chair was taken away because R1 went to an appointment and took the bus somewhere after and used her wheelchair for transport and no one knew where she was. RN-B said R1 had intact cognition and had been assessed safe to use the power chair in the facility and outside on the grounds. RN-B said R1 was her own decision maker. RN-B said R1 did not follow the rules of signing out and the facility was responsible for her when she left the facility so she was considered an elopement risk. During interview on 7/1/25 at 2:56 p.m., the administrator said the day R1 did not return immediately after her appointment she had received a call that R1 had not returned and did not answer her phone. She said minutes later she got another call that R1 was seen driving back to the facility in her chair. The administrator said the next morning they met as a team along with the corporate administrator and they determined she was not making safe decisions so the chair was taken away. The administrator said she aware R1 was very upset.	F0557		

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 **07/02/2025**

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

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F0557 SS = D	Continued from page 4 During interview on 7/1/25 at 3:56 p.m., the DON stated he knew the chair had been taken away after R1 did not return from an appointment and a second incident when staff had to convince her not to leave. The DON acknowledged R1 had tried to leave because they took her chair. The DON said there was no question of R1's ability to operate the chair appropriately but more about her not communicating where she was going to be. The DON said there was a concern about her history of drug use and the prevalence in this area but said he was not aware of any drug use while at the facility. When asked about less restrictive alternatives, the DON said R1 was still able to have the same independence in the manual chair as she had in the power chair but she covered more distance in the power chair. A resident rights policy was requested but not received.	F0557		
F0603 SS = G	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This 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 observation, interview and document review the facility failed to ensure 1 of 3 residents (R1) reviewed for use of electric wheelchairs in the community was free from involuntary seclusion. This resulted in actual psychosocial harm for R1 when the facility took away her personal mobile equipment (power wheelchair), which restricted R1's access to her community (including family), causing increased depressive symptoms, isolation and withdrawal from	F0603	F603 Free from Involuntary Seclusion - Revised 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R1 was provided power wheelchair. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents that have the potential to be affected by this deficient practice. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, DNS/designee has ensured that they can use their power wheel chairs freely. Any residents who have care plan changes, or become more limited to their community, will be assessed by DNS/designee for involuntary seclusion to ensure measures are put in place to assist the residents to increase access as appropriate and to reduce isolation and withdrawal. Staff education completed by DON/designee regarding Abuse and Neglect Policy, Abuse Definitions policy. Staff education completed by 7/28/2025. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and	07/28/2025

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F0603 SS = G	Continued from page 5 usual activities. Findings include: R1's Admission Record indicated she admitted to the facility on 4/21/25. Diagnosis included diabetes, arthritis, right above the knee amputation, post-traumatic stress disorder, depression and anxiety. R1's significant change Minimum Data Set (MDS) dated 4/11/25, identified intact cognition and indicated she displayed no behaviors during the assessment period. The MDS indicated R1 was independent with transfers. 4/8/25, PHQ-9 (patient health questionnaire) assessment (a self-report tool used to assess the severity of depression) score was 11 which indicated moderate depression. 6/27/25, PHQ-9 score was 16 which indicated moderate to moderately severe depression. R1's care plan dated 5/9/25, indicated she had a history of utilizing her motorized wheelchair off campus. The care plan identified the following approaches: 1. R1 will notify staff when leaving facility and expected return time. 2. R1 will utilize safety features when using wheelchair: Flag, seat belt, horn, reflectors. 3. Staff to assist R1 to get in wheelchair. 4. Staff to assist R1 in charging wheelchair. 5. R1 will not leave facility without battery fully charged. 6. If Resident had a change in condition facility would reevaluate R1's ability to safely operate wheelchair. 7. R1 will operate wheelchair in low speed only. 8. If R1 utilized wheelchair in an unsafe or reckless manor or under the influence of any alcohol or non-prescription drugs the facility had ability to prohibit the use of the wheelchair in facility and	F0603	Continued from page 5 will not recur? To ensure compliance, the DNS or designee will audit all residents during weekly IDT meetings to identify care plan changes or increased community limitations. Residents showing signs of isolation or withdrawal will be assessed for involuntary seclusion, and appropriate measures will be implemented to improve access and reduce isolation. 5. What is the date of completion? 7/28/2025	

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F0603 SS = G	Continued from page 6 campus. R1's Progress Notes indicated the following: -4/30/25, Occupation therapy note: R1 received her power wheelchair this date and demonstrated ability to transfer from manual chair to power chair, power chair to toilet and power chair to bed. R1 demonstrated appropriate use of controls. At this time R1 was instructed to keep the speed set at level one. R1 demonstrated ability to maneuver the wheelchair in her room, bathroom, up to table, in hallway, on/off elevator and with use of elevator controls. R1 used dressing stick to aid with getting the leg rest out of the way. R1 had a sensor system on the wheelchair which alerted her if she came too close to an object (due her limited neck range of motion). Plan to further assess R1 outdoors, R1 was instructed to only use the power wheelchair indoors at this time, until outdoor assessment and recommendations could be completed. -5/8/25. R1 told staff that she had a dentist appointment and she was planning on taking her wheelchair over so staff could cancel Medivan. Staff did not have appointment on the calendar for R1 and therefore no Medivan was set up. R1 was informed of this and that she had not been assessed to take her wheelchair outside of the facility. Resident then went down to therapy to ask about this. Administrator, therapy staff and writer attempted to talk to R1 about concerns and safety of crossing a busy highway with a new chair. R1 stated that she didn't have battery issues, and it was a new wheelchair so there should be no issues. She was informed that there still could be issues. Staff also brought up concerns about the lack of shoulder on the road and how she would deal with it if she got herself in a position where she tipped the wheelchair. Resident again stated she didn't think that would happen as she wasn't stupid and would not get herself in that situation. Staff attempted to explain to resident that we had concerns for safety. She stated she had taken it to the store the previous day and didn't have issues. When asked what store she just stated, the store. R1 felt the facility was just trying to be controlling. Resident did relent to taking Medivan to appointment, but later facility received a call from Medivan that she had not stayed for pickup. R1 was already back at the facility at that time. Therapy has now said that R1 was safe outside of building on facility grounds.	F0603		

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F0603 SS = G	Continued from page 7 -5/9/24, Writer and registered nurse (RN)-A reviewed R1's care plan with her regarding use of electric chair. It was read to her, she signed care plan and stated she understood what was read to her. -5/13/25, R1 left at 1:00 p.m. for appointment via Medivan to go to behavior health and had not returned. Attempted to call personal cell phone. R1 did not answer and voicemail was full. -5/13/25, Writer received call from unit nurse at 7:00 p.m. reporting that R1 had not returned from 1:00 p.m. appointment. Nurse reported R1 took Medivan to her appointment with her electric wheelchair and stated there was no indication or communication that R1 was going elsewhere after her appointment. Directed staff to attempt to reach R1 via number listed on her face sheet. Arrived at facility, confirmed R1 was not on the campus, confirmed location of her appointment, and called police department. A different staff member called to report R1 was spotted in town south of the facility and that R1 reported to staff she was headed back to facility. R1 returned to facility at 8:30 pm and reported no concerns to unit staff. 5/14/25, While R1 was out of the building for a procedure, management team discussed issues they were having with R1. Since receiving her electric scooter, R1 had been leaving the facility without letting staff know and had left an appointment before transportation arrived to pick her up. The previous day R1 had not returned after an appointment. Staff had located her, and she did return. After reviewing it was decided to remove R1's electric scooter. -5/14/25, R1 returned from appointment and went to her room. R1 came out of her room crying, stated she was leaving and told staff they could throw away all of her stuff. -5/14/25, at approximately 12:15 p.m. R1 had gone to the therapy room and accused them of having her scooter They let her know they didn't have it. She talked with her therapist and requested a meeting. Administrator, director of nursing (DON) and social worker met with R1 who was demanding to leave against medical advice (AMA). R1 wanted her scooter and wanted to go out when she wanted. Staff tried multiple times and ways to go over safety concerns, but she refused to listen. R1 left the room stating she was leaving. R1	F0603		

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F0603 SS = G	Continued from page 8 wheeled down the driveway toward the street. The administrator stayed with her. After a few minutes R1 returned to the building. Facility had staff sitting and watching R1's door so staff would know if she came out of her room. -5/15/25, R1 left her room and went to the elevator. Nurse on the unit asked to ride with her and said R1 would not speak to her. Writer went to the lower floor and R1 was going outside so activity director (AD) was asked to follow R1 who went to the cookie food truck in the parking lot. R1 was talking to people outside who were identified as R1's family. When R1 saw the AD, she asked if she was spying on her. 5/20/25- IDT weekly review: R1 had been approved for electric scooter but then was non-complaint with guidelines for leaving facility. R1 was aware she was to come back after appointments and not cancel transportation. She twice did not return in a timely manner, nor did she let staff know she wasn't returning. R1 had stayed in her room most of time since placed back in regular wheelchair but had gone to appointments and returned without issues. R1's Outpatient Supportive and Palliative Care Progress Note dated 6/25/25, indicated R1's priority was making sure her kids were safe and increase her independence. If she saw her kids, she had hope and drive to become independent. When she didn't see her kids, she became depressed, hopeless and lost her drive to improve. The note indicated there was conflict at the facility currently and it caused R1 much emotional distress, depression and anger. R1 had thought if becoming homeless would be a better option since she would have freedom. R1 confirmed she was not currently planning to leave the facility AMA, "she just feels desperate and hopeless and thinks about it because she feels she has no other options." R1 was not suicidal but had a serious mental health history and there was concern about her current state of her mental health with the increasing stress of the situation. During interview on 7/1/25 at 10:44 a.m., the interim DON stated he had only been at the facility for three weeks and said he was familiar with the situation. The DON said R1 was appropriate for independent living with services and the facility was actively working on it. In regard to the removal of R1's power chair, the DON said he would rather have a rights violation than have	F0603		

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F0603 SS = G	Continued from page 9 her out overdosing or getting hit by a bus. During observation and interview on 7/1/25 at 11:08 a.m., R1 was lying in bed watching television. There was a manual wheelchair next to her bed. R1 said the facility had taken her scooter away on May 15th while she was out of the facility for a medical procedure. R1 said she had gone to visit her kids and had taken the bus there and drove her wheelchair back to the facility. R1 said she used the cross walks, pushed the buttons and did everything safe the way she should have. R1 said the facility told her they had taken her chair away because she hadn't signed out. R1 said she had not had any accidents with the scooter and said she had passed the facility driving test. During interview on 7/1/25 at 1:52 p.m., occupational therapist (OT)-A stated they had pursued getting R1 the power chair because she had so many problems getting around in the manual chair outside the facility. OT-A said R1 was assessed as safe to use the power chair and was able to use the controls, navigate, make turns and move around stationary objects. OT-A said they did not assess specifically for safety in the community but said R1's chair had a flag, lights and if she got too close to an object her chair would vibrate. OT-A said R1 did quite well and said she thought R1 would do okay in the community. During interview on 7/1/25 at 2:05 p.m., NA-A and NA-B were interviewed. NA-B said he was working the day R1's chair had been taken away. NA-B said he had seen R1 out the window in the manual wheelchair, outside, and R1 was allegedly leaving the premises. NA-B said he was asked to stay late that day to be a sitter because they were worried she would elope. NA-B said R1 told him she felt her wheelchair had been wrongfully taken away. NA-B said he had noticed R1 was secluding herself more and said she used to come out and initiate her needs. NA-A said R1 used to come out to meals and had not been coming out since the chair was taken away. NA-A said R1 indicated she felt more isolated. During interview on 7/1/25 at 2:10 p.m., licensed social worker (LSW)-A stated R1 had been using her power chair to go to appointments and said she had been evaluated by therapy. LSW-A said R1 was upset about not having her chair and said she could tell R1 was more withdrawn. LSW-A said, "it was a nice piece of independence for her" and said she had noticed R1 had	F0603		

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F0603 SS = G	Continued from page 10 not been coming out of her room. During interview on 7/1/25 at 2:23 p.m., the social services coordinator said she had completed the PHQ-9 assessment for R1 and said the most recent one was focused on R1 not having her power chair. During interview on 7/1/25 at 2:38 p.m., RN-B stated the decision to take R1's chair away had been made by the administrator, DON and corporate staff and it was taken away because R1 had gone to an appointment and had not return after. RN-B said R1 was not happy about it. RN-B said R1 was not cognitively impaired and had been assessed as safe to use the chair in the facility and on the grounds. During interview on 7/1/25 at 2:56 p.m., the administrator stated R1 had gone through the process of getting the power chair and in mid-May she was planning to go across the street for a dentist appointment. The administrator said they did not feel it was safe and R1 agreed to take the Medivan but when the van went back to pick R1 up she had already left. The administrator said the next incident was when R1 had gone to see her kids and had driven back to the facility in the chair. The administrator said at that point the interdisciplinary team met with corporate leadership and they felt R1 was not making safe decisions. When asked about less restrictive alternatives, the administrator said she felt R1 had the ability to be as independent in a manual chair as she was in the power chair but said with the power chair she could go further away. In regard to the sitter outside R1's door, the administrator said they were afraid R1 would leave AMA. The administrator acknowledged R1 was her own decision maker and could leave the facility if she wanted to. The administrator said she aware R1 was very upset. During interview on 7/1/25 at 3:56 p.m., the DON stated he knew the chair had been taken away after R1 did not return from an appointment and a second incident when staff had to convince her not to leave. The DON acknowledged R1 had tried to leave because they took her chair. The DON said there was no question of R1's ability to operate the chair appropriately, and said the problem was more about her not communicating where she was going to be. The DON said there was a concern about her history of drug use and the prevalence in this area but said he was not aware of any drug use while at the facility. When asked about less	F0603		

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F0603 SS = G	Continued from page 11 restrictive alternatives, the DON said R1 was still able to have the same independence in the manual chair as she had in the power chair, but she covered more distance in the power chair. During interview on 7/2/25 at 12:22 p.m., mental health practitioner (P)-A stated R1 had a delicate mental health balance and had been sober for quite a while. P-A said R1 suffered from depression and said when she last saw R1 she could “see it all over her that something really bad was happening.” P-A said R1 was not currently suicidal but said it could happen if her back continued to be up against the wall. P-A said R1 had felt her only option was to leave AMA and become homeless. During interview on 7/2/25 at 11:28 a.m., the administrator said she had no reason to believe R1 would go out into the community to seek illegal substances. Facility policy Restraints dated 10/29/24, indicated residents were free from any physical or chemical restraint imposed for the purpose of discipline or convenience and not required to treat the residents’ medical condition. Convenience was described as any action taken by the location to control a residents’ behaviors or manage a resident’s behavior with a lesser amount of effort by the location and not in the resident’s best interest.	F0603		

Minnesota State Department of Health

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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 7/1/25 through 7/2/25, 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 and identify the date when they will be completed.	20000		07/02/2025

Office of Primary Care and Health Systems Management

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 The following complaints were reviewed with licensing orders issued at 1665. H50398288C (MN00114218, MN00114230) H50398088C (MN00114124) H50398451C (MN0113616) 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 The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is 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.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be	21850	Corrected	07/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER **Neilson Place**		STREET ADDRESS, CITY, STATE, ZIP CODE **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
21850	Continued from page 2 free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure respect and dignity for 1 of 3 residents (R1) reviewed when her personal power chair was removed from her room and use without her consent. Findings include: R1's Admission Record indicated she admitted to the facility on 9/19/23. Diagnosis included diabetes, arthritis, right above the knee amputation, post-traumatic stress disorder, depression and anxiety. R1's significant change Minimum Data Set (MDS) dated 4/11/25, identified intact cognition and indicated she displayed no behaviors during the assessment period. The MDS indicated R1 was independent with dressing, personal hygiene and transfers and did not ambulate. R1's care plan dated 5/9/25, indicated she had a history of utilizing her motorized wheelchair off campus. The care plan identified the following approaches: 1. R1 will notify staff when leaving facility and expected return time. 2. R1 will utilize safety features when using wheelchair: Flag, seat belt, horn , reflectors. 3. Staff to assist R1 to get in wheelchair. 4. Staff to assist R1 in charging wheelchair. 5. R1 will not leave facility without battery fully	21850		

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21850	Continued from page 3 charged. 6. If Resident had a change in condition facility would reevaluate R1's ability to safely operate wheelchair. 7. R1 will operate wheelchair in low speed only. 8. If R1 utilized wheelchair in an unsafe or reckless manor or under the influence of any alcohol or non-prescription drugs the facility had ability to prohibit the use of the wheelchair in facility and campus. R1's Progress Notes indicated the following: -5/8/25, R1 told staff that she had a dentist appointment and she was planning on taking her wheelchair over so staff could cancel Medivan. Staff did not have appointment on the calendar for R1 and therefore no medivan had been set up. R1 was informed of this and that she had not been assessed to take her wheelchair outside of the facility. R1 went to therapy to ask about it and administrator, therapy staff and writer attempted to talk to R1 about concerns and safety of crossing a busy highway with a new chair. R1 stated that she didn't have battery issues and it was a new wheelchair so there should be no issues. She was informed that there still could be issues. Staff also brought up concerns about the lack of shoulder on the road and how she would deal with it if she got herself in a position where she tipped the wheel chair. Resident again stated she didn't think that would happen as she wasn't stupid and would not get herself in that situation. Staff attempted to explain to R1 that we had concerns for safety. She stated she had taken it to the store the previous day and didn't have issues. When asked what store she just stated, the store. R1 felt that staff was just trying to be controlling. R1 did relent to taking medivan to appointment but staff received a call from Medivan that she had not stayed for pickup. R1 was already back at the facility at that time. Therapy has now said that R1 was safe outside of building on facility grounds. 5/13/25, Writer received a call from unit nurse at 7:00 p.m. reporting that R1 had not returned from 1:00 p.m. appointment. Nurse reported R1 took medivan to appointment with her electric wheelchair and stated there was no indication or communication that she was going elsewhere after her appointment. Directed staff to attempt to reach R1 via number listed on her face sheet. Writer arrived at facility, confirmed R1 was not	21850		

Minnesota State Department of Health

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21850	Continued from page 4 on the campus, confirmed location of her appointment, and called police department. A different staff member called to report resident was spotted in town south of facility and that resident reported to staff she was headed back to facility. 5/14/25, While R1 was out of the building for a procedure, management team discussed issues they were having with R1. Since receiving her electric scooter, R1 had been leaving the facility without letting staff know and had left appointment before transportation arrived to pick her up. The previous day R1 had not returned after an appointment. Staff had located her and she did return. After review it was decided to remove R1's electric scooter. During interview on 7/1/25 at 10:44 a.m., the interim DON stated he had only been at the facility for three weeks and said he was familiar with the situation. The DON said R1 was appropriate for independent living with services and the facility was actively working on it. In regard to the removal of R1's power chair, the DON said he would rather have a rights violation than have her out over dosing or getting hit by a bus. During observation and interview on 7/1/25 at 11:08 a.m., R1 was lying in bed watching television. There was a manual wheelchair next to her bed. R1 said the facility had taken her scooter away on May 15th while she was out of the facility for a medical procedure. R1 said she had gone to visit her kids and had taken the bus there and took her wheelchair back to the facility. R1 said she used the cross walks, pushed the buttons and did everything safe the way she should have. R1 said the facility told her they took her chair away because she hadn't signed out. R1 said she had not had any accidents with the scooter and said she had passed the facility driving test. During interview on 7/1/25 at 2:38 p.m., RN-B stated the previous DON, administrator and corporate staff made the decision to take R1's chair away and said R1 was not happy about it. RN-B said the chair was taken away because R1 went to an appointment and took the bus somewhere after and used her wheelchair for transport and no one knew where she was. RN-B said R1 had intact cognition and had been assessed safe to use the power chair in the facility and outside on the grounds. RN-B said R1 was her own decision maker. RN-B said R1 did not follow the rules of signing out and the facility	21850		

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21850	Continued from page 5 was responsible for her when she left the facility so she was considered an elopement risk. During interview on 7/1/25 at 2:56 p.m., the administrator said the day R1 did not return immediately after her appointment she had received a call that R1 had not returned and did not answer her phone. She said minutes later she got another call that R1 was seen driving back to the facility in her chair. The administrator said the next morning they met as a team along with the corporate administrator and they determined she was not making safe decisions so the chair was taken away. The administrator said she aware R1 was very upset. During interview on 7/1/25 at 3:56 p.m., the DON stated he knew the chair had been taken away after R1 did not return from an appointment and a second incident when staff had to convince her not to leave. The DON acknowledged R1 had tried to leave because they took her chair. The DON said there was no question of R1's ability to operate the chair appropriately but more about her not communicating where she was going to be. The DON said there was a concern about her history of drug use and the prevalence in this area but said he was not aware of any drug use while at the facility. When asked about less restrictive alternatives, the DON said R1 was still able to have the same independence in the manual chair as she had in the power chair but she covered more distance in the power chair. A resident rights policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies or procedures related to involuntary seclusion. The facility could audit all complaints of abuse to ensure appropriate assessments, interventions, and monitoring occur to prevent further abuse or neglect and educate all staff on those policies. The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21850		