DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3SPQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00823

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245039**

2. STATE VENDOR OR MEDICAID NO.
(L2) **106240900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEILSON PLACE**
(L4) **1000 ANNE STREET NORTHWEST**
(L5) **BEMIDJI, MN** (L6) **56601**

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/27/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35)
11/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Holly Kranz, Unit Supervisor — 12/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 12/31/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/08/2018
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

CMS Certification Number (CCN): 245039

December 28, 2018

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 19, 2018 the above facility is recommended for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
December 28, 2018

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: Project Number S5039029, H5039022, H55039017, H5039018 AND H5039019

Dear Administrator:

On October 5, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 10, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 24, 2018. (42 CFR 488.417 (b))

On November 16, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty. (42 CFR 488.430 through 488.444)

Also, the CMS Region V Office notified you in their letter of November 16, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 12, 2018.

On December 27, 2018, the Minnesota Department of Health and on December 28, 2018, The Centers for Medicare and September 19, 2018, the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 20, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 19, 2018. As a result of the revisit findings, the Department is discontinuing

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of October 5, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- The Category 1 remedy of state monitoring effective October 10, 2018 is discontinued

effective December 19, 2018.

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 24, 2018, is to be discontinued effective December 19, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 19, 2018, is to be discontinued. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 19, 2018, is to be discontinued.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of November 16, 2018:

• Federal Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Also, the CMS Region V Office notified you in their letter of November 16, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 12, 2018.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

December 28, 2018

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: Reinspection Results - Project Number S5039029

Dear Administrator:

On December 27, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 20, 2018, that included an investigation of complaint number H5039022. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3SPQ
Facility ID: 00823

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245039**

2. STATE VENDOR OR MEDICAID NO. (L2) **106240900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEILSON PLACE**
(L4) **1000 ANNE STREET NORTHWEST**
(L5) **BEMIDJI, MN** (L6) **56601**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/20/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **11/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **78** (L18)

13. Total Certified Beds **78** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks, NFE - NE II 10/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **01/01/1979** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

October 5, 2018

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: Project Number S5039029

Dear Administrator:

On August 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated survey, completed on August 24, 2018 that included an investigation of complaint number H5039022. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 20, 2018, a standard survey was completed at your facility by the Minnesota Department of Health and on September 19, 2018, the Minnesota Department of Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities particpating 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 a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 10, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy(ies) and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 12, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 12, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 12, 2018.

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.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for

its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

If substantial compliance with the regulations is not verified by November 24, 2018 (three months after

the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 February 24, 2019 (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.

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) 565-9462

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, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

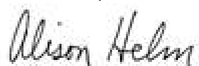
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 5, 2018

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders - Project Number S5039029

Dear Administrator:

The above facility was surveyed on September 17, 2018 through September 20, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5039022 that was found to be unsubstantiated. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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.

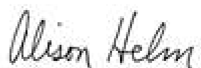
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00823	A. BUILDING: ______ B. WING ______	C 09/20/2018

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NEILSON PLACE	**1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601**

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1	2 000		

Continued From page 1

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.

On 9/17/18, to 9/20/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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 surveyors findings are the Suggested Method of Correction and 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.

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		10/25/18

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify a representative of a resident fall for 1 of 1 residents (R11) reviewed for notification of change. Findings include: R11's Face Sheet printed 9/20/18, indicated R11 had diagnoses that included Alzheimer's disease, and osteoarthritis. R11's quarterly Minimum Data Set (MDS) dated 6/14/18, indicated R11 had severe cognitive impairment. R11's care plan dated 7/1/15, indicated she had the potential for falls due to a history of falls, medications, cognitive deficits, incontinence and, at times, self transferring. On 9/18/18, at 11:39 a.m. family member (FM)-C was interviewed and stated she was not notified when R11 fell on 5/1/18, but was notified on 5/2/18, when the facility decided R11 needed to be checked at the hospital. On 5/1/18, at 6:09 a.m. a progress note indicated R11 called out for help at approximately 4:30 a.m. and directly after that staff heard resident fall. R11 was laying next to her dresser with her feet closer to her door. R11 complained of right hip pain once in bed, and was able to move to previous ability. On 5/2/18, at 7:16 a.m. a progress note indicated	2 265	corrected	

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2 265	Continued From page 4	2 265		

R11 was experiencing right hip pain, and would not transfer to her wheelchair. R11 was assisted to a seated position and to standing, but would not take a step with her right leg. Once sitting in her wheelchair, R11 denied pain.

On 5/2/18, at 11:51 a.m. a progress note indicated R11 had been complaining of right lower extremity pain since the fall on 5/1/18. At 11:30 a.m. R11 screamed, howled, gasped, braced and winced with even light touch of her right lower extremity, and would not tolerate any movement of her right lower extremity. At the time of the progress note, the writer had placed calls to FM-C and was awaiting a return call to approve an x-ray to rule out a fracture.

On 5/2/18, at 2:50 p.m. a progress note indicated FM-C returned the call at 1:30 p.m. and had been unaware of R11's fall the previous day (5/1/18, early a.m.). FM-C granted permission for the x-ray.

On 5/2/18, at 6:41 p.m. a progress note indicated R11 was admitted to the hospital for a pelvic fracture. Facility nursing staff called and updated FM-C.

R11's Variance/Fall Scene Investigation form dated 5/1/18, indicated R11's physician had been notified on 5/1/18, at 6:25 a.m. but the family had not been notified.

The facility's Healthcare Safety Zone report for R11's fall indicated the physician was notified on 5/1/18, at 6:25 a.m. but the family was not notified.

On 9/20/18, at 11:25 a.m., the director of nursing (DON) was interviewed and stated she would

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2 265	Continued From page 5 expect staff to notify family if a resident fell. The DON stated staff wouldn't call in the middle of the night, but in the morning. The DON confirmed there was no documentation to indicate family had been notified. The facility Assessing Falls and Their Causes policy dated 6/17/17, directed nursing staff will notify the resident's attending physician and family in an appropriate time frame. The facility Change in a Resident's Condition or Status policy dated 6/16, directed the facility would promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident representatives are promptly notified of changes. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's	2 560		10/25/18

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2 560	Continued From page 6 long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the failed to develop a comprehensive care plan to identify and direct staff to preferred resident activities for 1 of 3 residents (R18) reviewed for activities. Findings include: R18's Face Sheet printed 9/19/18, identified diagnoses that included liver cell carcinoma, lymphoid leukemia, and Type 2 diabetes. R18's admission Minimum Data Set (MDS) dated 4/9/18, indicated R18 had severe cognitive impairment, had adequate hearing and vision (with glasses), and was able to make self understood and understood others. The MDS also indicated R18 required extensive assistance with mobility. R18's quarterly MDS dated 7/9/18, indicated R18 had severe cognitive impairment, had minimal difficulty hearing, had moderately impaired vision and did not wear glasses, was usually understood, and could usually understand others. The MDS also indicated R18 required extensive assistance with mobility. R18's Activities - Preferences for Customary Routine and Activites assessment completed by nursing and dated 4/3/18, indicated it was very important for R18 to go outside to get fresh air	2 560	corrected	

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2 560	Continued From page 7	2 560		

Continued From page 7

when the weather was good, and very important for him to participate in religious services or practices. The assessment indicated it was somewhat important for R18 to have items to read, listen to music, be around animals, and do his favorite activities. It was not important for R18 to keep up with the news, or do things with groups of people.

R18's Care Area Assessment (CAA) dated 4/9/18, was a checklist that included activity preferences prior to admission, current activity pursuits, health issues that result in reduced activity participation, environmental or staffing issues that hinder participation, unique skill or knowledge that resident has the he or she could pass on to others, issues that result in reduced activity participation, and input from resident and/or family/representative regarding activities. The checklist was blank. The analysis of findings indicated R18 had cognitive decline, and had been on Hospice prior to and after admission. The analysis indicated R18 had limited mobility, and periods of unresponsiveness, and the facility would care plan for recreation as he may desire and is able.

R18's care plan dated 4/10/18, indicated R18 preferred activities that identify with prior lifestyle. The goal for R18 was he would express satisfaction with his daily routine and leisure activities, and would show no signs of distress with recreation. Activity interventions for R18 were to allow him to express feelings and desires, and encourage him to become involved with activities of choice as he is able. The interventions also indicated R18 had a stated preference for choosing own clothing, caring for belongings, choosing mode of bathing, choosing bedtime, family involvement, private phone calls,

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2 560	Continued From page 8	2 560		

reading, music, animals, doing his favorite activities, being outside, and religious activities.

On 9/17/18, at 6:01 p.m. family member (FM)-A was interviewed. FM-A stated the family has asked the facility to provide activities for R18, but it has not happened. The family has also asked the facility to go in and read to him; he likes tractor magazines and religious readings, but this hasn't occurred. FM-A stated R18 isn't they type of person that would like group activities, but would like one to one visits. FM-A stated R18 has told her he gets lonely. FM-A stated the family visits frequently, but they feel R18 should be provided more activities.

On 9/19/18, at 2:11 p.m. the activity director (AD)-A was interviewed. AD-A stated she completed activity assessments for new admissions. AD-A stated she had not completed an admission activity assessment on R18 (nursing staff completed the assessment), and also had not completed a care plan for him. AD-A stated activity staff do 1:1 activities with residents, but she did not have a 1:1 program set up for R18. AD-A stated she expected the nursing assistants to do spontaneous groups on their unit, and expected them to help with all activities. AD-A stated she would expect the nursing assistants to tell her what R18 needs, and then she would provide it for him.

On 9/20/18, at 1:40 p.m. the director of nursing (DON) was interviewed. The DON stated R18's family has provided him with movies and TV shows, and staff play them for him. The DON stated R18's family also visits nearly every day, so that is part of his activity program.

The facility Activity Assessment Policy dated of

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2 560	Continued From page 9 2/15, directed the activity assessment is to be conducted by activity department personnel in conjunction with other staff, and the assessment is used to develop an individual activities care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure comprehensive care plans are completed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 575	MN Rule 4658.0430 Subp. 1 Health Information Management Service Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations.	2 575		10/25/18

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2 575	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resuscitation code status was consistent in all areas of the medical record for 2 of 4 residents (R36, R43) reviewed for Advanced Directives. Findings include: R36's Face Sheet printed 9/19/18, indicated R36's resuscitation status was Do Not Resuscitate (DNR). R36's Physician's Order Report dated 9/19/18, indicated R36 was a DNR status. R36's care plan dated 9/6/18, included code status of DNR, R36's advanced directives would be followed, and included No CPR. The nursing assistant group sheets printed 9/19/18, listed R36's resuscitation status as DNR. R36's Resuscitation Status Form signed by the MD on 11/2/17, and indicated code status of Full Code - all available reasonable technology is used in the event of cardiac or respiratory arrest. The Resuscitation Status Form included the comments spoke with daughter on 9/27/17, and she stated at last hospitalization this was discussed, and R36 requested full code as long as he was awake. R43's Face Sheet printed 9/19/18, indicated R43's resuscitation status was Full Code (to resuscitate). R43's Physician Order Report printed 9/19/18,	2 575	corrected	

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2 575	Continued From page 11	2 575		

indicated R43's resuscitation status was DNR.

R43's care plan directed Full Code status, and was undated.

The nursing assistant group sheets printed 9/19/18, listed R43's resuscitation status as Full Code.

R43's chart included a Provider Order for Life Saving Treatment (POLST) form signed by the MD on 8/15/18, indicating code status of DNR. A Resuscitation Status Form signed by the MD on 8/15/18, indicated status as DNR.

R43's Health Care Directive dated 6/16/12, and signed/notarized on 7/12/12, indicated R43's resuscitation status was CPR.

On 9/19/18, at 12:20 p.m. trained medication aide (TMA)-A was interviewed and stated she would find a resident's resuscitation status in the front of the chart on the Face Sheet. The health information management technician (HIMT)-B joined the interview and stated staff should be able to look at the front cover of the chart. HIMT-B checked front cover of chart for R36, and verified the chart was missing the resuscitation status on the outside front cover. HIMT-A stated staff would then try to find the order. HIMT-A stated the electronic health record (EHR) is the number one place status for nursing staff to check code status, and that it is usually posted on the (outside) front of the paper medical record. At 12:58 p.m. HIMT-A stated staff working directly with the residents would check the group sheet.

On 9/19/18, at 1:03 p.m. social services director (SS)-A was interviewed and stated the goal was to have the code status match throughout the

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2 575	Continued From page 12	2 575		

medical record.

On 9/19/18, at 12:36 p.m. registered nurse (RN)-B stated staff would look at the group sheets to find a resident's resuscitation status. RN-B stated If staff were unsure, they should check the front (cover) of the chart. If not seen there, staff should check the order. RN-B stated staff might check the POLST. RN-B stated nursing assistants learn where to find the code status during new employee orientation. RN-B stated the ward clerk or nursing staff send the resuscitation status form to the doctor for signature. Once signed, the ward clerk or nurse can make the change in the medical record.

The facility Advance Directive Policy and Procedure undated, directed the resident wishes regarding advance directives will be communicated to the staff via the care plan, front of resident's medical chart, on the face sheet, and to the resident's physician.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's medical records are accurate.
The Director of Social Services or designee could educate all appropriate staff on the policies and procedures.
The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 900	Continued From page 13	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and reassess pressure ulcers to prevent the development and the worsening of pressure ulcers, and consistently monitor pressure ulcers for 1 of 4 residents (R18) reviewed for pressure ulcers. This resulted in harm for R18 who developed a deep tissue injury on the left heel, an unstageable pressure ulcer to the right hip that worsened, and multiple Stage 2 pressure areas to the coccyx and buttocks that worsened. Findings include: Pressure ulcer stages from the National Pressure Ulcer Advisory Panel (NPUAP):	2 900	corrected	10/25/18

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2 900	Continued From page 14 Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. R18's Face Sheet printed 9/19/18, identified diagnoses that included liver cell carcinoma, lymphoid leukemia, and Type 2 diabetes. R18's quarterly Minimum Data Set (MDS) dated 7/9/18, indicated R18 had severe cognitive impairment, and required extensive assistance of staff with bed mobility, transfers, toileting, personal hygiene, and eating. The MDS also identified R18 was at risk for the development of pressure ulcers, and currently had two Stage 2 pressure ulcers and one Unstageable pressure ulcer, neither of which was present or were at a lower stage on the prior assessment dated 4/8/18. The MDS also indicated R18 had a pressure reduction device in the bed and the chair, and was on a turning and repositioning program.	2 900		

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2 900	Continued From page 15	2 900		

Continued From page 15

R18's Care Area Assessment (CAA) for falls dated 4/9/18, was a checklist that included extrinsic risk factors, intrinsic risk factors, medications that increase risk for pressure ulcer development, diagnoses and conditions that present complications or increase risk for pressure ulcers, and treatments and other factors that cause complications or increase risk. All of these areas were left blank. The second half of the CAA included the analysis of findings; document the description of the problem, causes and contributing factors related to the care area listed. This part of the CAA had a note which indicated Stage 1 pressure ulcer on buttocks per nurse notes/nursing interdisciplinary team (IDT) observation, is at risk for further pressure ulcer due to limited mobility, poor nutrition, bowel incontinence, terminal condition on hospice, medications. Has open area on ball of foot and abrasions on legs. Crawled on floor at home. The decision was made to care plan.

R18's care plan dated 4/10/18, indicated R18 had a potential for alteration in skin integrity due to limited mobility, bowel incontinence, medications, terminal condition, and cognitive deficit. The care planned interventions directed 1-2 staff to turn and reposition every 1-2 hours, monitor skin for redness/breakdown daily, pressure guard mattress and cushion in wheelchair, and Prevalon boots on both feet at all times. On 8/8/18, a pressure ulcer problem was added to the care plan. The care plan indicated R18 had a pressure ulcer on his right hip, and Stage 2 pressure ulcers on his coccyx. The intervention directed to monitor for signs and symptoms of infection.

R18's nursing assistant care guide sheet directed a pressure reduction mattress, reposition R18

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every 2 hours, float heels when in bed, and Prevalon boots (reduce pressure on the heel) when not in bed.

On 9/17/18, at 6:30 p.m. R18 was observed with an alternating pressure mattress to the bed, a cushion on the wheelchair, and Prevalon boots in place.

On 9/19/18, at 8:30 a.m. R18 was observed being repositioned in a timely manner. At 9:00 a.m. R19 was observed to have an alternating pressure mattress to the bed, a cushion on the wheelchair, and Prevalon boots in place.

On 9/17/18, at 6:16 p.m. family member (FM)-A was interviewed. FM-A stated R18 developed a pressure ulcer on his left heel sometime around the beginning of June. FM-A stated R18 was trying to get out of bed, and his heel ended up resting on the floor. No staff came to check on him for a long time, and R18 developed a deep tissue injury. FM-A stated staff told her he liked to keep his heel hanging off the bed and resting on the floor, but FM-A stated this wasn't true. FM-A also stated R18 had a pressure ulcer on his right hip.

On 9/19/18, at 1:00 p.m. the pressure ulcer on R18's right hip was observed with licensed practical nurse (LPN)-B and registered nurse (RN)-F. RN-F stated half of the pressure ulcer was a Stage 3, and the other half of the pressure ulcer was unstageable. RN-F stated the pressure ulcer measured 7 centimeters (cm) x 4.3 cm, and had slough (dead tissue) and scabbed areas. RN-F stated R18's heel pressure ulcer would not be available to be observed, as the dressing change was every 3-5 days, and she had changed it yesterday.

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R18's Skin Risk Assessment with Braden Scale (used to help determine a person's risk for developing pressure ulcers) dated 4/2/18, indicated R18 was at risk of developing a pressure ulcer, and listed interventions that included pressure ulcer device in chair and bed, turning and repositioning program, and pressure ulcer care. Skin Risk Assessment with Braden Scales were completed on 4/5/18, 4/12/18, 4/19/18, 4/26/18, and all indicated R18 was at risk of developing a pressure ulcer. A Skin Risk Assessment with Braden Scale was last completed on 7/9/18, and this also indicated R18 was at risk of developing a pressure ulcer. The facility did not do skin assessments following the development of the pressure ulcer to the left heel on 6/3/18, the development of the pressure ulcer to the left buttocks on 7/30/18, the development of the pressure ulcer to the right hip on 8/5/18, the development of the pressure ulcers to the coccyx on 8/7/18, and the development of the pressure ulcer to the right buttock on 8/16/18.

Review of R18's medical record indicated the following:

On 4/2/18, a progress note identified as initial skin assessment indicated R18's heels, buttocks, and front and back torso were unremarkable.

On 4/9/18, a progress note identified a Stage 1 pressure ulcer on R18's buttocks.

On 4/23/18, a progress note indicated no new open areas, but lacked description of the Stage 1 pressure ulcer on R18's buttocks. A note by the Hospice nurse indicated nurses reported wounds were healing.

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On 6/3/18, a progress note indicated R18 was found with his left heel on the floor, and when straightening him in bed, it was noted he had a 10 cm fluid filled blister on the heel pad of his left foot. R18's heel was purple and very boggy (soft). The area was considered a Deep Tissue Injury (DTI)in evolution. A Mepiplex (foam) dressing was applied.

On 6/6/18, a progress note indicated a home care nurse saw R18 to assess his heel and his skin. The note indicated the left heel pressure ulcer was a suspected DTI from a combination of sheer, friction and pressure. The pressure ulcer was not measured. The note also identified a small, sheer area on R18's coccyx, no further information was identified.

On 6/6/18, a wound consult was completed. The nurse documented family reported left heel ulcer to staff over the weekend. Resident had Prevalon boots, however, staff reported the boots were worn inconsistently. A 6 cm x 6 cm pressure ulcer was noted, with a mostly resolved blister. The nurse documented R18 was at high risk for worsening and new pressure ulcers due to neuropathy, immobility and most likely vascular disease due to diabetes. The left heel ulcer appeared related to pressure, friction and shear, and was suspicious for DTI due to the purplish center. Orders were given for Prevalon boots at all times in and out of bed, and foam heel dressing every three days and as needed. The nurse further recommended to monitor for changes, and to notify Hospice staff if the pressure ulcer opened and was draining. The nurse also recommended R18 might benefit from added gel and/or Aquacel if changes are noted, and directed staff to continue with daily skin inspection and pressure reduction interventions.

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On 6/21/18, a progress note indicated the left heel pressure ulcer was unstageable, and deep purple in color. The pressure ulcer was not measured.

On 6/25/18, a progress note indicated R18's left heel had a black scab on it. The pressure ulcer was not measured.

On 7/2/18, a progress note indicated R8's heel pressure ulcer was black in color and intact, with a small amount of dark red drainage on the old dressing. The pressure ulcer was not measured.

On 7/5/18, a progress note indicated R18's heel pressure ulcer measured 7 cm x 6 cm, and was black in color.

On 7/9/18, a progress note indicated R18's heel pressure ulcer was a dark brown and yellow loose scab. The scab came off during the dressing change, and the skin underneath had good blood return, and was close to being healed. There were three areas on the heel that were open, and they measured 3 cm x 1 cm with no depth, 1 cm x 0.3 cm with yellow slough (was unstageable), and 4 cm by 0.2 cm.

On 7/17/18, a progress note indicated R18's left heel DTI continued to have small black eschar at back of heel. The pressure ulcer was not measured.

On 7/21/18, a progress note indicated R18's left heel pressure ulcer was approximately 2 cm x 2 cm unstageable area.

On 7/24/18, a progress note indicated R18's left heel pressure ulcer measured approximately 2

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cm round, and was unstageable.

On 7/28/18, a progress note indicated R18's left heel pressure ulcer measured 2 cm by 2 cm, and was unstageable.

On 7/30/18, a progress note indicated R18's heel pressure ulcer measured 2 cm x 1.5 cm, had eschar and slough, and was unstageable. The note also indicated R18 had a new Stage 2 pressure ulcer to his left buttocks that measured 2.5 cm x 0.5 cm. The facility did not reassess following the development of the left buttocks pressure ulcer. A Mepiplex dressing was applied.

On 8/2/18, a progress note indicated R18's heel pressure ulcer had small amounts of drainage and slough. The pressure ulcer was not measured or staged. The facility continued with the Mepiplex dressing.

On 8/5/18, a progress note indicated R18's right lateral hip shear was reddened, and he would be kept off his right hip to allow for better healing. The pressure ulcer was not measured or staged. The facility did not reassess following the development of the right hip pressure ulcer.

On 8/6/18, a progress note indicated R18 had a warm, red, hard, swollen area measuring 18.2 cm x 13.5 cm to his right hip. The pressure ulcer was not staged. A Mepiplex dressing was applied.

On 8/7/18, a progress note indicated R18 had a Stage 1 pressure ulcer to his coccyx that measured 8 cm x 8 cm, and within that area there were further pressure ulcers. On the left coccyx, there was an unstageable pressure ulcer measuring 0.5 cm x 1 cm, and a second pressure ulcer was a Stage 2 measuring 0.2 cm x 0.2 cm.

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Medial to that pressure ulcer was a Stage 2 pressure ulcer measuring 0.3 cm x 0.3 cm. Above the gluteal crease was a Stage 2 pressure ulcer measuring 0.8 cm x 0.5 cm. A Mepiplex dressing was applied. The pressure ulcer on R18's hip measured 6 cm x 4 cm, and was not staged. The facility did not reassess following the development of the pressure ulcers on the coccyx.

On 8/8/18, a progress note indicated R18's left heel pressure ulcer measured 1.1 cm x 1.3 cm, was unstageable, with macerated edges and eschar to the center of the pressure ulcer.

On 8/16/18, a progress note indicated R18 had an unstageable pressure ulcer on his right buttock that was black in color and draining. The pressure ulcer was not measured. The note lacked indication of what type of treatment was done for this pressure ulcer. It was also noted the left heel pressure ulcer had a new dressing in place. The heel pressure ulcer was not staged or measured. The progress note indicated no other skin issues were noted.

On 8/23/18, a progress note indicted R18's unstageable pressure ulcer on the right buttock was large, had drainage, and was black in color. The pressure ulcer was not measured. The note lacked indication of what type of treatment was done for this pressure ulcer. The heel pressure ulcer had a new dressing in place, but the heel pressure ulcer was not measured or staged.

On 8/30/18, a progress note indicated R18 sacral dressing was changed. The pressure ulcers on R18's coccyx were not described in the note. The note also indicated R18 had Methicillin-resistant Staphylococcus aureus (MRSA, a type of staph

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2 900	Continued From page 22 infection that is resistant to many antibiotics) in his right hip he was uncomfortable, so the pressure ulcer was not measured. The note further indicated the left heel pressure ulcer had an intact foam dressing. On 8/31/18, a progress note indicated R18 had an unstageable pressure ulcer to his coccyx that measured approximately 1.4 cm x 1 cm. The pressure ulcer on R18's right hip measured 8 cm x 4.5 cm, and was not staged. On 9/11/18, a progress note indicated the pressure ulcer on R18's right hip measured 7.7 cm x 4.8 cm. The pressure ulcer was not staged. The pressure ulcer to R18's coccyx measured 0.5 cm in diameter, and was unstageable. The pressure ulcer to R18's left heel was a DTI that was now an open area that measured 1.5 cm x 2.0 cm with a depth of 0.4 cm. On 9/20/18, at 9:01 a.m. RN-A was interviewed. RN-A stated R18's right hip pressure ulcer started out as a shearing, and quickly developed into a pressure ulcer. RN-A stated the pressure ulcers on his coccyx and buttocks have waxed and waned. RN-A stated R18's heel pressure ulcer started out when he placed his heel on the floor, and the facility did not determine how long it had been on the floor. RN-A further stated they complete a skin risk assessment when residents are admitted, and again every quarter. RN-A stated documentation on pressure ulcers was done weekly and as needed (however, review of R18's medical record indicated weekly documentation did not occur). On 9/20/18, at 10:57 a.m. nursing assistant (NA)-D was interviewed and stated they make sure they reposition R18 every 2 hours.	2 900		

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2 900	Continued From page 23 On 9/20/18, at 12:58 p.m. RN-A was interviewed again. RN-A stated R18 developed a Stage 1 pressure ulcer a few days after he was admitted. RN-A stated R18 was at moderate risk for pressure ulcers according to his skin risk assessment. RN-A stated she placed R18 on an every two hour repositioning program when he was admitted. RN-A stated the facility did not reassess R18 following the development of the pressure ulcers. On 9/20/18, at 1:40 p.m. the director of nursing (DON) was interviewed. The DON stated staff was assessing and reassessing R18's pressure ulcers, and they did this on the Skin Risk Assessment with Braden Scale. The DON was unable to provide documentation of reassessment following the development of R18's pressure ulcers to the hip, coccyx, and buttocks. The facility policy Pressure Ulcer Risk Assessment dated 12/15, indicated the purpose of the policy was to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. The policy directed a comprehensive skin risk assessment and Braden Scale would be completed upon admission, with each additional assessment, quarterly, annually, and with significant changes. The policy further directed skin would be assessed for the presence of developing pressure ulcers on a weekly basis, or more frequently if indicated. The policy also directed nurses would conduct skin assessments at least weekly to identify changes. The facility policy Pressure Ulcer Treatment dated 12/17, indicated the purpose of the policy was to provide guidelines for the care of existing	2 900		

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pressure ulcers and the prevention of additional pressure ulcers. The policy directed the pressure ulcer treatment program should focus on the following strategies, which included assessing the resident and the pressure ulcer(s), managing tissue loads, and pressure ulcer care. The policy further directed pressure ulcer treatment required a comprehensive approach, including determining the cause of pressure and relieve, redistributing pressure, implementing pressure relieving devices, and initiating a skin grid and care plan.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and promote new pressure ulcers from developing.
The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.
The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		10/25/18

Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value

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must be offered to residents who refuse food served.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide nutritional interventions per resident preferences and family requests for 1 of 3 residents (R18) reviewed for nutrition.

corrected

Findings include:

R18's Face Sheet printed 9/19/18, identified diagnoses that included liver cell carcinoma, lymphoid leukemia, and Type 2 diabetes.

R18's quarterly Minimum Data Set (MDS) dated 7/9/18, indicated R18 had severe cognitive impairment, and required extensive assistance of staff with eating. The MDS also identified R18 had signs and symptoms of a swallowing disorder - coughing or choking during meals or when swallowing medications. The MDS further identified R18 had not had a weight loss or a weight gain of 5% or more in the last month, or 10% or more in the last 6 months. The MDS also identified R18 was on a mechanically altered diet.

R18's Nutrition Assessment dated 4/5/18, indicated R18's food intake during the assessment period was poor at breakfast, good one day at lunch and poor one day at lunch, and poor at supper. The assessment also indicated R18 was on an "as tolerated" diet, and required supervision (oversight, encouragement, or cueing) at meals, occasionally needing

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assistance, but could feed himself at times, depending on the time of day. The assessment indicated R18 had coughing or choking during meals or when swallowing medications. R18's weight was noted as 252 pounds on 4/2/18.

R18's Care Area Assessment for nutrition dated 4/10/18, indicated R18's Body Mass Index (BMI; a measurement of body fat based on height and weight) was elevated, and since he was on Hospice, trying to lose weight was not a realistic or appropriate goal.

R18's care plan dated 4/5/18, indicated R18 would eat and drink as he wished, and was on a mechanical diet, with nectar thick liquids. The care plan further directed staff to offer a bedtime snack, and offer alternative meals if he is eating poorly, or expresses dislike to the meal being served. If noted difficulty chewing, offer softer, easier to chew alternative.

On 9/17/18, at 6:16 p.m. family member (FM)-A was interviewed. FM-A stated R18 has had a significant weight loss since admission. FM-A stated R18 has had a lot of coughing a lot with meals, and has not had a swallowing evaluation because he is on Hospice. FM-A stated R18 used to get ice cream at night, but nobody will feed it to him, so he no longer receives it. FM-A stated R18 loves milkshakes and malts, and when family requested he receive this, they were told the facility doesn't have the capacity to make them. FM-A stated they have requested R18 receive extra calories in his food like half and half, 2% or whole milk, or butter on his toast, but he hasn't received this. FM-A stated she also has concerns staff does not always plate food according to what is on the menu. FM-A stated there are no substitute meals offered, and the food is generally

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cold. FM-A stated R18 will ask for cold cereal as an alternative, because he knows this is something they always have.

On 9/19/18, at 9:44 a.m. R18 was observed being fed by licensed practical nurse (LPN)-B. R18 ate a bowl of cold cereal, 2 slices of bacon, milk, coffee and orange juice. R18's lower dentures were loose and flopping in his mouth. R18 did not show any signs of coughing.

On 9/20/18, at 9:14 a.m. R18 was observed being fed by nursing assistant (NA)-E. R18 had some instances of coughing while he was being fed. R18 ate 1/2 bowl of cold cereal, and drank all of his coffee, and a half glass of milk and a half glass of orange juice.

Review of R18's weights indicated the following:
4/2/18: 252 pounds (lbs)
4/9/18: 247 lbs
4/23/18: 243 lbs
5/28/18: 244 lbs
6/4/18: 246 lbs
6/14/18: 242 lbs
6/25/18: 236 lbs
7/9/18: 231 lbs
8/13/18: 233 lbs
9/10/18: 228 lbs, a weight loss of 24 lbs, or 9% in 5 months.

On 9/20/18, at 8:55 a.m. registered nurse (RN)-A was interviewed and stated it was possible to get R18 a milkshake or malt if he or family requested, but she was not aware of any requests.

On 9/20/18, at 10:55 a.m. nursing assistant (NA)-D was interviewed and stated even if R18 was sleeping, he wanted to get up for meals. NA-D stated she would get R18 a milkshake or

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malt if he or family requested, but she was not aware of any requests.

On 9/20/18, at 1:18 p.m. the interim dietician (D)-E was interviewed. D-E stated she was filling in while the facility dietician was on leave. D-E stated she could not speak for what the dietician had done, however she would try to determine why R18 was losing weight, would speak with him and his family about adding higher calorie foods or a nutritional supplement, and would ask him and his family if they would like a swallowing evaluation done.

On 9/20/18, at 1:40 p.m. the director of nursing (DON) was interviewed and stated R18 was on Hospice.

The facility policy Initial Nutrition Assessment last reviewed 7/25/18, directed interventions will be developed within the context of the resident's prognosis and personal preferences. The policy further directed the care plan shall address, to the extent possible the resident's personal preferences, and nutrition therapy will be consistent with the resident's stated wishes and goals.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resients are provided with their choice of food.
The Director of Social Services or designee could educate all appropriate staff on the policies and procedures.
The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance.

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2 965	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand	21390	corrected	10/25/18

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hygiene was maintained for 1 of 1 residents (R2) observed during blood glucose checks and insulin administration. In addition, the facility failed to ensure proper cleaning of a glucometer between residents and following the use of the glucometer for 2 of 2 residents (R2, R38) reviewed for blood glucose checks. In addition, the facility failed to ensure proper hand hygiene was maintained during wound care for 1 of 2 residents (R24) observed during wound care, and 1 of 3 residents (R18) observed during personal cares. In addition, the facility failed to ensure hand hygiene was maintained during food preparation in neighborhood kitchens. In addition, the facility failed to ensure a urinary drainage bag was kept off the floor to prevent the risk of cross contamination for 1 of 1 residents (R31) observed for urinary catheter. In addition, the facility failed to ensure a wheelchair maintained a cleanable surface to prevent cross contamination for 1 of 1 residents (R13) whose wheelchair was reviewed.

Findings include:

R2's Face Sheet printed 9/20/18, indicated R2's diagnoses included diabetes.

R2's Physician Orders started 9/13/18, included orders for Humalog (rapid-acting insulin) 30 units subcutaneous (under the skin) with main meals three times a day and per sliding scale with meals three times a day:
-if blood sugar is 151 to 200, give 5 units.
-if blood sugar is 201 to 250, give 10 units.
-if blood sugar is 252-399, give 15 units.
-if blood sugar is greater than 400, call the physician.

R38's Face Sheet printed 9/20/18, indicated R38's diagnoses included diabetes.

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21390	Continued From page 31 R38's Physician Orders started 7/26/18, included orders for blood glucose monitoring with meals three times daily. On 9/17/18, at 5:04 p.m. licensed practical nurse (LPN)-A set up the multi-patient use glucometer and put a test strip in it at the cart outside R2's room. LPN-A put on gloves, but did not sanitize hands first. LPN-A threw something in the garbage bag hanging on the side of the cart, entered R2's room and placed the glucometer on R2's tray table next to her. LPN-A cleansed R2's right middle finger with an alcohol wipe, picked up the lancet and poked R2's finger. LPN-A obtained the blood sample on the test strip in the glucometer, set the glucometer on the tray table, wiped R2's finger with the alcohol wipe, removed the test strip from the glucometer, put it into his gloved hand, and removed gloves. LPN-A picked up the glucometer, exited R2's room, put the glucometer on the nurse's cart, placed the gloves into the garbage bag on the side of the cart, checked R2's sliding scale insulin on the computer. R2's blood sugar result was 147. LPN-A re-entered R2's room and sanitized hands. LPN-A read the menu, opened the medication cupboard, took out the insulin, turned on the water, set up the medications and insulin. LPN-A drew up 30 units of Humalog into the syringe, R2 pulled up her shirt to expose her abdomen, LPN-A injected the insulin into the right side of R2's abdomen with bare hands and no gloves. LPN-A put the needle into the sharps container, exited R2's room, and went back to the cart. The uncleaned glucometer remained on the cart. LPN-A picked up the glucometer, put it back on the cart, and stated, "It has to get docked." LPN-A brought the glucometer back to the nurse's station sink, took out germicidal wipes	21390		

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from the cupboard above the sink, quickly wiped the glucometer with the gray top germicidal wipe (PDI Sani-cloth AF3 germicidal wipe), and put the glucometer on the docking station. LPN-A returned to the sink and put the sani-wipes away in the cupboard above the sink. LPN-A stated at that time, and stated he did not know if there was a certain amount of time for the germicidal wipe to be in contact with the glucometer. LPN-A stated he usually would clean the glucometer between residents, and verified the glucometer was not cleaned between R2 and R38. LPN-A stated gloves are to be worn during blood glucose checks, but not needed when administering insulin. LPN-A stated hand sanitizer is used when going in and out of resident rooms. LPN-A stated there could have been cross-contamination when the glucometer was not cleaned between residents, setting it on the cart before cleansing, not washing hands after removing gloves, and not wearing gloves during insulin administration.

R24's Face Sheet printed 9/20/18, indicated R24's diagnoses included functional quadriplegia (paralysis of all four limbs) related to a neuro-muscular disorder, and anemia.

R24's Physician Orders started 9/6/18, included coccyx/sacral wound care treatment to be completed every 3 days and as needed.

R24's care plan reviewed and revised 9/14/18, indicated R24 had a Stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer pressure injury on the coccyx per the National Pressure Ulcer Advisory Panel) and was to receive treatments as ordered.

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21390	Continued From page 33 On 9/19/18, at 10:04 a.m. RN-B washed hands after entering R24's room. RN-B gloved, lowered R24's incontinent brief, removed R24's soiled dressing that contained a small amount of tan drainage and blood from the coccyx/sacrum, removed the soiled gloves, and without hand hygiene, donned clean gloves. RN-B sprayed R24's pressure ulcer with wound cleanser, dabbed with gauze, and described the wound with a small amount of slough and undermining. RN-B removed her soiled gloves, and without performing hand hygiene donned clean gloves. RN-B measured the pressure ulcer. RN-B removed the soiled gloves, and without performing hand hygiene donned clean gloves, and placed a dressing on the pressure ulcer. RN-B removed the soiled gloves, pulled up R24's incontinent brief and blanket, and washed her hands before exiting R24's room. On 9/19/18, RN-B verified she did not wash or sanitize her hands between glove changes, and stated she does not usually wash her hands between glove changes. On 9/20/18, at 10:55 a.m. director of nursing (DON) verified the glucometer should be cleaned before and after going into each resident room and between residents. The DON verified the glucometer should be kept wet for 3 minutes with the gray San-wipe. The DON verified gloves should be worn when administering insulin, and hands should be washed or sanitized before and after leaving a resident's room, and after glove removal. The facility policy and procedure for nova StatStrip Whole Blood Glucose Testing dated 8/17, indicated the facility glucometer was a multi-patient use glucometer and directed	21390		

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cleaning of the glucometer exterior between each patient with an approved germicidal wipe (such as PDI Sani-Cloth AF3 Germicidal Wipes) for the contact time directed by the container instructions.

The facility policy and procedure for Subcutaneous Injections dated 12/16, directed nursing staff to perform hand antisepsis and put on gloves prior to administering insulin.

The PDI Sani-Cloth AF3 Germicidal Wipes label directed the contact time for disinfection of blood-borne pathogens to be 3 minutes.

The facility policy and procedure for Hand Hygiene dated 7/18, directed staff to wash or use a waterless hand antiseptic upon entering or leaving the resident care area, after contact with a patient's intact skin, body fluids or secretions, wound dressing, non-intact skin, after contact with contaminated surfaces and/or objects or medical equipment in the immediate vicinity of the resident, and after removing gloves.

R18's Face Sheet printed 9/19/18, identified diagnoses that included liver cell carcinoma, lymphoid leukemia, and Type 2 diabetes.

R18's quarterly Minimum Data Set (MDS) dated 7/9/18, indicated R18 had severe cognitive impairment, required extensive assistance of staff with toileting and personal hygiene, and had an indwelling urinary catheter.

On 9/19/18, at 8:39 a.m. morning cares were observed with nursing assistant (NA)-F and NA-G. Both performed hand hygiene. NA-F donned a gown and gloves, while NA-G filled a basin with water. NA-G donned gloves and a

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gown. NA-F proceeded to wash R18's face. NA-F removed R18's shirt, and NA-F washed R18's upper body, and then both placed a clean shirt on R18. NA-F washed R18's legs while NA-G changed his gloves and performed hand hygiene. NA-F used the same washcloth to wash R18's perineal area, and then cleansed around R18's urinary catheter. Without performing hand hygiene or changing gloves, NA-F used a clean washcloth to wash R18's buttocks. NA-F and NA-G proceeded to dress R18. without performing hand hygiene or changing gloves. NA-F placed R18's oxygen tubing on his nose. NA-G drained R18's urinary catheter into a receptacle, and dumped the urine into the toilet. Without performing hand hygiene or changing gloves, NA-G placed the mechanical lift sling under R18. NA-F removed his soiled gloves, performed hand hygiene, and donned clean gloves. NA-G placed the soiled linens into a bag, and dumped the bath water. NA-F and NA-G proceeded to get R18 up in his wheelchair. Immediately following morning cares, NA-f and NA-G were interviewed. Both verified they had not performed hand hygiene or changed gloves.

On 9/20/18, at 9:11 a.m. registered nurse (RN)-A was interviewed. RN-A stated she would expect staff to perform hand hygiene and change gloves.

On 9/20/18, at 1:40 p.m. the director of nursing (DON) was interviewed. The DON stated she would expect staff to perform hand hygiene and change gloves.

On 9/19/18, at 7:53 a.m. nursing assistant (NA)-D was observed wearing gloves as she prepared breakfast for the Mulberry unit kitchen. NA-D sprayed down dirty dishes to go into the dishwasher, and returned to the stove to tend to

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what was cooking. NA-D did not remove her soiled gloves, perform hand hygiene or don clean gloves after spraying down the dirty dishes and returning to cooking. Registered nurse (RN)-A spoke to NA-D, and NA-D removed her soiled gloves and donned clean gloves without performing hand hygiene.

On 9/19/18, at 7:53 a.m. NA-D said she recalled getting infection control training when she started employment. NA-D did not recall learning staff are to wash their hands after removing soiled gloves, and stated she thought putting on clean gloves gave her a clean surface on her hands.

On 9/19/18, at 7:54 a.m. RN-A stated her expectation was staff wash their hands after each time they remove soiled gloves. RN-A verified NA-D did not wash her hands after removing the soiled gloves.

On 9/19/18, at 8:11 a.m. NA-A was observed as she prepared breakfast with associated kitchen tasks for the Strawberry unit kitchen. NA-A was observed to remove her soiled gloves and don clean gloves without performing hand hygiene.

On 9/19/18, at 8:14 a.m. NA-A stated she had received infection control training, and the training included handwashing technique. NA-A stated the training included washing hands after glove removal. NA-A stated she had not washed her hands after glove removal, but she should have.

On 9/19/18, at 8:17 a.m. RN-C stated it is an expectation staff wash their hands whenever they remove their gloves. RN-C stated the expectation extends to when staff remove gloves in the kitchen.

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The facility's Hand Hygiene Policy and Procedure dated 7/11/18, indicated the employees will perform hand hygiene at the appropriate time and in the proper manner. The procedure included that hands are to be washed with antimicrobial soap and water or cleaned with a waterless hand antiseptic gel or foam after removing gloves.

R31's Face Sheet printed 9/19/18, included diagnoses of congestive heart failure, Type two diabetes, chronic kidney disease, long term diuretic therapy, and urine retention.

R31's quarterly Minimum Data Set (MDS) dated 7/3/18, indicated R31 had severely impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS further indicated R31 did not ambulate, and had a urinary catheter.

On 9/18/18, at 9:01 a.m. R31 was observed in bed. The urinary drainage bag was hanging from the bed frame, uncovered, and laying on the floor.

On 9/20/18, at 8:35 a.m. R31 was observed in bed. The urinary drainage bag was hanging from the bed frame, uncovered, and laying on the floor

On 9/20/18, at 8:38 a.m. registered nurse (RN)-A verified the urinary drainage bag was touching the floor. RN-A stated the urinary drainage bag should not be touching the floor, and should be covered in a bag.

On 9/20/18, at 9:45 a.m. the director of nursing (DON) stated urinary drainage bags should not be touching the floor.

The facility's Urinary Catheter Care policy dated 8/16/18, directed staff to be sure the catheter

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tubing and drainage bag were kept off the floor.

R13's Face Sheet printed 9/19/18, included diagnoses of traumatic lower extremity paraplegia, and an injury to the lumbar spinal cord.

R13's quarterly MDS dated 7/6/18, indicated R13 had moderately impaired cognition, and required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS further indicated R13 did not ambulate, required supervision with locomotion on the unit, and was independent with eating after set up.

R13's care plan dated 7/8/18, indicated R13 had a full lap tray on the wheelchair to place personal items on.

On 9/17/18, at 5:25 p.m. R13 was observed in the unit dining room. R13's wheelchair had a full lap tray with brackets that slid over the arm rests to secure it. On the lap tray under R13's right elbow, was black tape around the tray. On both sides of the outer edges of the wheelchair covering the knee pads black terry cloth type material was observed secured with silver duct tape .

On 9/20/18, at 10:30 a.m. during the environmental tour the assistant administrator (AA) verified the tape on the lap tray, and the wheelchair knee pads. The AA stated tape should not be used to cover worn areas, and staff should be putting in a work order. The AA further stated the facility had a computer system that all and any staff could use when items needed repairs.

The facility's Wheelchair Use policy dated 3/18/17, directed to check wheelchairs regularly for needed repairs. If repairs were needed, inform

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	00823	A. BUILDING: ___ B. WING ___	C 09/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 39 maintenance in person or by a work order. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff follow infection control practices. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide individualized	21435	corrected	10/25/18

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and meaningful activities for 1 of 3 residents (R18) reviewed for activities.

Findings include:

R18's Face Sheet printed 9/19/18, identified diagnoses that included liver cell carcinoma, lymphoid leukemia, and Type 2 diabetes.

R18's admission Minimum Data Set (MDS) dated 4/9/18, indicated R18 had severe cognitive impairment, had adequate hearing and vision (with glasses), and was able to make self understood and understood others. The MDS also indicated R18 required extensive assistance with mobility. R18's quarterly MDS dated 7/9/18, indicated R18 had severe cognitive impairment, had minimal difficulty hearing, had moderately impaired vision and did not wear glasses, was usually understood, and could usually understand others. The MDS also indicated R18 required extensive assistance with mobility.

R18's Activities - Preferences for Customary Routine and Activites assessment completed by nursing and dated 4/3/18, indicated it was very important for R18 to go outside to get fresh air when the weather was good, and very important for him to participate in religious services or practices. The assessment indicated it was somewhat important for R18 to have items to read, listen to music, be around animals, and do his favorite activities. It was not important for R18 to keep up with the news, or do things with groups of people.

R18's Care Area Assessment (CAA) dated 4/9/18, was a checklist that included activity preferences prior to admission, current activity pursuits, health issues that result in reduced

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activity participation, environmental or staffing issues that hinder participation, unique skill or knowledge that resident has the he or she could pass on to others, issues that result in reduced activity participation, and input from resident and/or family/representative regarding activities. The checklist was blank. The analysis of findings indicated R18 had cognitive decline, and had been on Hospice prior to and after admission. The analysis indicated R18 had limited mobility, and periods of unresponsiveness, and the facility would care plan for recreation as he may desire and is able.

R18's care plan dated 4/10/18, indicated R18 preferred activities that identify with prior lifestyle. The goal for R18 was he would express satisfaction with his daily routine and leisure activities, and would show no signs of distress with recreation. Activity interventions for R18 were to allow him to express feelings and desires, and encourage him to become involved with activities of choice as he is able. The interventions also indicated R18 had a stated preference for choosing own clothing, caring for belongings, choosing mode of bathing, choosing bedtime, family involvement, private phone calls, reading, music, animals, doing his favorite activities, being outside, and religious activities.

On 9/17/18, at 6:01 p.m. family member (FM)-A was interviewed. FM-A stated the family has asked the facility to provide activities for R18, but it has not happened. The family has also asked the facility to go in and read to him; he likes tractor magazines and religious readings, but this hasn't occurred. FM-A stated R18 isn't they type of person that would like group activities, but would like one to one visits. FM-A stated R18 has told her he gets lonely. FM-A stated the family

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visits frequently, but they feel R18 should be provided more activities.

On 9/17/18, at 6:45 p.m. R18 was observed in his room, sitting in his wheelchair. The TV was playing an episode of I Love Lucy.
On 9/18/18, at 9:08 a.m. R18 was observed lying on his bed. The TV was playing an episode of I Love Lucy.
On 9/19/18, at 12:48 p.m. R18 was observed in bed sleeping. The TV was playing an episode of I Love Lucy.
On 9/20/18, at 8:08 a.m. R19 was lying in bed fully dressed. R18 was not sleeping. Neither R18's TV or radio were on.
On 9/20/18, at approximately 2:00 p.m. R18 was observed sitting in his wheelchair in his room. Neither the TV or radio was on.
Throughout the survey from 9/17/18, through 9/20/18, R18 was not observed in any group activities.

R18's Activity Participation Documentation from 4/2/18, through 9/19/18, indicated the following:

April: R18 attended the following group activities: spiritual/religious groups 3 times. R18's independent activities included listened to the radio/music 1 time, watched TV/movie/sports/news 3 times, and had company 5 times. R18 had 20 days in April when he was not in a group or independent activity

May: R18 attended the following group activities: exercise group 2 times, attended spiritual/religious activity once, and attended movies/plays/poetry/theater 4 times. R18's independent activites included TV/movie/sports/news 10 times, reading/writing/newspaper 2 times, radio/music

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two times, and company 5 times. R18 had 20 days in May when he was not in a group or independent activity.

June: R18 attended the following group activities: spiritual/religious groups 3 times, and movies/plays/poetry/theater 5 times. R18's independent activities included TV/movie/sports/news 6 times, and company 5 times. R18 had 22 days in June when he was not in a group or independent activity.

July: R18 attended the following group activities: spiritual/religious groups 3 times, and movies/plays/poetry/theater 2 times. R18's independent activities included TV/movies/sports/news 6 times, and company 9 times. R18 had 21 days in July when he was not in a group or independent activity.

August: R18 attended the following group activites: music 2 times. R18's independent activities included TV/movies/sports/news 5 times, company 3 times, and 1:1 with staff 3 times. There was no documentation on what the 1:1 activity consisted of. R18 had 26 days in August when he was not in a group or independent activity.

September: From September 1-19, R18 did not attend any group activities. During this same time, R18 had 1 independent activity of TV/movies/sports/news. R18 had 18 days from September 1-19 when he was not in a group or independent activity.

On 9/19/18, at 2:11 p.m. the activity director (AD)-A was interviewed. AD-A stated she completed activity assessments for new admissions. AD-A stated she had not completed

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an admission activity assessment on R18 (nursing staff completed the assessment), and also had not completed a care plan for him. AD-A stated activity staff do 1:1 activities with residents, but she did not have a 1:1 program set up for R18. AD-A stated she expects the nursing assistants to do spontaneous groups on their unit, and expects them to help with all activities. AD-A stated she would expect the nursing assistants to tell her what R18 needs, and then she would provide it for him.

On 9/20/18, at 8:50 a.m. registered nurse (RN)-A was interviewed. RN A stated all staff are expected to offer residents activities. RN-A stated the facility uses volunteers also, and R18 has Hospice visits. RN-A stated she was unaware R18's family had concerns with his activity participation.

On 9/20/18, at 10:48 a.m. nursing assistant (NA)-D was interviewed and stated she usually doesn't lead any organized activities on her unit, the activity staff do that. NA-D stated she has not noticed an activity staff person in with R18. NA-D stated she will often put in a movie for R18 after he tells her what he would like to watch. NA-D stated Hospice also visits him.

On 9/20/18, at 1:40 p.m. the director of nursing (DON) was interviewed. The DON stated R18's family has provided him with movies and TV shows, and staff play them for him. The DON stated R18's family also visits nearly every day, so that is part of his activity program.

The facility Activity Assessment Policy dated of 2/15, directed an activity assessment is conducted and maintained for each resident, and the assessment is to be conducted within 14 days

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of a resident's admission to the facility. The policy further directed the assessment is to be conducted by activity department personnel in conjunction with other staff, and the assessment is used to develop an individual activities care plan.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's receive individualized and meaningful activites.
The Director of Social Services or designee could educate all appropriate staff on the policies and procedures.
The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245039	A. BUILDING **02 - BUILDING 1** B. WING ______	**09/19/2018**

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

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K 000	INITIAL COMMENTS Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 19, 2018. At the time of this survey Neilson Place 02 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code. Neilson Place was constructed in 2004, is 2-stories, without a basement and was determined to be of a Type I (332)construction. In 2009, 3 additions were constructed, a services wing to the south and connecting links to an apartment building to the north. The two connecting links into the north assisted living building are 1-story, Type II (111) construction. The building is divided into 3 smoke zones on each floor by 1 hour fire barriers. The facility has corridor smoke detection and smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". All sleeping rooms have single station smoke detectors with annunciation in the corridor and at the nurse's station that serves that room with additional automatic fire detection in all rooms. The fire alarm is monitored for automatic fire department notification. The building is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a capacity of 78 beds and had a	K 000		

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

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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K 000	Continued From page 1 census of 78 at the time of the survey. The facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		