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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5ZUC

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 **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/08/2020** (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: **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 :
Teresa Ament, Unit Supervisor 10/28/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/28/2020 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 28, 2020

CMS Certification Number (CCN): 245039

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 October 7, 2020 the above facility is certified 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 28, 2020

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: August 20, 2020

Dear Administrator:

On September 10, 2020, we notified you a remedy was imposed. On October 8, 2020 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 7, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 10, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 10, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 7, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

ID: 5ZUC

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: **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 **08/20/2020** (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 :
Amy Charais, HFE - NE II 10/08/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/27/2020 (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
September 10, 2020

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: August 20, 2020

Dear Administrator:

On August 20, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 10, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 10, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 10, 2020.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 10, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Neilson Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Susie Haben, Unit Supervisor
Email: susie.haben@state.mn.us
Phone: 320-223-7356

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 20, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/17/20 - 8/20/20, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		9/21/20

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

Electronically Signed | 09/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide inspection documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. In addition, the facility failed to form a policy for emergency generator maintenance. This deficient practice had the potential to affect all 78 residents residing in the facility along with staff and visitors. Findings include: During the facility tour on 8/18/20, between 9:00 am to 12:00 p.m. the generator weekly inspection log was reviewed. The inspection log identified	E 041	On 9/9/2020 the facilities emergency generator was inspected and the inspection was documented. On 9/14/2020 the Supervisor, Power Plant/designee wrote a policy for emergency generator maintenance. On 9/16/2020 the Supervisor, Power Plant/designee educated maintenance staff on the policy for emergency generator maintenance as well as documenting the emergency generator inspection. Beginning 9/21/2020 the Supervisor, Power Plant/designee will audit the emergency generator inspection log to ensure it has been documented. Audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 3 there was no record of a generator inspection for the week of 5/25/20. The assistant administrator and director of maintenance confirmed the generator was not tested the week of 5/25/20. The facility Emergency Operations Plan reviewed 1/23/20, failed to identify a policy for emergency generators. A policy on emergency generators was requested and was not provided. During interview on 8/20/20, at 1:10 p.m. the supervisor of power plant (SPP) stated the facility did not have a policy on emergency generators. SPP was not aware why there was not a specific policy for maintaining and testing the emergency generators, however, the facility followed the bi-monthly testing log and weekly inspections logs.	E 041	will be completed weekly for 6 weeks. Results will be forwarded to the QAPI committee for further recommendation.	
F 000	INITIAL COMMENTS On 8/17/20, through 8/20/20, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5039039C H5039040C H5039041C H5039042C The following complaint was found to be SUBSTANTIATED with no deficiencies.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 H5039043C however, as a result of the investigation unrelated deficiencies were cited at F609 and F610 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 5 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the stated agency (SA) neglect of care for 1 of 2 residents (R18) reviewed for abuse. Findings include: R18's annual Minimum Data Set (MDS) dated 6/1/20, indicated she had intact cognition and required total assistance for locomotion on and off the unit. R18's care plan dated 6/5/20, identified a risk for a decline in wheel chair mobility and a self care deficit related to bilateral amputations, pain and diagnosis of hemiplegia (paralysis of one side of the body). A review of R18's Resident Progress Note dated 5/9/20, indicated R18 came out for breakfast and requested Tylenol for face pain, R18 had been outside previously and got a sun burn to the right side of her face. R18's skin was peeling and her lip was slightly swollen. Staff had been applying lotion to R18's face.	F 609	On 8/20/2020 a vulnerable adult report was filed to the state agency regarding the allegation of neglect for R18. By 9/25/2020 the Social Services Manager/designee reviewed the incidents and grievances of all current residents since 8/20/2020 to ensure that any residents who had alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were reported to the MDH Nursing Home online reporting portal. On 9/14/2020 the Administrator reviewed the facility policy on abuse and neglect and determined no changes were necessary. By 10/7/2020 the Social Worker/designee will provide education on vulnerable adult reporting requirements, facility policy and the reporting communication structure for vulnerable adult allegations to all-staff. Beginning 9/28/2020 the Social Worker/designee will review all resident grievances and incidents 3 times a week	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 6 During interview on 8/17/20, at 7:21 p.m. R18 stated she had gotten a sunburn while outside a few months prior. R18 stated, "I think I fell asleep and I got terribly burned on my face" and said, "oh god did I ever blister." During an interview on 8/19/20, the administrator stated when determining whether an incident is reportable to the SA he reviewed the facility policy. The administrator stated he was not aware of the incident in which R18 had a blistering sun burn and stated if it truly was a blistering sun burn that would have been a major event and the nurse manager should have filled out an incident report. The administrator confirmed and incident report had not been completed. On 8/20/20, at 10:10 a.m. family member (FM)-A stated staff had not been letting R18 face time with her and she could not understand why. FM-A stated she went and saw R18 through the window and stated when R18 turned her face she saw the sun burn. FM-A stated R18's face was swollen and stated "it looked awful." FM-A stated she asked R18 who popped the blister on her face but R18 did not know. FM-A stated she had a photo of the burn and said around the corner of R18's right lip there were blisters and a line going along her cheek and the bottom half was red and indented. FM-A stated the burn was on the right side of R18's face, ear and cheek and down by her neck. FM-A stated she called and asked about the burn and was told that staff brought R18 outside and forgot about her. During a subsequent interview on 8/20/20, at approximately 1:00 p.m. the administrator stated a report had not been made to the SA and stated he did not feel the incident was reported because	F 609	for 6 weeks to ensure any residents who had alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported according to facility policy and state/federal regulations. Results will be forwarded to the QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 7 there was "no proof" R18 had blistered. A facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 9/5/19, identified neglect as the failure of the facility to provide services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy indicated reports of neglect would be reported to the SA no later than two hours if the events that cause the allegation involve abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate a burn for 1 of 1 resident (R18) reviewed for neglect of care who had sustained a sunburn which blistered.	F 610	On 8/26/2020 the investigation of R18's sunburn allegation was concluded and submitted to the state agency. By 9/25/2020 the Social Services	10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 8 Findings include: R18's annual Minimum Data Set dated 6/1/20 indicated she had intact cognition and required total assistance for locomotion on and off the unit. R18's care plan dated 6/5/20, identified a risk for a decline in wheel chair mobility and a self care deficit related to bilateral amputations, pain and diagnosis of hemiplegia. During interview on 8/17/20, at 7:21 p.m. R18 stated she had gotten a sunburn while outside a few months prior. R18 stated, "I think I fell asleep and I got terribly burned on my face" and said, "oh god did I ever blister." A review of R18's Resident Progress Note dated 5/9/20, indicated R18 came out for breakfast and requested Tylenol for face pain, R18 had been outside previously and got a sun burn to the right side of her face. R18's skin was peeling and her lip was slightly swollen. Staff had been applying lotion to R18's face. During interview on 8/19/20, at 9:57 a.m. nursing assistant (NA)-J stated she was not working the day R18 was sun burned but thought staff had brought R18 outside and forgot to put sun block on her. At 10:02 a.m. NA-I stated she was not working the day R18 got burned but stated she heard R18 had been left outside for a few hours. NA-I stated R18 was pretty burnt and it was painful. NA-I stated R18 could not physically get in or out of the building on her own.	F 610	Manager/designee reviewed all allegations of abuse, neglect, exploitation, or mistreatment since 8/20/2020 to ensure there is evidence that all alleged violations were thoroughly investigated. On 9/14/2020 the Administrator reviewed the facility policy on abuse and neglect and determined no changes were necessary. By 10/7/2020 the Social Worker/designee will provide education on vulnerable adult reporting requirements, facility policy and the requirement for thoroughly investigating all allegations. Beginning 9/28/2020 the Social Worker/designee will review all resident grievances and incidents 3 times a week for 6 weeks to ensure any residents who had alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were thoroughly investigated. Results will be forwarded to the QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9	F 610		

At 10:09 a.m. NA-K stated she was not working the day R18 got burned but stated she thought the umbrella may have moved. NA-K stated "all I know is it was really red for a few days."

At 10:11 a.m. registered nurse (RN)-D stated she was not aware of the incident, had not looked into, and did not know who brought R18 outside that day however, if R18 had sustained a burn, an incident report should have been made out. RN-D reviewed R18's medical record and verified a Progress Note written by licensed practical nurse (LPN)-A was the only documentation related to the incident.

At 10:18 a.m. LPN-A stated she had worked a day or two after R18 sustained the burn and verified R18 had pain related to the burn. LPN-A verified she was the nurse who documented R18's pain and swollen lip.

At 12:39 p.m. the administrator stated any incident that comes up including falls, skin tears, skin injury or security events should have been investigated and stated he was not aware of the incident. The administrator stated if R18 truly had a blistering sunburn that would have been a "major event" and RN-D should have been aware of it and completed an incident report.

On 8/20/20, at 10:10 a.m. family member (FM)-A stated staff had not been letting R18 face time with her and she could not understand why. FM-A stated she went and saw R18 through the window and stated when R18 turned her face she saw the sun burn. FM-A stated R18's face was swollen and stated "it looked Awful." FM-A stated she asked R18 who popped the blister on her face but R18 did not know. FM-A stated she had a photo

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 10 of the burn and said around the corner of R18's right lip there were blisters and a line going along her cheek and the bottom half was red and indented. FM-A stated the burn was on the right side of R18's face, ear and cheek and down by her neck. FM-A stated she called and asked about the burn and was told that staff brought R18 outside and forgot about her. A facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 9/5/19, identified neglect as the failure of the facility to provide services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy indicated repots of neglect would be promptly and thoroughly investigated.	F 610		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 3 of 5 residents (R56, R46 and R420) reviewed for activities.	F 679	On 8/25/2020 R420 discharged from the facility. R420 was readmitted to the facility 9/14/2020 and his baseline care plan including activities was completed 9/15/2020. Effective 9/25/2020 the facility	10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 11 Findings include: R56's quarterly Minimum Data Set (MDS) dated 7/25/20, identified R56 had severe cognitive impairment and required extensive assistance with cares. R56's Activity Care Area Assessment (CAA) dated 1/23/20, identified R56 was shy and uneasy around others and declined to participate in large group activities. The CAA further identified R56 preferred to listen to music in her room, being around animals and doing things with groups of people. On 8/17/20, at 6:57 p.m. R56 was observed in the common room, seated in her wheelchair watching television. On 8/19/20, at 8:25 a.m. R56 was observed in the common room, seated in her wheelchair in front of the television. On 8/19/20, at 9:52 a.m. R56 was observed in bed on her back. The lights were off, there was no television or music on in the room. When interviewed on 8/19/20, at 10:06 a.m. nursing assistant (NA)-B she had attempted to do nail care for the female residents last week including R56. NA-B stated after meals she would position R56 in front of the television. NA-B also stated R56 liked having music on when she was in her room. During interview on 8/20/20, at 8:48 a.m. NA-G stated she relied on the activity aide to do 1:1 activities with the residents including R56. NA-G indicated R56 liked music and would scoot	F 679	is offering and providing individualized and meaningful activities for R56, R46 and R420. By 10/7/2020, the Recreational Therapist/designee will review all current residents' activity documentation to ensure they are being offered and provided individualized and meaningful activities. By 9/25/2020, the Recreational Therapist/designee will review and revise as necessary the facilities policies on providing and documenting individualized activities; and by 10/7/2020 will educate all activity and nursing staff on ensuring all residents are offered and provided individualized and meaningful activities, along with documentation of activities offered and/or provided. Beginning 10/5/2020 the Manager of Social Services/Activities/designee will audit six resident's activity participation documentation and interview two residents weekly for 6 weeks, to ensure residents are being offered and provided individualized and meaningful activities. Results will be forwarded to the QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 12	F 679		

around the unit in her wheelchair. NA-G confirmed she had not turned on any music for R56 that day.

During interview on 8/20/20, at 8:58 a.m. registered nurse (RN)-A stated there had been more 1:1 activities, some distance bingo and church was put on the television on Sundays if there was staff available to turn it on.

When interviewed on 8/20/20, at 1:35 p.m. activity aide (AA)-A stated R56 liked music and that more 1:1's visits were being done with her, but probably were not documented. AA-A stated R56 scooted around the unit in her wheelchair and indicated R56 did not like television.

R56's Activity (Group and independent Leisure) Participation Documentation dated August 2020, revealed August 1st though the 18th R56 was offered to participate in TV/Movie/Sports/News ten out of eighteen days, Radio and music was offered two out of eighteen days, had one family visit in eighteen days and had three staff 1:1 activities in eighteen days. According the the documentation, other independent activities such as reading/writing/newspaper, crafts, helping others and games/puzzles, had not been offered to R56.
R46's undated face sheet included diagnoses of dementia, displaced intertrochanteric fracture of left femur, multiple fractures of ribs, repeated falls, heart disease and hypertension.

R46's admission MDS dated 7/9/20, indicated impaired cognition and the need for extensive assist with transfer, bed mobility, dressing and grooming. The activities section of the MDS indicated R46 enjoyed the outdoors, music and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 13	F 679		

participating in favorite activities.

R46's Communication CAA dated 7/14/20, indicated R46 had hearing loss and problem understanding others and being understood. The CAA also indicated R46 had cognitive deficit and was not able to read.

R46's Activity CAA dated 7/15/20, indicated the care plan was developed for 1:1's and independent leisure activities because of COVID-19 restrictions and R46's dementia.

R46's Care plan, with revision date of 7/14/20, indicated R46 had impaired activity participation due to covid restrictions. The care plan directed staff to adapt activity equipment to meet R46's needs such as sitting with R46 when she colored and visiting about living on her farm in Oklahoma. R46's care plan directed staff to assess environmental factors that may hinder activity involvement such as being in her room more and to provide R46 with 1:1 interventions as needed or desired so socialization and stimulation decreases any decline.

R46's activity log for the month of August 2020, indicated R46 was in the hospital from 8/13/20, through 8/17/20. The log indicated R46 had participated with independent television and music on 8/18/20 and 8/19/20. With the exception of three days, the log lacked any 1:1 visits with R46 for the remaining 14 days of August 2020.

On 8/18/20, at 1:46 p.m. R46's room was observed laying in her bed with the door closed. The room was dark and there was no television or music playing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 14	F 679		

On 8/19/20 at 8:53 a.m. R46 was observed lying in bed, sleeping. The room was dark and no television or music was playing. R46 had refused to get out of bed.

-At 9:28 a.m. R46 was observed lying in bed, sleeping. The room was dark and no television or music was playing. NA-A entered the room to assist R46 into her wheelchair for breakfast, however. R46 refused to get out of bed despite several verbal attempts and stated she just wanted to remain in bed.

-At 2:07 p.m. R46 was observed lying in her bed. The room was dark and no television or music was playing. The door to the room remained closed due to on isolation precautions. NA-A stated R46 had refused to get out of bed for the entire shift.

On 8/20/20, at 9:57 a.m. NA-A stated anyone who was going to enter R46's room needed to sign in on the log by her door. On review of the sign in logs for entry to R46's room, NA-A verified the activity aides signature was not on the sign in logs indicating they had not entered her room to provide activities, since her hospital return on 8/18/20. NA-A stated there was just one activity aide for the facility and she was on vacation today.

At 10:00 a. m. NA-N stated R46 refused to get out of bed at all the day before, but they were going to try to get her up now. NA-N stated in the past, she used to take R46 out on the balcony on nice days and R46 used to come to dining area for her meals and other "stuff", but now she was quarantined. NA-N stated she wished they had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 15	F 679		

more time to sit with residents and read to them.

On 8/20/20 at 1:00 p.m. R46 was observed in her room, seated in the wheelchair, awake. R46's television was on, however R46's head hung down with her chin resting on her chest. R46 was dressed and groomed. R46 began moving a glass about her bedside table. R46 stated she did not know what was playing on the television and that she did not have any favorite television shows. R46 again put her head down with her chin resting on her chest and appeared to fidget with her blanket. R46 did not appear to be actively watching the television.
R420's admission MDS dated 8/12/20, indicated R420 had moderate cognitive impairment, was able to make own decisions and enjoyed leisure activities. The MDS identified R420 had activity preference which included: music, news, group activities and being outside. Activity preferences included on the MDS music, news, group activities and being outside.

R420's baseline care plan dated 8/6/20, identified an area to complete activity interventions and preferences; however, the section was blank.

R420's Activity assessment dated 8/13/20, identified leisure interests which included games, crafts, music, being outside, talking and conversing.

On 8/18/20, at 2:06 p.m. R420 was observed in his room, seated in his recliner, awake and watching the television. R420's room was noted to not have any type of reading material or a radio to play music.

On 8/19/20, at 10:06 a.m. R420 was observed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 16	F 679		

his room, seated in his recliner awake, actively watching television. R420's room remained void of any reading material or radio to play music. R420 stated no one had been to his room to offer activities.

When interviewed on 8/17/20, at 4:43 p.m. R420 stated there was nothing to do in his room except watch television. R420 stated he sat in his room most of the day except for therapy, because he was in quarantine. R420 stated he wished there was more to do than be in his room and watch TV.

When interviewed on 8/18/20, at 4:17 p.m. NA-H stated residents that were in quarantine were provided 1:1 visits by staff while providing personal cares and that there were no group activities except for Bingo. NA-H indicated she was not aware of a therapeutic recreation schedule and stated she did not know who assessed or reassessed residents' activity preferences.

When interviewed on 8/20/20, at 9:20 a.m. activity coordinator (A)-B stated the blue binder was for floor staff to document residents' independent leisure and small group activities. A-B stated there was an independent leisure activity cart that was offered to the residents' once a week and as needed, in order to provide activities in the residents' rooms. A-B she would offer activities on each unit, once a week. A-B stated there was no schedule for providing 1:1 resident visits as those visits were provided during the provision of personal cares. A-B indicated she completed the 1:1 resident assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 17	F 679		

When interviewed on 8/20/20, at 10:32 a.m. A-A stated A-B was the therapeutic recreation coordinator and was responsible to complete all resident activity assessments, care plans and created the schedule for resident activities. A-A reviewed R420's baseline care plan and verified the activities section was blank. A-A stated the baseline care plan was to be completed within 48 hours after admission to the facility.

The facility provided activities calendar dated 8/16/20 - 8/22/20 revealed the following scheduled activities:

-1:1 activities would be provided throughout the day, everyday.
-Bingo was scheduled for 8/17/20, 8/18/20, 8/19/20, and was also held on select units, daily.
-Outdoor visits were scheduled for 8/16/20, 8/17/20, 8/19/20, 8/20/20, 8/21/20.
-Church services scheduled 8/16/20.
-Ice cream treats scheduled on 8/21/20.

The facility provided an Activity (Group and independent Leisure) Participation Documentation dated August 2020, which revealed R420 participated in TV/Movie/Sports/News. Other listed independent activities such as reading/writing/newspaper, crafts, radio/music, company, helping others, games/puzzles and 1:1's were blank which indicated not offered/provided.

The Activities Participation policy dated October 2018, specified "an ongoing program to support residents in their choice of activities....all nursing and activity staff are required to review the resident's care plan and residents preferences listed on their activity documentation sheet."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 18 Finally, the Activities Participation policy stated staff were to communicate resident/family leisure request to an activities staff member.	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 19 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clinical justification for the use of an indwelling catheter and failed to provide education related to the effects of catheter use for 1 of 1 resident (R18) reviewed with a catheter. Findings include: R18's annual Minimum Data Set (MDS) 6/1/20, indicated intact cognition. The MDS indicated R18 required extensive to total assistance with activities of daily living and identified the use of an indwelling catheter. R18's care plan dated 6/5/20, identified the use of an indwelling urinary catheter related to skin breakdown and family request. R18's Physician's Orders indicated the following: 1/15/19, Place indwelling catheter. No diagnosis identified. 3/8/19, indicated keep Foley (urinary catheter) in place until wounds are assessed by wound care. A wound care visit note dated 3/19/19, indicated R18 was evaluated for wounds to her bilateral ischial areas (sit bones). The wound care orders included treatment and directed staff to encourage offloading. The wound care orders did not address the use of the indwelling catheter. R18's clinical record lacked evidence of an assessment, patient education or clinical justification for use of the indwelling catheter.	F 690	On 8/27/2020 the Nurse Manager spoke to R18's provider who recommended removing the Foley catheter. The Nurse Manager notified the resident and resident representative of R18's providers recommendation to remove the catheter on 8/27/2020, they both refused to have the catheter removed. Education on the risks of leaving the catheter in without clinical justification were provided by the Nurse Manager and documented on 8/27/2020. On 8/27/2020 R18 had an eVisit with their provider who spoke to the resident about removing the foley catheter and the resident replied "no way". On 9/16/2020 the DON/designee reviewed all current residents with indwelling catheters have clinical justification for a catheter. By 9/25/2020 the DON/designee will review and revise as necessary the facility's policy on catheters and by 10/7/2020 will provide education to nurses on the facility's catheter policy, the appropriate use of catheters and if resident/resident representative refuses removal to provide education on the risks of catheter use without clinical justification. Beginning 10/7/2020 the DON/designee will review all residents with catheters weekly for 6 weeks to ensure they have clinical justification documented for catheter use. Results will be forwarded to the QAPI committee for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 20 During observation and interview on 8/17/20, at 7:08 p.m. R18 was seated in a reclining wheel chair in her room. R18 stated she had a urinary catheter. R18 stated "the doctor said I didn't need it but I said I wanted it." On 8/20/20, at 9:11 a.m. registered nurse (RN)-D stated R18 had the catheter placed because she was incontinent and it was causing pain in her wounds. RN-D stated R18's family member had called and requested the catheter due to R18's incontinence and the physician ordered the catheter to be placed until wound care evaluated R18 in March of 2019. RN-D further stated there was no diagnosis listed for the catheter. At 2:00 p.m. the director of nursing (DON) stated the facility tried to avoid using catheters. The DON stated R18's catheter had been placed due to her sores and said there had been multiple conversations about R18's catheter amongst the staff. The DON stated R18 did not want the catheter removed. In regard to discussion of the risk of long term catheter use or clinical justification for use of the catheter, the DON stated she would look however, no further information was provided. A policy related to catheter use was requested but not received.	F 690	recommendation.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 21 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow up on pharmacy recommendations for 2 of 5 residents (R9, R18) reviewed for unnecessary medications.	F 756	On 9/18/2020 R18 and R9's physician's were again provided the April drug regime recommendation by the pharmacist. By 9/25/2020 R18 and R9's pharmacy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 22 Findings include: R9's quarterly Minimum Data Set (MDS) dated 5/21/20, indicated she required extensive assistance from two staff for all activities of daily living. R9's care plan dated 6/3/20, identified a diagnosis of elevated lipids and directed staff to provide medications as ordered and monitor for muscle pain. R9's Physician Order Report dated 8/20/20, identified and order for atorvastatin (cholesterol lowering medication) tablet 40 milligrams (mg) oral at bed time. The order had a start date of 11/12/19. A Consultant Pharmacist's Medication Review dated April 2020, indicated the following: Medication: atorvastatin 40 mg. Irregularity or comments: According to..... the treatment of high cholesterol in patients over 75 years old may not be necessary, and that "an even less favorable risk-benefit ratio may be seen in patients over 85, where benefits may be more diminished and risks from statin drugs more increased (cognitive impairment, falls, neuropathy, and muscle damage)." Suggested course of action: Could this statin be discontinued? Follow-up or action taken: Physician circled rejected and indicated "will review at next appt. (appointment)" A physician Progress Note dated 6/26/20, indicated a tele-health visit was conducted and	F 756	recommendations from April will be documented by the physician that they have been reviewed along with any rationale for their decision if applicable. By 10/7/2020 the DON/designee will review the August drug regime review to ensure that all irregularities identified by the pharmacist are documented that they have been reviewed, if any action has been taken to address it, and if there is to be no change in the medication, that the attending physician documented their rationale. By 10/7/2020 the DON/designee will review and revise as necessary the facility's policy regarding the drug regime review. Nursing leaders will be educated on the facility's policy including the importance of ensuring ensure that all irregularities identified by the pharmacist are documented that they have been reviewed, if any action has been taken to address it, and if there is to be no change in the medication, that the attending physician documented their rationale. By 10/7/2020 all physicians who currently follow residents at the facility will receive a letter outlining their responsibility to document the review of pharmacy recommendations, any action taken to address it and if there is to be no change in the medication, that the attending physician documented their rationale. Beginning 10/7/2020 the DON/designee will review the monthly drug regimen review for 3 months to ensure that all irregularities identified by the pharmacist are documented that they have been reviewed, if any action has been taken to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 23 indicated R9 was feeling well, had some residual pain related to previous fracture and indicated no shortness of breath, chest pain, nausea, vomiting..... The Progress Note lacked evidence the use of atorvastatin was reviewed. R18's Annual MDS dated 6/1/20, indicated she had intact cognition and required total to extensive assistance for all activities of daily living. R18's care plan dated 6/5/20, identified a diagnosis of Diabetes Mellitus and directed staff to monitor for signs of hyper and hypoglycemia. The care plan indicated R18 received insulin. R18's Physician's Order Report dated 8/20/20, identified an order for Novolog (insulin aspart) 100 units per milliliter (ml) per sliding scale before meals and at bedtime. A Consultant Pharmacist's Medication Review dated April 2020, indicated the following: Medication: Novolog 100 units/ml per sliding scale before meals and at bedtime. Irregularity or comments: Long-term use of sliding scale insulin is not recommended due to lack of evidence for efficacy. Suggested course of action: Consider discontinuing use of sliding scale insulin and manage blood glucose with basal/bolus insulin based on daily sliding scale requirements Follow-up or action taken: Physician circled rejected with no clinical rationale for the continued use of sliding scale insulin was documented by the physician. During interview on 8/20/20, at 8:45 a.m. the	F 756	address it, and if there is to be no change in the medication, that the attending physician documented their rationale. Results will be forwarded to the QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 24 director of nursing (DON) stated the pharmacist reviewed medications monthly and made recommendations. The DON stated the recommendations were given to the clinical managers and the clinical manager was responsible to reach out to the physician. At 1:31 p.m. the DON stated she was not aware the physician had to document a clinical rational for a rejection of the pharmacy recommendation. A policy related to follow up on the consultant pharmacists recommendations was requested but not received.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 25 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide clinical justification for the ongoing use of psychotropic medications for 1 of 5 residents (R9) reviewed for unnecessary medications. Findings include: R9's annual Minimum Data Set (MDS) dated 11/19/19, indicated she was severely cognitively impaired, had minimal symptoms of depression and suffered from delusions. The MDS indicated R9 displayed behaviors 1-3 days during the	F 758	On 8/21/2020 R9's provider documented clinical justification for the ongoing use of their psychotropic medication. R9's psychotropic medication will be reviewed again by 9/25/2020. By 9/25/2020 the Consulting Pharmacist in collaboration with Nursing Leadership will complete a review of all psychotropic medications to ensure there is clinical justification documented for their continued use. By 10/7/2020 the DON/designee will review and revise as necessary the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 26 assessment period. R9's quarterly MDS dated 2/19/20, and 5/21/19. indicated she did not display any physical, verbal or other behaviors nor did she display any delusions. R9's Behavioral Symptom Care Area Assessment (CAA) dated 11/20/19, indicated she displayed other behavioral symptoms directed toward others and indicated she had delusions. The CAA also indicated R9's nurses notes reflected calling out especially at night and/or when alone and R9 was very confused and forgetful. The CAA indicated R9 required a care plan for the behavior of calling out. The CAA did not describe R9's delusions. R9's Patient Health Questionnaire-9 (PHQ-9) (assesses degree of depression severity via questionnaire) assessment dated 2/17/20, indicated a score of 3 out of 27 indicating minimal depression. R9's PHQ-9 assessment dated 5/18/20, indicated R9 reported no signs or symptoms of depression. R9's Physician's Order Report dated 8/20/20, identified the following medications: -Seroquel (antipsychotic medication) order date 2/21/20, 50 milligrams (mg) take 0.5 tablets every night at bed time. Target behaviors: statements about dying, crying and yelling out. -Citalopram (antidepressant medication) order date 6/30/20, 20 mg oral once daily for target behaviors: yelling out and crying. A facility document titled Yearly Data Summary dated 2020, indicated the following:	F 758	facility's policy regarding psychotropic medication use, and will educate nursing staff on this policy, including the need for documented clinical justification for ongoing use of psychotropic medications. Beginning 10/7/2020 the DON/designee will audit all psychotropic medications monthly for three months to ensure that they all have clinical justification documented for their continued use. Results will be forwarded to the QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 27	F 758		

Target behaviors and data: yelling out, fear of being alone, statements of sadness, crying:

January 2020, number of behaviors indicated "0."
February 2020, number of behaviors indicated "0."
March 2020, number of behaviors indicated "0."
April 2020, number of behaviors indicated "0."
May 2020, number of behaviors indicated "0."
June 2020, number of behaviors indicated "0."
July 2020, number of behaviors indicated "0."

A review of R9's certified nurse practitioner (CNP) Progress Notes indicated the following:

-2/18/20, Staff had expressed that R9 seemed unhappy and was difficult to please. R9 was trying to adjust to her move within the long term care facility. This was further complicated by probable pain related to a fracture of her left arm. A trial of Citalopram 10 mg daily and time will help her through this adjustment period. The Progress Note referred to a PHQ-9 score of 10 dated 7/11/18.

-4/7/20, Nursing reported R9 had settled into her new environment - "had a rocky start and was quite unhappy and verbally disruptive." R9 was now taking her medications, eating well, stated she was able to talk to her children on the phone and watch television and appears to be "quite content." R9 had been started on Citalopram 10 mg daily for yelling out,crying and making statements about dying which have all improved." Will increase Citalopram to 20 mg and continue Seroquel 25 mg.

-4/21/20, R9 up in wheel chair at time of visit, smiling, calm, interactive. Stated she was getting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 28	F 758		

settled in and liked it at the facility. R9 appeared to be understanding and accepting of visitor restrictions and was able to tell stories about her boys from when they were kids. Continue anti-depressant for the time being.

During an interview with R9 on 7/17/20, at 3:09 p.m. she stated she had been in the facility since fall. R9 stated all of the staff were very nice to her. R9 stated her three sons had visited her the previous day and she played bingo, watched television and went for a walk every day. During the interview, three male visitors appeared outside her window to wave to her.

On 8/19/20, at 2:00 p.m. nursing assistant (NA)-I was asked about documentation of behaviors and stated that the nurses documented all of the resident behaviors not the NAs.

During interview on 8/20/20, at 8:45 a.m. the director of nursing (DON) indicated she was not familiar with the regulations.

On 8/20/20, at 10:52 p.m. NA-I stated when R9 was first admitted to the facility. she was rude to staff but had seemed better since March. NA-I stated she felt R9 was " a hundred percent perfect."

On 8/20/20, at 10:55 a.m. licensed practical nurse (LPN)-A stated R9 was very crabby when she first admitted to the facility but had not displayed any behaviors since about a month after admission.

A facility policy titled Antipsychotic Medication Reduction dated 12/21/18, indicated during the first year a resident is prescribed a psychopharmacological medication the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 29 should attempt to taper the medication unless clinically contraindicated.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement systems for the prevention, identification and control of infections, including potential infections not treated with an antibiotic, failed to implement recommended COVID-19 infection control procedures related to the use of gowns when in direct contact for 5 of 5	F 880	DPOC PPE On 8/31/2020 R46, and on 9/8/2020 R24 are beyond 14 days since newly or readmitted to the facility and no longer require isolation or gown use. R69 discharged from the facility on 8/25/2020,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 residents (R46, R24, R69, R370, R420) who were newly admitted to the facility and remained under the required 14 day new admission isolation period and for 1 of 1 resident (63) on transmission based precautions due to the colonization of extended spectrum beta-lactamases (ESBL) which required the staff to utilize gowns when in direct contact with the resident. Lastly, the facility failed to deep clean 1 of 1 resident (R69) room after isolation precautions were lifted. These practices had the potential to affect all 78 residents residing in the facility. Findings include: During an interview on 8/20/20, at 1:18 p.m. the director of nursing (DON) stated she had been helping with the infection control tracking in the facility. The DON stated the former infection control preventionist had left the facility however, had collected data related to antibiotics and reported the information at QAPI meetings. The DON stated she was still working on collecting the data for July and had not yet started August and had been using a report in the electronic record to determine which residents had received antibiotics each month and transferred the data onto a spreadsheet. The DON stated staff talked about infections and Covid-19 daily, during the interdisciplinary team meetings. When asked about tracking of infections not treated with an antibiotic, the DON stated she was "not sure about that piece" and was unable to provide evidence of ongoing tracking and trending for infections not treated with an antibiotic. A facility policy titled Infection Control Plan dated	F 880	R370 discharged from the facility on 8/31/2020. R420 was discharged from the facility on 8/25/2020 and was readmitted on 9/14/2020. As of 9/14/2020 R420s care plan and door signage was reviewed and updated to assure all appropriate PPE is worn (including gowns) when under isolation for 14 days due to being newly admitted to the facility per recommended COVID-19 infection control procedures. Effective 9/14/2020 staff are wearing appropriate PPE for R63□s ESBL precautions, as of 9/18/2020 R63 no long resides in the facility. On 09/14/2020 the DON reviewed all residents on standard and transmission based precautions to assure staff were wearing the appropriate PPE when entering the resident room, and that signage on resident doors appropriately identifies all PPE to be worn by staff. - Policy/Procedures/System Changes On 09/14/2020, the QAPI committee conducted an RCA to identify the issues that resulted in the deficiency related to appropriate PPE use and developed further corrective actions to prevent recurrence. By 09/25/2020, the DON will review/revise/implement standard and transmission based precautions procedures, including proper PPE to be worn, and donning and doffing of PPE, including source control. - Training/Education By 10/7/2020 the DON/designee will educate all staff regarding the appropriate PPE to be worn for residents in standard and transmission based precautions,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32 2/17/20, indicated the policy established a facility wide system for the prevention, identification, investigation and control of infections of residents, staff and visitors. The policy indicated procedures for the infection control program included a system of surveillance designed to identify possible communicable diseases or infections before they could spread to other persons in the facility to include daily infections, urinary tract infections, clostridium difficile, pneumonia and respiratory infections, skin and soft tissue infections and tracking of resident infections for patterns, trends and healthcare associated infections. R46's face sheet included diagnosis of dementia, displaced intertrochanteric fracture of left femur, multiple fractures of ribs, repeated falls, heart disease and hypertension. R46's admission MDS dated 7/9/20 indicated impaired cognition and the need for extensive assist with ADL's. R46's Care plan revised 8/17/20, indicated R46 required Covid-19 isolation until 8/31/20. The care plan directed any staff entering the room was to don a surgical mask, eye goggles or face shield and gloves and anyone upon entering and leaving the room must perform hand hygiene. Place an isolation sign on resident's door, use dedicated or disposable equipment and no visitors at this time The care plan also identified self care deficit and directed staff to assist R46 with her personal cares. On 8/18/20 at 1:46 p.m. R46's room door was observed to have laminated sign with picture indicators of personal protective equipment (PPE) to wear when in the room which included pictures	F 880	including residents on EBSL precautions. Training will include donning and doffing procedures. Staff training and competency will be documented. By 10/05/2020, the DON and IP will complete the education modules provided by QSEP CMS Targeted COVID-19 Training for Nursing Home Management. By 10/7/2020 the DON/designee will educate all residents and their representatives on the infection prevention program. - Monitoring/Auditing Beginning 9/28/2020 the DON/IP/designee will audit donning and doffing of PPE by staff for residents in transmission-based precautions on all shifts 4x weekly for one week, then twice weekly for one week once compliance is met. The audits will continue until 100% compliance with proper use of PPE for staff, visitors and residents. The DON/IP will review results of audits and report to QAPI Committee for review and further recommendation. Beginning 9/28/2020, the DON/IP/designee will conduct real time audits for any aerosolizing procedures performed to ensure proper PPE is in use. The DON/IP will review results of audits and report to QAPI Committee for review and further recommendation. Equipment/Environment R69 discharged from the facility on 8/25/2020 and the room was deep cleaned upon discharge. As of 9/18/2020, all residents under transmission based precautions have been reviewed and no residents will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 of gloves, mask, face shield, and gowns however, the picture of gowns was crossed off with an X in bold black marker. The cart outside the room was supplied with gloves, visitor log, wipes and hand sanitizer. The cart did not have any isolation gowns. On 8/19/20 at 8:53 a.m. NA-L was observed to don a faceshield over her surgical mask. NA-L stated she was there to do a 30 minute fall risk check on R46 as R46 was at risk for falls. NA-L donned gloves, however did not don an isolation gown, knocked on R46's door and entered the room. NA-L stated she would check on R46 and also check her incontinent brief to see if she needed to be changed. NA-L confirmed R46's brief was wet with urine, and proceeded to assist R46 with peri care. NA-L removed R46's soiled brief, provided pericare with disposable wipes, and placed a clean brief under her and fastened it. NA-L's uniform pants was observed to touch R46's bed, bed linen, and soiled brief. NA-L offered to assist R46 up into her wheelchair at which time R46 indicated she preferred to remain in bed. NA-L placed R46's foot cushions on her feet, covered R46 with her blanket and placed the call light beside R46. NA-L uniform shirt was observed to touch R46's bare legs and bed linens. NA-L exited R46's room. On 8/19/20 at 9:28 a.m. NA-M was observed to put on a face shield and glove, sign in and entered R46's room for a 30 minute check. NA-M did not apply an isolation gown. Approximately one minute later, NA-M exited R46's room, utilized foaming hand sanitizer, removed her shield, wiped them with disinfectant wipes, put the shield into a paper bag, and signed time out on R46's log.	F 880	required to be removed from precautions at this time. Therefore there are no requirements to deep clean resident□s room. - Policy/Procedure/System Changes On 09/14/2020, the QAPI committee conducted an RCA to identify the issues that resulted in the deficiency regarding care/cleaning of resident equipment and the environment and developed further corrective actions to prevent recurrence. By 09/25/2020, The DON/IP/EVS manager will review/revise procedures for cleaning of rooms for residents with discontinued transmission based precautions. As of 09/24/2020, additional EVS staff are available to provide cleaning of resident rooms. - Training/Education By 10/7/2020, the DON/designee will train staff assigned to cleaning of rooms in proper procedures for cleaning a resident room for residents in transmission-based precautions and following discontinuation of transmission-based precautions and competency will be assessed. - Monitor/Auditing Beginning 9/28/2020, the DON/designee will audit for proper cleaning and disinfection of resident equipment and resident rooms, on all shifts every day for one week, then may decrease frequency as determined by Administrator review of compliance. The DON will review results of audits and report to QAPI Committee for review and further recommendation. Surveillance By 09/25/2020, the DON and IP will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 On 8/20/20 at 12:49 p.m. clinical unit manager (CM)-A stated upon admission and hospital return, the residents were put under quarantine and isolated to their room for a 14 day period. CM-A verified the policy was for the staff to wear a face shield over their mask and to glove upon entering quarantined resident rooms and that the facility did not require staff to wear isolation gowns when the resident was under 14 day quarantine. CM-A stated the current policy had been in effect for about a month. CM-A stated she thought the facility had plenty of isolation gowns available and they were not in short supply. On 8/20/ 20 at 2:06 p.m. The administrator stated the facility policy for use of PPE was the Long Term Toolkit sent out by the Minnesota Department of health. The administrator stated the policy did not direct staff to wear isolation gowns for new admission or hospital returns as the facility was in conservation mode. The administrator stated the facility policy directed staff to use the minimum of gloves, shield and mask for residents that are on 14 day quarantine but not COVID-19 positive. The administrator stated the facility was prioritizing gown use, but they did have backups in place, such as cloth gowns. R63's face sheet included diagnoses of Alzheimer disease, fracture of left ileum, diabetes, cerebral vascular disease and dementia. R63's quarterly MDS dated 7/30/20, indicated the need for limited assist with transfers and supervision with dressing and toileting.	F 880	review/revise policy on infection prevention surveillance to include surveillance of residents with symptoms of infection not receiving antibiotics. By 09/28/2020 the DON/IP/designee will educate staff on the procedures for conducting daily surveillance of residents using the Resident Symptom Tracking Tool, which tracks all symptoms for residents, regardless of whether they are on an antibiotic. Beginning 09/28/2020 staff will conduct daily infection prevention surveillance using the Resident Symptom Tracking Tool. To ensure compliance with the process this information will be reported daily during IDT meetings and provided to DON/infection prevention for further recommendations. Results will be forwarded to the QAPI committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35	F 880		

R63's care plan with revision date of 8/7/20, indicated R63 was colonized with a multi-drug resistant organism of extended spectrum beta-lactamases (ESBL-a type of enzyme produced by some bacteria). The care plan directed staff to use enhanced barrier precautions and isolation during high touch procedures. The care plan indicated a gown and gloves were required for care activities such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting.

On 8/19/20 at 1:09 p.m. R63 was observed in her room, seated in her wheelchair, attempting to lie down on her bed. NA-N entered R63's room to assist her and R63 requested to go to the bathroom. NA-N propelled R63 into the bathroom, positioned her wheelchair in front of the toilet and donned gloves. NA-N was wearing a surgical mask however, did not don an isolation gown. NA-N prompted R63 to stand. NA-N assisted R63 to pull down her pants, removed her urine soaked brief and assisted R63 to sit on the toilet. NA-N changed her gloves and assisted R63 to stand, cleansed her peri area and put on a clean brief. NA-N wheeled R63 to the bedside and assisted her into bed. NA-N removed her gloves, gathered up the garbage, washed her hands and exited the room.

On 8/19/20 at 1:15 p.m. In a group interview, NA-N stated she was not aware R63 was on transmission based precautions. LPN-B stated staff were to wear isolation gowns when toileting R63 and indicated there was a sign on the outside of her door to notify staff of what to do. LPN-B verified there was no other signage located in R63's room to alert staff that she required transmission based precautions. At this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36	F 880		

time, LPN-B verified the precaution sign on R63's door was not visible when the door was open. LPN-B stated she did not know how NA-N would have known R63 was on transmission based precautions if she entered the room to assist R63 when the R63's door was open, as there were no other signs visible to indicate precautions were needed.

On 8/20/20 at 10:26 a.m. RN-A stated R63 was on transmission based precautions because she was colonized with ESBL in her urine. RN-A verified she would expect the NA's to wear isolation gowns when providing cares or assisting R63 with toileting. RN-A stated the NA's would know that by the transmission based precaution sign on R63's door, and it was also documented on the NA's care sheet.
R24's significant change of status MDS dated 6/9/20, indicated R24 had impaired cognition and required extensive assistance of one to two staff with activities of daily living (ADL's).

R24's Physician's Order Report dated 8/20/20, indicated diagnosis's of vascular dementia with behavioral disturbance, pneumonia due to inhalation of food and vomit, weakness and heart failure.

R24's care plan dated 8/17/20, indicated R24 was to remain in Covid 19 isolation until 8/28/20, with the goal to prevent possible spread to others. The care plan directed staff to wear a surgical mask, eye goggles or face shield, and gloves when entering R24's room. The care plan indicated an isolation sign was placed on R24's door and to place surgical mask on the resident for transport, use dedicated and disposable equipment, and no visitors at this time. The care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37	F 880		

plan also indicated R24 had self care deficit due to stroke with right sided weakness, cognitive and communication deficits with goals to participate in ADL's. Approaches indicated R24 required assistance from staff with all ADL's.

On 8/17/20, at 5:05 p.m. a droplet precautions (used for residents to prevent the spread of suspected disease through cough, sneeze or talking) sign was observed posted on R24's room door which included instructions to enter wearing gloves, and a mask with shield. A container hanging from the outside of the door contained small, medium, and large gloves, a garbage bag, and gold and purple topped disinfectant wipes.

On 8/17/20, at 5:05 p.m. the surveyor asked to enter the room and was provided a shield to wear and was told a gown was not necessary.

On 8/19/20, at 8:30 a.m. RN-A and an NA-J were observed to enter R24's room wearing surgical masks, gloves and a face shield. R24 was in bed. RN and NA-J proceeded to assist R24 to wash hands and face, change T-shirt, and don pants and socks. During this time, RN-A and NA-J assisted R24 from bed and onto the bathroom toilet followed by pericare at which time RN-A removed a soiled protective dressing from R24's coccyx. Upon completion of care, R24 was assisted back to wheelchair. Throughout the observation, both RN-A's and NA-J uniforms were observed to brush up against R24's bed linens, bare skin, and clothing.
R69's MDS dated 8/10/20, indicated R69 had intact cognition and required extensive assistance with transfer.

R69's care plan dated 8/11/20, indicated staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38	F 880		

visitors must don PPE which included a surgical mask, eye goggles/shield, and gloves. COVID-19 isolation precautions until 8/18/20. COVID-19 precautions were in addition to standard precautions.

On 8/17/20, at 7:10 p.m. a sign on R69's door read in black bold letters to sanitize hands prior to entering, A laminated picture of PPE was posted inside the room which included pictures of gloves, mask, and face shield. The picture of isolation gowns was crossed off indicating not needed. The cart positioned outside the room was noted to be supplied with gloves, a visitor log, wipes, and hand sanitizer. No gowns had been stocked in the cart.

During interview on 8/17/20, at 7:10 p.m. R69 stated, "Nobody wears gowns when they come in."

During interview on 8/20/20, at 9:06 a.m. NA-A stated when a resident came off of isolation precautions, they usually moved to another resident room on the other side of the unit at which time the isolation room would be deep cleaned. NA-A stated someone should have cleaned R69's room after isolation precautions expired, since he stayed in the same room. NA-A stated if the individual was COVID-19 positive, they would use bleach wipes and thoroughly clean that room. NA-A was unsure who cleaned R69's room after isolation precautions were lifted on 8/18/20. NA-A stated before entering isolation rooms, she would sanitize her hands and put on gloves. NA-A further stated she already had her mask and face shield on. Coming out of the room, she would take gloves off and sanitize hands. NA-A further stated gowns are not needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

at this time with new admissions. She was unsure why they stopped wearing gowns, but managers advised that the State Agency does not require use of gowns any longer for new admissions.

During interview on 8/20/20, at 9:46 a.m. RN-B stated when a resident came off of quarantine and had no symptoms of COVID the room was cleaned the same way as other days (swept, mopped and cleaned with disinfectant if needed or done on bath day). For COVID-19 positive residents they would obtain the bin from housekeeping, which has a checklist on how to disinfect the room with bleach products. RN-B stated there was a systematic guide in the bin to direct staff on proper procedure. Housekeeping was responsible for cleaning common areas of the facility and the railings in the hallway. RN-B stated housekeeping was helping with terminal cleaning of resident's rooms after discharge. NA's were responsible for the daily cleaning in resident's rooms along with the resident's laundry. RN-B stated when a residents isolation period was lifted she removed the isolation signs on the doors along with the sign in/out log sheets and then the staff would clean the room as they normally would. RN-B stated the NA's have a check off list to follow for bath days for cleaning reminders.

During interview on 8/20/20, at 9:54 a.m. Housekeeper (H)-A stated housekeeping responsibility for cleaning common areas and help with terminal cleaning of residents rooms after discharge. H-A further stated nursing staff responsibilities include cleaning residents rooms.

R370's care plan dated 8/11/20, identified R370 required COVID-19 isolation precautions until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40	F 880		

8/25/20. R370's care plan identified several interventions which included entering the room must don a surgical mask, eye goggles, or face shield and gloves.

During interview on 8/17/20, at 5:30 p.m. RN-B stated the staff are to wear a face shield, mask and gloves in each room. If staff needed a gown, they could obtain these at the nurse's station. RN-B verified new admissions were placed on a 14 day quarantine period isolated to their rooms with isolation precautions, but if they had no Covid-19 symptoms, the staff should not be wearing gowns when entering the room. RN-B confirmed the isolation gown directive on the posted isolation precaution signs was crossed off as gowns were not required to be worn for new residents with no symptoms of Covid-19.

On 8/18/20, at 2:25 p.m. NA-D was observed to walk out of the R370's room wearing a facemask and faceshield that did not cover the side of NA-D's eyes or face.

During interview on 8/18/20, at 2:32 p.m. NA-D stated it was important to a wear face shield to protect herself from residents who could cough, sneezes, and protect from germs getting into her eyes. NA-D stated she was not sure why her face shield did not fully wrap around her glasses, but does not feel like germs would get into her eyes. She stated the face shield catches her glasses and does not wrap around them. NA-D stated she did not wear gowns due to a lack of supply. Further, NA-D stated the staff used to wear gowns when entering Covid-19 isolation rooms, but stopped three to four weeks ago.

During observation on 8/18/20, at 3:43 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41	F 880		

unidentified NA entered R370's room with face shield, mask, and gloves on. The NA did not apply an isolation gown. Upon entering the room, the NA applied a blood pressure cuff to R370's arm, obtained R370's temperature and oxygen level. Throughout the observation, the NA's uniform was noted to come into contact with the side rail as she leaned over R370.

On 8/18/20, at 3:45 observed RN-C wearing face shield, mask and gloves during direct patient wound care for R370. RN-C's clothing came in direct contact with R370's bed. RN-C was within six feet of R370 for approximately one hour during wound care.

On 8/19/20, at 2:03 p.m. a laminated sign was noted on R370's room door. The sign identified R370 was on precautions from 8/11/20 - 8/25/20, and included pictures of gloves, mask, faceshield and gowns; however, the picture of the gowns was crossed off indicating not needed. A cart was positioned outside of R370's door which contained gloves and hand sanitizer. The cart did not contain any isolation gowns.

During interview on 8/19/20 2:31 p.m. NA-E stated she cleaned resident rooms with disinfectant Sani wipes and also used bleach wipes for deep cleaning along with glass cleaner. NA-E stated they performed a deep clean once a week on the resident's bath day and surface cleaning on a daily basis or as needed. NA-E also stated weekly cleaning of the the room consisted of sweeping, mopping, cleaning the bathroom and dusting the rooms as well. NA-E stated they do not document their daily cleaning. NA-E stated in between the weekly cleaning, if she noted a room needed to be cleaned or items

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42	F 880		

picked up or if a resident asked her to clean their room, she would do so.
R420's admission MDS dated 8/12/20, identified R420 had diagnoses which included heart failure, arthritis, chronic obstructive pulmonary disease (COPD) pneumonia and respiratory failure. The MDS identified R420 had moderate cognitive impairment and required physical assistance with his ADL's.

R420's care plan dated 8/11/20, identified R420 required COVID-19 isolation precautions until 8/20/20. R420's care plan interventions included: anyone entering room must don surgical mask, eye goggles or face shield and gloves.

On 8/18/20, at 2:08 p.m. a droplet precaution sign was observed on R420's door which included instructions to apply gloves, a mask and face shield upon entry to the room. The picture identifying gown use was crossed off indicating not needed. A three tiered cart was positioned outside of R420's room which contained gloves, visitor log, wipes and hand sanitizer. The cart was not stocked with isolation gowns.

During an observation on 8/18/20, at 3:16 p.m. NA-F entered R420's room without a gown on, however NA-F was wearing mask, face shield and gloves. Shortly there-after, NA-F exited with gloves, mask and a face shield on.

When interviewed on 8/18/20, at 3:23 p.m. NA-F stated the picture on the door indicated R420 was on droplet precautions and directed staff to wear gloves, mask and face shields. NA-F verified the directive to wear an isolation gown was crossed off which indicated they were not needed. NA-F stated it had been about a month since gowns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43 were last required to be worn when in a resident room with droplet precautions related to COVID-19 isolation precautions. When interviewed on 08/19/20, 9:34 a.m. occupational therapist (OT)-B was observed wearing gloves, mask and face shield during an occupational therapy session in R420's room. OT-B stated she had not been wearing an isolation gown when inside R420's room providing occupational therapy which included transfer exercises requiring direct contact with R420. OT-B stated it had been weeks since gowns were required to be worn in a resident's rooms who was on droplet precautions for isolation related to COVID-19. Policy titled "Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise", dated 8/14/20 indicates that healthcare workers, when in close contact or providing cumulative care for 15 minutes or more, will wear eye protection unless the resident is wearing a surgical or cloth mask. Gowns to be worn if the resident is COVID positive or has an additional infection such as clostridium difficile.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident equipment in a clean and sanitary manner for 1 of	F 921	On 8/20/2020 R56's wheelchair was cleaned. As of 8/25/2020 R420 was discharged and was then readmitted to a	10/7/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 44 1 resident (R56) whose wheelchair was soiled. In addition, the facility failed to maintain resident room cleanliness for 2 of 2 residents (R420, R220) who had debris scattered on their floors. Findings include: R56's quarterly Minimum Data Set (MDS) dated 7/25/20, indicated R56 had severe cognitive impairment and required extensive assistance of two staff with cares. The MDS identified R56 had diagnoses of dementia, schizophrenia, anxiety and osteoarthritis. The MDS indicated R56 used a wheelchair and required extensive assistance of one staff with locomotion on the unit. R56's current care plan revised 7/31/20, identified R56 required extensive assistance with activities of daily living (ADL's) and used a wheelchair for locomotion, required staff to propel to specific destinations. During observation on 8/17/20, at 3:28 p.m. R56 was seated in front of the television in the common area. R56's wheelchair had of dry crusted debris on the right side of the wheelchair cushion 3 inches in diameter, the frame and side of arm rest contained a one eight inch coating of brown and white substance identified by nursing assistant (NA)-B to be crumbs and dried food. On the left side of the wheelchair there was an approximately one inch white spot with a line of dried white substance down the side of the wheelchair to the bottom frame with white substance lines around the wheel spokes and onto the tire. The frame and spokes of wheel contained a layer of crusted white and brown substance.	F 921	different room on 9/14/2020. As of 8/21/2020 R220 no longer resides in the facility. Both R420 and R220's rooms identified during survey were cleaned following their discharge. By 10/5/2020 nursing managers/designee will review all current resident wheelchairs and residents rooms to ensure they are clean and sanitary. On 09/14/2020, the QAPI committee conducted an RCA to identify the issues that resulted in the deficiency regarding care/cleaning of resident equipment and the environment and developed further corrective actions to prevent recurrence. As of 09/24/2020, additional EVS staff are available to provide cleaning of resident rooms. By 9/25/2020 the DON/designee will review the facilities procedures on cleaning resident equipment and resident rooms to ensure proper disinfection and cleaning, following the manufacturer instructions for use of the cleaning products. By 10/7/2020, the DON/designee will train all nursing/EVS staff responsible for resident care equipment and environment on proper disinfection and cleaning and competency will be assessed. The training and competency will be documented. Beginning 9/28/2020, the DON/designee will audit for proper cleaning and disinfection of resident equipment and resident rooms, on all shifts every day for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 45 When interviewed on 8/19/20, at 10:06 a.m. NA-B stated resident wheelchairs were to be spot cleaned when staff observed food or liquid debris on them and the staff person that observed the debris was to spot clean it. NA-B further stated wheelchairs were washed in the wheelchair washer weekly, on bath day, by the evening or overnight staff and then were brought to the hallway outside of the resident's room to allow the wheelchair to dry. Wheelchair cushion covers were to be washed by hand then hung up to dry. During interview on 8/19/20, at 1:43 p.m. NA-C indicated resident wheelchairs were washed weekly on their bath day, but if there was a spill or crumbs on the wheelchair in between washing, it should be cleaned right away by the staff member that identified the wheelchair was dirty. NA-C stated the were to be kept clean for resident comfort and dignity as she "would not want my family to sit in a dirty, crumby wheelchair." When interviewed on 8/20/20, at 8:58 a.m. registered nurse (RN)-A stated any staff member was able to spot check and clean a wheelchair, and verified the night shift performed thorough cleaning per the schedule. RN-A confirmed R56's wheelchair and cushion had a buildup of dried liquid and food crumbs and stated she would expect R56's wheelchair to have been kept clean. An undated facility policy titled, Wheelchair Washing, indicated afternoon and nights were responsible for washing all resident wheelchairs on the day they received their baths. The policy lacked direction for periodic cleaning of resident wheelchairs. R420's admission Minimum Data Set (MDS) dated 8/12/20 identified R420 had moderate	F 921	one week, then may decrease frequency as determined by Administrator review of compliance. The DON will review results of audits and report to QAPI Committee for review and further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 46	F 921		

cognitive impairment and had diagnoses which included heart failure, chronic obstructive pulmonary disease, pneumonia and respiratory failure. The MDS identified R420 required physical assistance with ADL's.

On 8/18/20, at 9:52 a.m. R420 stated food crumbs had been at the end of the bed for "over a week". Food crumbs were observed at the end of his bed on the floor and a cloth arm protector was on the floor by nightstand. R420 stated no one had cleaned his room or picked up things from the floor since being admitted to facility over a week ago. R420 voiced his frustration with lack of cleaning from staff. R420 stated staff had not been in his room to clean for over a week.

On 8/18/20, at 3:28 p.m. a facility housekeeper walked past R420's room, was not observed to enter or look into R420's room.

On 8/19/20, at 7:21 a.m. the food crumbs on R420's floor remained at the end of R420's bed. R420 stated no one had been in his room to clean and stated he wanted his room to be cleaned.

On 8/19/20, at 10:06 a.m. upon entry of R420 room, R420 was in recliner, sitting upright in seated position, awake and watching TV. It was observed several, less than a dozen, food crumbs on the floor by end of bed. R420 confirmed no one had been there to clean his/her room. R220's admission MDS dated 8/18/20, identified R220 had diagnoses which included hip fracture, arthritis and was cognitively intact. The MDS identified R220 required physical assistance with ADL's.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 47	F 921		

On 8/19/20, at 8:54 a.m. R220 stated random staff would take her garbage out but no one had cleaned her room. R220 stated she had cleaned her floors by the recliner with her foot and a paper towel due to needing space cleaned and the staff had never offered to clean for her. At this time, 2 tissues were observed below the window and throughout the floor of her room.

On 8/19/20, at 9:17 a.m. NA-G stated the NA's would deep clean resident rooms on their shower days and the housekeeping staff cleaned the building. NA-G stated the NA's were responsible for maintaining resident room cleanliness which deep cleaning such as changing linens, sweeping and mopping the floor, and wiping down the shower and toilet. NA-G stated she was not aware when R220's room was last cleaned. NA-G confirmed R220's floor had random trash below the window and throughout the floor of R220 room and stated the floor needed to be swept. NA-G stated if a room was in need of cleaning, it should be cleaned however, felt there was not enough nursing staff to provide resident cares and cleaning.

When interviewed on 8/19/20, at 12:53 p.m. housekeeper (H)-B stated housekeeping was responsible for cleaning all the common areas of the facility which included all entrances and the elevators. H-B stated the elevators and entrances were cleaned three times a day, handrails were cleaned one to two times a day. H-B stated the aides were responsible to clean the residents' rooms unless housekeeping was specifically asked to clean a resident room.

On 8/20/20, at 12:57 p.m. the facility administrator verified the nurses and NA's were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 48 responsible for cleaning residents' rooms and stated the facility was trying to get more housekeeping staff but had not been successful. The administrator stated the expectation of the nurses and aides was to clean residents' rooms daily, when it was needed, noticeable or requested by a resident. Cleaning policy was requested and not provided.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING **02 - BUILDING 1** B. WING _____	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Neilson Place 02 Main Building was found not 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. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS	K 000		

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

Electronically Signed | 09/18/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING **02 - BUILDING 1** B. WING _____	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING **02 - BUILDING 1** B. WING _____	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 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 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 NOT MET.	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 353	Cleaning of all sprinkler heads throughout	9/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING **02 - BUILDING 1** B. WING _____	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 3 facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 The standard for testing and maintenance of sprinkler systems, section 5.2.1.1.2 This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the residents, staff and visitors. Findings include: During the facility tour between 9:00 am to 12:00 pm on 08/18/2020 Observations revealed multiple sprinkler heads throughout the facility were covered with dust and dirt. This deficient condition was confirmed by the Assistant Administrator and the Director of Maintenance.	K 353	the facility was completed using compressed air 9/11/2020 and is documented and on file in the Supervisor, Power Plant's office. Staff training on routine cleaning of sprinkler heads was completed by the Supervisor, Power Plan on 9/16/2020 along with creating an annual cleaning schedule for sprinkler heads.	
K 918 SS=F	. Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		9/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING **02 - BUILDING 1** B. WING _____	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 4 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect all residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 08/18/2020documentation review revealed there was no record of a generator inspection for the week of May 25th. This deficient condition was confirmed by the	K 918	On 9/9/2020 the facilities emergency generator was inspected and the inspection was documented. On 9/14/2020 the Supervisor, Power Plant/designee wrote a policy for emergency generator maintenance. On 9/16/2020 the Supervisor, Power Plant/designee educated maintenance staff on the policy for emergency generator maintenance as well as documenting the emergency generator inspection. Beginning 9/21/2020 the Supervisor, Power Plant/designee will audit the emergency generator inspection log to ensure it has been documented. Audits will be completed weekly for 6 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING **02 - BUILDING 1** B. WING _____	**08/18/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 5 Assistant Administrator and the Director of Maintenance.	K 918	Results will be forwarded to the QAPI committee for further recommendation.	

Electronically delivered
September 10, 2020

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: 5ZUC11

Dear Administrator:

The above facility was surveyed on August 17, 2020 through August 20, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Unit Supervisor
Email: susie.haben@state.mn.us
Phone: 320-223-7356

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.

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

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 08/20/2020

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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/17/20 - 8/20/20, a survey was conducted to determine compliance for state licensure. 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.	2 000		

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 08/20/2020

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
2 000	Continued From page 1 In addition, complaint investigations were also completed at the time of the licensing survey. The following complaints were found to be UNSUBSTANTIATED: H5039039C H5039040C H5039041C H5039042C The following complaint was found to be SUBSTANTIATED with no orders issued. H5039043C However, as a result of the investigation an unrelated Correction order was issued 626.557 Subd.3-1980	2 000		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clinical justification for the use of an indwelling catheter and failed to provide education related to the effects of catheter use for 1 of 1 resident (R18) reviewed with a catheter. Findings include:	2 835	Will be corrected per F690 POC	10/7/20

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 08/20/2020

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
2 835	Continued From page 2 R18's annual Minimum Data Set (MDS) 6/1/20, indicated intact cognition. The MDS indicated R18 required extensive to total assistance with activities of daily living and identified the use of an indwelling catheter. R18's care plan dated 6/5/20, identified the use of an indwelling urinary catheter related to skin breakdown and family request. R18's Physician's Orders indicated the following: 1/15/19, Place indwelling catheter. No diagnosis identified. 3/8/19, indicated keep Foley (urinary catheter) in place until wounds are assessed by wound care. A wound care visit note dated 3/19/19, indicated R18 was evaluated for wounds to her bilateral ischial areas (sit bones). The wound care orders included treatment and directed staff to encourage offloading. The wound care orders did not address the use of the indwelling catheter. R18's clinical record lacked evidence of an assessment, patient education or clinical justification for use of the indwelling catheter. During observation and interview on 8/17/20, at 7:08 p.m. R18 was seated in a reclining wheel chair in her room. R18 stated she had a urinary catheter. R18 stated "the doctor said I didn't need it but I said I wanted it." On 8/20/20, at 9:11 a.m. registered nurse (RN)-D stated R18 had the catheter placed because she was incontinent and it was causing pain in her wounds. RN-D stated R18's family member had called and requested the catheter due to R18's incontinence and the physician ordered the catheter to be placed until wound care evaluated	2 835		

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 08/20/2020

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
2 835	Continued From page 3 R18 in March of 2019. RN-D further stated there was no diagnosis listed for the catheter. At 2:00 p.m. the director of nursing (DON) stated the facility tried to avoid using catheters. The DON stated R18's catheter had been placed due to her sores and said there had been multiple conversations about R18's catheter amongst the staff. The DON stated R18 did not want the catheter removed. In regard to discussion of the risk of long term catheter use or clinical justification for use of the catheter, the DON stated she would look however, no further information was provided. A policy related to catheter use was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide ongoing assessment and follow up on physician's orders related to urinary catheters. The DON or designee could conduct audits of residents with catheters to ensure appropriate diagnosis and education are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
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	21435		10/7/20

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 08/20/2020

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
21435	Continued From page 4 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 meaningful activities for 3 of 5 residents (R56, R46 and R420) reviewed for activities. Findings include: R56's quarterly Minimum Data Set (MDS) dated 7/25/20, identified R56 had severe cognitive impairment and required extensive assistance with cares. R56's Activity Care Area Assessment (CAA) dated 1/23/20, identified R56 was shy and uneasy around others and declined to participate in large group activities. The CAA further identified R56 preferred to listen to music in her room, being around animals and doing things with groups of people. On 8/17/20, at 6:57 p.m. R56 was observed in the common room, seated in her wheelchair watching television. On 8/19/20, at 8:25 a.m. R56 was observed in the common room, seated in her wheelchair in front of the television.	21435	Will be corrected per F679 POC	

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 08/20/2020

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
21435	Continued From page 5	21435		

On 8/19/20, at 9:52 a.m. R56 was observed in bed on her back. The lights were off, there was no television or music on in the room.

When interviewed on 8/19/20, at 10:06 a.m. nursing assistant (NA)-B she had attempted to do nail care for the female residents last week including R56. NA-B stated after meals she would position R56 in front of the television. NA-B also stated R56 liked having music on when she was in her room.

During interview on 8/20/20, at 8:48 a.m. NA-G stated she relied on the activity aide to do 1:1 activities with the residents including R56. NA-G indicated R56 liked music and would scoot around the unit in her wheelchair. NA-G confirmed she had not turned on any music for R56 that day.

During interview on 8/20/20, at 8:58 a.m. registered nurse (RN)-A stated there had been more 1:1 activities, some distance bingo and church was put on the television on Sundays if there was staff available to turn it on.

When interviewed on 8/20/20, at 1:35 p.m. activity aide (AA)-A stated R56 liked music and that more 1:1's visits were being done with her, but probably were not documented. AA-A stated R56 scooted around the unit in her wheelchair and indicated R56 did not like television.

R56's Activity (Group and independent Leisure) Participation Documentation dated August 2020, revealed August 1st though the 18th R56 was offered to participate in TV/Movie/Sports/News ten out of eighteen days, Radio and music was offered two out of eighteen days, had one family visit in eighteen days and had three staff 1:1

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 08/20/2020

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
21435	Continued From page 6	21435		

activities in eighteen days. According the the documentation, other independent activities such as reading/writing/newspaper, crafts, helping others and games/puzzles, had not been offered to R56.

R46's undated face sheet included diagnoses of dementia, displaced intertrochanteric fracture of left femur, multiple fractures of ribs, repeated falls, heart disease and hypertension.

R46's admission MDS dated 7/9/20, indicated impaired cognition and the need for extensive assist with transfer, bed mobility, dressing and grooming. The activities section of the MDS indicated R46 enjoyed the outdoors, music and participating in favorite activities.

R46's Communication CAA dated 7/14/20, indicated R46 had hearing loss and problem understanding others and being understood. The CAA also indicated R46 had cognitive deficit and was not able to read.

R46's Activity CAA dated 7/15/20, indicated the care plan was developed for 1:1's and independent leisure activities because of COVID-19 restrictions and R46's dementia.

R46's Care plan, with revision date of 7/14/20, indicated R46 had impaired activity participation due to covid restrictions. The care plan directed staff to adapt activity equipment to meet R46's needs such as sitting with R46 when she colored and visiting about living on her farm in Oklahoma. R46's care plan directed staff to assess environmental factors that may hinder activity involvement such as being in her room more and to provide R46 with 1:1 interventions as needed or desired so socialization and stimulation

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 08/20/2020

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
21435	Continued From page 7 decreases any decline. R46's activity log for the month of August 2020, indicated R46 was in the hospital from 8/13/20, through 8/17/20. The log indicated R46 had participated with independent television and music on 8/18/20 and 8/19/20. With the exception of three days, the log lacked any 1:1 visits with R46 for the remaining 14 days of August 2020. On 8/18/20, at 1:46 p.m. R46's room was observed laying in her bed with the door closed. The room was dark and there was no television or music playing. On 8/19/20 at 8:53 a.m. R46 was observed lying in bed, sleeping. The room was dark and no television or music was playing. R46 had refused to get out of bed. -At 9:28 a.m. R46 was observed lying in bed, sleeping. The room was dark and no television or music was playing. NA-A entered the room to assist R46 into her wheelchair for breakfast, however. R46 refused to get out of bed despite several verbal attempts and stated she just wanted to remain in bed. -At 2:07 p.m. R46 was observed lying in her bed. The room was dark and no television or music was playing. The door to the room remained closed due to on isolation precautions. NA-A stated R46 had refused to get out of bed for the entire shift. On 8/20/20, at 9:57 a.m. NA-A stated anyone who was going to enter R46's room needed to sign in on the log by her door. On review of the sign in logs for entry to R46's room, NA-A verified the	21435		

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 08/20/2020

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
21435	Continued From page 8	21435		

activity aides signature was not on the sign in logs indicating they had not entered her room to provide activities, since her hospital return on 8/18/20. NA-A stated there was just one activity aide for the facility and she was on vacation today.

At 10:00 a. m. NA-N stated R46 refused to get out of bed at all the day before, but they were going to try to get her up now. NA-N stated in the past, she used to take R46 out on the balcony on nice days and R46 used to come to dining area for her meals and other "stuff", but now she was quarantined. NA-N stated she wished they had more time to sit with residents and read to them.

On 8/20/20 at 1:00 p.m. R46 was observed in her room, seated in the wheelchair, awake. R46's television was on, however R46's head hung down with her chin resting on her chest. R46 was dressed and groomed. R46 began moving a glass about her bedside table. R46 stated she did not know what was playing on the television and that she did not have any favorite television shows. R46 again put her head down with her chin resting on her chest and appeared to fidget with her blanket. R46 did not appear to be actively watching the television.

R420's admission MDS dated 8/12/20, indicated R420 had moderate cognitive impairment, was able to make own decisions and enjoyed leisure activities. The MDS identified R420 had activity preference which included: music, news, group activities and being outside. Activity preferences included on the MDS music, news, group activities and being outside.

R420's baseline care plan dated 8/6/20, identified an area to complete activity interventions and

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 08/20/2020

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
21435	Continued From page 9	21435		

preferences; however, the section was blank.

R420's Activity assessment dated 8/13/20, identified leisure interests which included games, crafts, music, being outside, talking and conversing.

On 8/18/20, at 2:06 p.m. R420 was observed in his room, seated in his recliner, awake and watching the television. R420's room was noted to not have any type of reading material or a radio to play music.

On 8/19/20, at 10:06 a.m. R420 was observed in his room, seated in his recliner awake, actively watching television. R420's room remained void of any reading material or radio to play music. R420 stated no one had been to his room to offer activities.

When interviewed on 8/17/20, at 4:43 p.m. R420 stated there was nothing to do in his room except watch television. R420 stated he sat in his room most of the day except for therapy, because he was in quarantine. R420 stated he wished there was more to do than be in his room and watch TV.

When interviewed on 8/18/20, at 4:17 p.m. NA-H stated residents that were in quarantine were provided 1:1 visits by staff while providing personal cares and that there were no group activities except for Bingo. NA-H indicated she was not aware of a therapeutic recreation schedule and stated she did not know who assessed or reassessed residents' activity preferences.

When interviewed on 8/20/20, at 9:20 a.m. activity coordinator (A)-B stated the blue binder

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 08/20/2020

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
21435	Continued From page 10	21435		

was for floor staff to document residents' independent leisure and small group activities. A-B stated there was an independent leisure activity cart that was offered to the residents' once a week and as needed, in order to provide activities in the residents' rooms. A-B she would offer activities on each unit, once a week. A-B stated there was no schedule for providing 1:1 resident visits as those visits were provided during the provision of personal cares. A-B indicated she completed the 1:1 resident assessments.

When interviewed on 8/20/20, at 10:32 a.m. A-A stated A-B was the therapeutic recreation coordinator and was responsible to complete all resident activity assessments, care plans and created the schedule for resident activities. A-A reviewed R420's baseline care plan and verified the activities section was blank. A-A stated the baseline care plan was to be completed within 48 hours after admission to the facility.

The facility provided activities calendar dated 8/16/20 - 8/22/20 revealed the following scheduled activities:

-1:1 activities would be provided throughout the day, everyday.
-Bingo was scheduled for 8/17/20, 8/18/20, 8/19/20, and was also held on select units, daily.
-Outdoor visits were scheduled for 8/16/20, 8/17/20, 8/19/20, 8/20/20, 8/21/20.
-Church services scheduled 8/16/20.
-Ice cream treats scheduled on 8/21/20.

The facility provided an Activity (Group and independent Leisure) Participation Documentation dated August 2020, which revealed R420 participated in

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 08/20/2020

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
21435	Continued From page 11 TV/Movie/Sports/News. Other listed independent activities such as reading/writing/newspaper, crafts, radio/music, company, helping others, games/puzzles and 1:1's were blank which indicated not offered/provided. The Activities Participation policy dated October 2018, specified "an ongoing program to support residents in their choice of activities....all nursing and activity staff are required to review the resident's care plan and residents preferences listed on their activity documentation sheet." Finally, the Activities Participation policy stated staff were to communicate resident/family leisure request to an activities staff member. SUGGESTED METHOD FOR CORRECTION: The activity director or designee could develop systems of ensuring activity programming for residents. The Activity Director could educate all appropriate staff and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21435		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21530		10/7/20

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 08/20/2020

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
21530	Continued From page 12 available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow up on pharmacy recommendations for 2 of 5 residents (R9, R18) reviewed for unnecessary medications. Findings include: R9's quarterly Minimum Data Set (MDS) dated	21530	Will be corrected per F756 POC	

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 08/20/2020

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
21530	Continued From page 13 5/21/20, indicated she required extensive assistance from two staff for all activities of daily living. R9's care plan dated 6/3/20, identified a diagnosis of elevated lipids and directed staff to provide medications as ordered and monitor for muscle pain. R9's Physician Order Report dated 8/20/20, identified and order for atorvastatin (cholesterol lowering medication) tablet 40 milligrams (mg) oral at bed time. The order had a start date of 11/12/19. A Consultant Pharmacist's Medication Review dated April 2020, indicated the following: Medication: atorvastatin 40 mg. Irregularity or comments: According to..... the treatment of high cholesterol in patients over 75 years old may not be necessary, and that "an even less favorable risk-benefit ratio may be seen in patients over 85, where benefits may be more diminished and risks from statin drugs more increased (cognitive impairment, falls, neuropathy, and muscle damage)." Suggested course of action: Could this statin be discontinued? Follow-up or action taken: Physician circled rejected and indicated "will review at next appt. (appointment)" A physician Progress Note dated 6/26/20, indicated a tele-health visit was conducted and indicated R9 was feeling well, had some residual pain related to previous fracture and indicated no shortness of breath, chest pain, nausea, vomiting..... The Progress Note lacked evidence the use of atorvastatin was reviewed.	21530		

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 08/20/2020

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
21530	Continued From page 14 R18's Annual MDS dated 6/1/20, indicated she had intact cognition and required total to extensive assistance for all activities of daily living. R18's care plan dated 6/5/20, identified a diagnosis of Diabetes Mellitus and directed staff to monitor for signs of hyper and hypoglycemia. The care plan indicated R18 received insulin. R18's Physician's Order Report dated 8/20/20, identified an order for Novolog (insulin aspart) 100 units per milliliter (ml) per sliding scale before meals and at bedtime. A Consultant Pharmacist's Medication Review dated April 2020, indicated the following: Medication: Novolog 100 units/ml per sliding scale before meals and at bedtime. Irregularity or comments: Long-term use of sliding scale insulin is not recommended due to lack of evidence for efficacy. Suggested course of action: Consider discontinuing use of sliding scale insulin and manage blood glucose with basal/bolus insulin based on daily sliding scale requirements Follow-up or action taken: Physician circled rejected with no clinical rationale for the continued use of sliding scale insulin was documented by the physician. During interview on 8/20/20, at 8:45 a.m. the director of nursing (DON) stated the pharmacist reviewed medications monthly and made recommendations. The DON stated the recommendations were given to the clinical managers and the clinical manager was responsible to reach out to the physician. At 1:31	21530		

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 08/20/2020

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
21530	Continued From page 15 p.m. the DON stated she was not aware the physician had to document a clinical rational for a rejection of the pharmacy recommendation. A policy related to follow up on the consultant pharmacists recommendations was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for	21535		10/7/20

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 08/20/2020

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
21535	Continued From page 16 Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide clinical justification for the ongoing use of psychotropic medications for 1 of 5 residents (R9) reviewed for unnecessary medications. Findings include: R9's annual Minimum Data Set (MDS) dated 11/19/19, indicated she was severely cognitively impaired, had minimal symptoms of depression and suffered from delusions. The MDS indicated R9 displayed behaviors 1-3 days during the assessment period. R9's quarterly MDS dated 2/19/20, and 5/21/19. indicated she did not display any physical, verbal or other behaviors nor did she display any delusions. R9's Behavioral Symptom Care Area Assessment (CAA) dated 11/20/19, indicated she displayed other behavioral symptoms directed toward others and indicated she had delusions. The CAA also indicated R9's nurses notes reflected calling out especially at night and/or when alone and R9 was very confused and forgetful. The CAA indicated R9 required a care plan for the behavior	21535	Will be corrected per F758 POC	

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 08/20/2020

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
21535	Continued From page 17 of calling out. The CAA did not describe R9's delusions. R9's Patient Health Questionnaire-9 (PHQ-9) (assesses degree of depression severity via questionnaire) assessment dated 2/17/20, indicated a score of 3 out of 27 indicating minimal depression. R9's PHQ-9 assessment dated 5/18/20, indicated R9 reported no signs or symptoms of depression. R9's Physician's Order Report dated 8/20/20, identified the following medications: -Seroquel (antipsychotic medication) order date 2/21/20, 50 milligrams (mg) take 0.5 tablets every night at bed time. Target behaviors: statements about dying, crying and yelling out. -Citalopram (antidepressant medication) order date 6/30/20, 20 mg oral once daily for target behaviors: yelling out and crying. A facility document titled Yearly Data Summary dated 2020, indicated the following: Target behaviors and data: yelling out, fear of being alone, statements of sadness, crying: January 2020, number of behaviors indicated "0." February 2020, number of behaviors indicated "0." March 2020, number of behaviors indicated "0." April 2020, number of behaviors indicated "0." May 2020, number of behaviors indicated "0." June 2020, number of behaviors indicated "0." July 2020, number of behaviors indicated "0." A review of R9's certified nurse practitioner (CNP) Progress Notes indicated the following:	21535		

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 08/20/2020

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
21535	Continued From page 18 -2/18/20, Staff had expressed that R9 seemed unhappy and was difficult to please. R9 was trying to adjust to her move within the long term care facility. This was further complicated by probable pain related to a fracture of her left arm. A trial of Citalopram 10 mg daily and time will help her through this adjustment period. The Progress Note referred to a PHQ-9 score of 10 dated 7/11/18. -4/7/20, Nursing reported R9 had settled into her new environment - "had a rocky start and was quite unhappy and verbally disruptive." R9 was now taking her medications, eating well, stated she was able to talk to her children on the phone and watch television and appears to be "quite content." R9 had been started on Citalopram 10 mg daily for yelling out,crying and making statements about dying which have all improved." Will increase Citalopram to 20 mg and continue Seroquel 25 mg. -4/21/20, R9 up in wheel chair at time of visit, smiling, calm, interactive. Stated she was getting settled in and liked it at the facility. R9 appeared to be understanding and accepting of visitor restrictions and was able to tell stories about her boys from when they were kids. Continue anti-depressant for the time being. During an interview with R9 on 7/17/20, at 3:09 p.m. she stated she had been in the facility since fall. R9 stated all of the staff were very nice to her. R9 stated her three sons had visited her the previous day and she played bingo, watched television and went for a walk every day. During the interview, three male visitors appeared outside her window to wave to her.	21535		

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 08/20/2020

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
21535	Continued From page 19 On 8/19/20, at 2:00 p.m. nursing assistant (NA)-I was asked about documentation of behaviors and stated that the nurses documented all of the resident behaviors not the NAs. During interview on 8/20/20, at 8:45 a.m. the director of nursing (DON) indicated she was not familiar with the regulations. On 8/20/20, at 10:52 p.m. NA-I stated when R9 was first admitted to the facility. she was rude to staff but had seemed better since March. NA-I stated she felt R9 was " a hundred percent perfect." On 8/20/20, at 10:55 a.m. licensed practical nurse (LPN)-A stated R9 was very crabby when she first admitted to the facility but had not displayed any behaviors since about a month after admission. A facility policy titled Antipsychotic Medication Reduction dated 12/21/18, indicated during the first year a resident is prescribed a psychopharmacological medication the facility should attempt to taper the medication unless clinically contraindicated. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21535		

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 08/20/2020

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
21695	Continued From page 20	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident equipment in a clean and sanitary manner for 1 of 1 resident (R56) whose wheelchair was soiled. In addition, the facility failed to maintain resident room cleanliness for 2 of 2 residents (R420, R220) who had debris scattered on their floors. Findings include: R56's quarterly Minimum Data Set (MDS) dated 7/25/20, indicated R56 had severe cognitive impairment and required extensive assistance of two staff with cares. The MDS identified R56 had diagnoses of dementia, schizophrenia, anxiety and osteoarthritis. The MDS indicated R56 used a wheelchair and required extensive assistance of one staff with locomotion on the unit. R56's current care plan revised 7/31/20, identified R56 required extensive assistance with activities of daily living (ADL's) and used a wheelchair for locomotion, required staff to propel to specific destinations. During observation on 8/17/20, at 3:28 p.m. R56 was seated in front of the television in the	21695	Will be corrected per F921 POC	10/7/20

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 08/20/2020

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
21695	Continued From page 21	21695		

common area. R56's wheelchair had of dry crusted debris on the right side of the wheelchair cushion 3 inches in diameter, the frame and side of arm rest contained a one eight inch coating of brown and white substance identified by nursing assistant (NA)-B to be crumbs and dried food. On the left side of the wheelchair there was an approximately one inch white spot with a line of dried white substance down the side of the wheelchair to the bottom frame with white substance lines around the wheel spokes and onto the tire. The frame and spokes of wheel contained a layer of crusted white and brown substance.

When interviewed on 8/19/20, at 10:06 a.m. NA-B stated resident wheelchairs were to be spot cleaned when staff observed food or liquid debris on them and the staff person that observed the debris was to spot clean it. NA-B further stated wheelchairs were washed in the wheelchair washer weekly, on bath day, by the evening or overnight staff and then were brought to the hallway outside of the resident's room to allow the wheelchair to dry. Wheelchair cushion covers were to be washed by hand then hung up to dry.

During interview on 8/19/20, at 1:43 p.m. NA-C indicated resident wheelchairs were washed weekly on their bath day, but if there was a spill or crumbs on the wheelchair in between washing, it should be cleaned right away by the staff member that identified the wheelchair was dirty. NA-C stated the were to be kept clean for resident comfort and dignity as she "would not want my family to sit in a dirty, crumby wheelchair."

When interviewed on 8/20/20, at 8:58 a.m. registered nurse (RN)-A stated any staff member was able to spot check and clean a wheelchair,

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 08/20/2020

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
21695	Continued From page 22	21695		

and verified the night shift performed thorough cleaning per the schedule. RN-A confirmed R56's wheelchair and cushion had a buildup of dried liquid and food crumbs and stated she would expect R56's wheelchair to have been kept clean.

An undated facility policy titled, Wheelchair Washing, indicated afternoon and nights were responsible for washing all resident wheelchairs on the day they received their baths. The policy lacked direction for periodic cleaning of resident wheelchairs.

R420's admission Minimum Data Set (MDS) dated 8/12/20 identified R420 had moderate cognitive impairment and had diagnoses which included heart failure, chronic obstructive pulmonary disease, pneumonia and respiratory failure. The MDS identified R420 required physical assistance with ADL's.

On 8/18/20, at 9:52 a.m. R420 stated food crumbs had been at the end of the bed for "over a week". Food crumbs were observed at the end of his bed on the floor and a cloth arm protector was on the floor by nightstand. R420 stated no one had cleaned his room or picked up things from the floor since being admitted to facility over a week ago. R420 voiced his frustration with lack of cleaning from staff. R420 stated staff had not been in his room to clean for over a week.

On 8/18/20, at 3:28 p.m. a facility housekeeper walked past R420's room, was not observed to enter or look into R420's room.

On 8/19/20, at 7:21 a.m. the food crumbs on R420's floor remained at the end of R420's bed. R420 stated no one had been in his room to clean and stated he wanted his room to be

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 08/20/2020

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
21695	Continued From page 23 cleaned. On 8/19/20, at 10:06 a.m. upon entry of R420 room, R420 was in recliner, sitting upright in seated position, awake and watching TV. It was observed several, less than a dozen, food crumbs on the floor by end of bed. R420 confirmed no one had been there to clean his/her room. R220's admission MDS dated 8/18/20, identified R220 had diagnoses which included hip fracture, arthritis and was cognitively intact. The MDS identified R220 required physical assistance with ADL's. On 8/19/20, at 8:54 a.m. R220 stated random staff would take her garbage out but no one had cleaned her room. R220 stated she had cleaned her floors by the recliner with her foot and a paper towel due to needing space cleaned and the staff had never offered to clean for her. At this time, 2 tissues were observed below the window and throughout the floor of her room. On 8/19/20, at 9:17 a.m. NA-G stated the NA's would deep clean resident rooms on their shower days and the housekeeping staff cleaned the building. NA-G stated the NA's were responsible for maintaining resident room cleanliness which deep cleaning such as changing linens, sweeping and mopping the floor, and wiping down the shower and toilet. NA-G stated she was not aware when R220's room was last cleaned. NA-G confirmed R220's floor had random trash below the window and throughout the floor of R220 room and stated the floor needed to be swept. NA-G stated if a room was in need of cleaning, it should be cleaned however, felt there was not enough nursing staff to provide resident cares and cleaning.	21695		

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 08/20/2020

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
21695	Continued From page 24 When interviewed on 8/19/20, at 12:53 p.m. housekeeper (H)-B stated housekeeping was responsible for cleaning all the common areas of the facility which included all entrances and the elevators. H-B stated the elevators and entrances were cleaned three times a day, handrails were cleaned one to two times a day. H-B stated the aides were responsible to clean the residents' rooms unless housekeeping was specifically asked to clean a resident room. On 8/20/20, at 12:57 p.m. the facility administrator verified the nurses and NA's were responsible for cleaning residents' rooms and stated the facility was trying to get more housekeeping staff but had not been successful. The administrator stated the expectation of the nurses and aides was to clean residents' rooms daily, when it was needed, noticeable or requested by a resident. Cleaning policy was requested and not provided. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure an environmental cleaning program was developed to accurately reflect ongoing housekeeping scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

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 08/20/2020

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
21980	Continued From page 25	21980		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead	21980		10/7/20

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 08/20/2020

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
21980	Continued From page 26 agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report to the stated agency (SA) neglect of care for 1 of 2 residents (R18) reviewed for abuse. Findings include: R18's annual Minimum Data Set (MDS) dated 6/1/20, indicated she had intact cognition and required total assistance for locomotion on and off the unit. R18's care plan dated 6/5/20, identified a risk for a decline in wheel chair mobility and a self care deficit related to bilateral amputations, pain and diagnosis of hemiplegia (paralysis of one side of the body). A review of R18's Resident Progress Note dated 5/9/20, indicated R18 came out for breakfast and requested Tylenol for face pain, R18 had been outside previously and got a sun burn to the right side of her face. R18's skin was peeling and her lip was slightly swollen. Staff had been applying lotion to R18's face.	21980	Will be corrected per F609 POC	

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 08/20/2020

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
21980	Continued From page 27 During interview on 8/17/20, at 7:21 p.m. R18 stated she had gotten a sunburn while outside a few months prior. R18 stated, "I think I fell asleep and I got terribly burned on my face" and said, "oh god did I ever blister." During an interview on 8/19/20, the administrator stated when determining whether an incident is reportable to the SA he reviewed the facility policy. The administrator stated he was not aware of the incident in which R18 had a blistering sun burn and stated if it truly was a blistering sun burn that would have been a major event and the nurse manager should have filled out an incident report. The administrator confirmed and incident report had not been completed. On 8/20/20, at 10:10 a.m. family member (FM)-A stated staff had not been letting R18 face time with her and she could not understand why. FM-A stated she went and saw R18 through the window and stated when R18 turned her face she saw the sun burn. FM-A stated R18's face was swollen and stated "it looked awful." FM-A stated she asked R18 who popped the blister on her face but R18 did not know. FM-A stated she had a photo of the burn and said around the corner of R18's right lip there were blisters and a line going along her cheek and the bottom half was red and indented. FM-A stated the burn was on the right side of R18's face, ear and cheek and down by her neck. FM-A stated she called and asked about the burn and was told that staff brought R18 outside and forgot about her. During a subsequent interview on 8/20/20, at approximately 1:00 p.m. the administrator stated a report had not been made to the SA and stated he did not feel the incident was reported because	21980		

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 08/20/2020

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
21980	Continued From page 28 there was "no proof" R18 had blistered. A facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 9/5/19, identified neglect as the failure of the facility to provide services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy indicated reports of neglect would be reported to the SA no later than two hours if the events that cause the allegation involve abuse. The Administrator and/or designee could review the facility polices in regards to reporting of allegations of neglect and/or mistreatment to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted. The administrator or designee could routinely monitor to ensure reports are submitted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245039	NEILSON PLACE

Type of Survey (select all that apply):

A	I	K			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 35569	08-17-2020	08-20-2020	0.75	1.00	24.00	2.00	0.00	11.00
2. 40938	08-17-2020	08-20-2020	0.00	1.00	24.50	2.50	7.00	7.50
3. 41575	08-19-2020	08-20-2020	0.00	16.00	0.00	0.00	0.00	12.00
4. 42585	08-17-2020	08-20-2020	0.00	1.00	24.00	2.00	6.00	3.00
5. 43081	08-17-2020	08-20-2020	0.00	0.00	29.00	2.50	7.00	31.00
6. 43082	08-17-2020	08-20-2020	0.00	0.00	29.00	0.00	7.00	38.00
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 18.00

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245039	NEILSON PLACE

Type of Survey (select all that apply):

A	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 35569	08-19-2020	08-20-2020	0.25	0.00	1.50	0.00	0.00	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245039	NEILSON PLACE

Type of Survey (select all that apply):

A	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 35569	08-19-2020	08-20-2020	0.25	0.00	1.50	0.00	0.00	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245039	NEILSON PLACE

Type of Survey (select all that apply):

A	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 35569			0.25	0.00	0.00	0.00	0.00	0.00
2. 40938	08-19-2020	08-20-2020	0.00	0.00	3.00	0.00	0.00	0.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245039	NEILSON PLACE

Type of Survey (select all that apply):

A	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 35569			0.25	0.00	0.00	0.00	0.00	0.00
2. 42585	08-19-2020	08-20-2020	0.00	0.00	3.00	0.00	0.00	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245039	NEILSON PLACE

Type of Survey (select all that apply):

A	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 35569	08-19-2020	08-20-2020	0.25	0.00	2.00	0.00	0.00	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 12.00

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245039	NEILSON PLACE

Type of Survey (select all that apply):

H	I	K			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 36536	08-18-2020	08-18-2020	1.00	0.00	3.00	0.00	6.00	3.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 2.50

Total Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

Minnesota Department of Health: Protecting, maintaining improving the health of all Minnesotans.

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **08/17/20** To F2: **08/20/20**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **NEILSON PLACE**	Provider Number: **245039**	Fiscal Year ending:
Address: **1000 ANNE STREET NORTHWEST, BEMIDJI, BELTRAMI, MN 56601**		
Telephone Number: F6 **218-751-0220**	State/County Code: **MN / BELTRAMI**	State/Region Code: **MN / 05**
A. F9 **01 - Skilled Nursing Facility (SNF) - Medicare Participation** B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **05 - Non Profit - Nonprofit Corporation**		
Owned or leased by Multi-Facility Organization: F13 **No** Name of Multi-Facility Organization: F14		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0**	

Huntington's Disease F21 **0** Ventilator/Respiratory Care F22 **0** Other Spec Rehab. F23 **0**	
Does the facility currently have an organized resident group? F24	**Yes**
Does the facility currently have an organized group of family members of residents? F25	**No**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28 **NA**	Hours waived per week: F29 **NA**
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 **NA**	Hours waived per week: F31 **NA**

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

Name of Person Completing Form: **Adam Coe**	Date: **08/21/20**

- Share This

Spotlight

Minnesota eLicensing

Questions?

Please contact our Health Regulation Division: health.fpc-web@state.mn.us or 651-201-4101.

See also > Health Regulation

Minnesota Department of Health: Protecting, maintaining improving the health of all Minnesotans.

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

NEILSON PLACE				
Provider No. **245039**	Medicare F75 **11**	Medicaid F76 **42**	Other F77 **25**	Total Residents F78 **78**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **14**	F80 **39**	F81 **25**
Dressing	F82 **19**	F83 **57**	F84 **2**
Transferring	F85 **19**	F86 **45**	F87 **14**
Toilet Use	F88 **20**	F89 **52**	F90 **6**
Eating	F91 **43**	F92 **33**	F93 **2**

A. Bowel/Bladder Status	**B. Mobility**
F94 **6** With indwelling or external catheter. F95 Of total number of residents with catheters, **4** were present on admission.	F100 **1** Bedfast all or most of time.. F101 **40** In chair all or most of time. F102 **4** Independently ambulatory.

F96 **48** Occasionally or frequently incontinent of bladder.

F97 **34** Occasionally or frequently incontinent of bowel.

F98 **24** On individually written bladder training program.

F99 **2** On individually written bowel training program.

F103 **33** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **14** With contractures.

F107 Of total number of residents with contractures, **4** had contractures on admission.

C. Mental Status

F108 **1** With mental retardation.

F109 **31** With documentation signs and symptoms of depression.

F110 **22** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **36** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **20** With behavioral symptoms.

F113 **20** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **6** With pressure sores (exclude stage I).

F116 **3** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **62** Receiving preventive skin care.

F118 **3** With rashes.

E. Special Care

F119 **2** Receiving hospice care benefit.

F120 **1** Receiving radiation therapy.

F121 **1** Receiving chemotherapy.

F127 **0** Receiving suction.

F128 **24** Receiving injections (exclude vitamin B12 injections)

F129 **3** Receiving tube feedings.

F122 **2** Receiving dialysis. F123 **5** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion. F124 **16** Receiving respiratory treatment. F125 **0** Receiving tracheostomy care. F126 **0** Receiving ostomy care.	F130 **14** Receiving mechanically altered diets including pureed and all chopped food (not only meat). F131 **25** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy). F132 **7** Assistive devices while eating.

F. Medication	**G. Other**
F133 **52** Receiving any psychoactive medication. F134 **16** Receiving antipsychotic medications. F135 **8** Receiving antianxiety medications. F136 **47** Receiving antidepressant medications. F137 **0** Receiving hypnotic medication. F138 **10** Receiving antibiotics. F139 **63** On pain management program.	F140 **9** With unplanned significant weight loss/gain. F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language). F142 **0** Who use non-oral communicationdevices. F143 **57** With advance directives. F144 **58** Received influenza immunization. F145 **60** Received pneumococcal vaccine.

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Tammy Nelson	**MDS Coordinator**	**08/21/2020**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

- Share This

S5039033

MINNESOTA DEPARTMENT OF HEALTH
Health Regulation Division
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for Administrator: adam.coe@sanfordhealth.org

Administrator: ADAM COE

National Provider Identifier (NPI) Number: 1659376663
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: NEILSON PLACE City: BEMIDJI

Name of Legal Entity Operating Provider: SANFORD HEALTH OF NORTHERN MINNESOTA

Name and Address of Governing Board President:

Name: KAY MACK
Address: 2324 CARR LAKE RD SW
City/State/Zip: BEMIDJI, MN 56601

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: City:

Name of Legal Entity Operating Provider:

Name and Address of Governing Board President:

Name:
Address:
City/State/Zip:

SIGNATURE

Completed by: Adam Coe
Title: Administrator
Date: 8/18/2020

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245039	**NEILSON PLACE**	*K4 **08/18/2020**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

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

F5039030

2012 LIFE SAFETY CODE
Form Approved OMB Exempt

FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245039	K2

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Neilson Place	A. BUILDING 01 B. WING C. FLOOR K3	1000 Anne St Bemidji, MN	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
☑ MEDICARE ☑ MEDICAID	08/18/2020 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF
1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/IID UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW
1. ☑ ENTIRE FACILITY 2. ☐ DISTINCT PART OF (SPECIFY) _____

3. ☐ IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ☐ YES b. ☐ NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
78	na	78	78	na

7. A. (●) THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)
1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (●) ACCEPTANCE OF A PLAN OF CORRECTION 3. ☐ RECOMMENDED WAIVERS 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN
B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Sign)	TITLE	OFFICE	DATE
Robert Baermann	Deputy State Fire Marshal	Minnesota State Fire Marshal Division	8/19/20
SURVEYOR ID: 36536 K10			
FIRE AUTHORITY OFFICIAL (Signature)	TITLE Fire Safety Supervisor	OFFICE Minnesota State Fire Marshal Division	DATE 08-19-2020

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: • Requirements of Chapter 18 and 19. • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	**Sprinkler Requirements for Major Rehabilitation** If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	○	○	◉	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623	○	○	◉	
K132	**Multiple Occupancies – Contiguous Non-Health Care Occupancies** Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K133	**Multiple Occupancies – Construction Type** Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: • The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1. • The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3	○	○	◉	
K161	**Building Construction Type and Height** 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	◉	○	○	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.

		Construction Type	
1	◉	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered
2	○	II (111)	One story non-sprinklered Maximum 3 stories sprinklered
3	○	II (000)	Not allowed non-sprinklered Maximum 2 stories sprinklered
4	○	III (211)	
5	○	IV (2HH)	
6	○	V (111)	
7	○	III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered
8	○	V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7 18.1.6.4, 18.1.6.5	○	○	●	

		Construction Type	
1	○	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered
2	○	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered
3	○	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered
4	○	III (211)	
5	○	IV (2HH)	
6	○	V (111)	
7	○	III (200)	Not allowed non-sprinklered
8	○	V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

K162	**Roofing Systems Involving Combustibles** 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790	○	○	●	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	○	○	◉	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	◉	○	○	
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	◉	○	○	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	○	○	◉	
K222	**Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	◉	○	○	
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	○	○	◉	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	◉	○	○	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	○	○	◉	
K227	**Ramps and Other Exits** Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	○	○	◉	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	**Aisle, Corridor or Ramp Width** 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	◉	○	○	
	2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	○	○	◉	
K233	**Clear Width of Exit and Exit Access Doors** 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7	◉	○	○	
	2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7	○	○	◉	
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	**Dead-End Corridors and Common Path of Travel** 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2	○	○	◉	
K251	2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	○	○	◉	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	◉	○	○	
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	○	○	◉	
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	◉	○	○	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2	○	○	◉	
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room to room door less than or equal to 50 feet. 18.2.6, 19.2.6	◉	○	○	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	◉	○	○	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	◉	○	○	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	◉	○	○	
K292	**Life Support Means of Egress** 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	**Exit Signage** 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	
	2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	○	○	◉	
	SECTION 3 – PROTECTION				
K300	**Protection – Other** List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K311	**Vertical Openings – Enclosure** 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 *If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.* ☐	◉	○	○	
	2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	**Hazardous Areas – Enclosure** 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 19.3.2.1, 19.3.5.9	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☑	☑	☐
b. Laundries (larger than 100 sq. ft.)	☑	☑	☐
c. Repair, Maintenance, and Paint Shops	☑	☑	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☑	☑	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☑	☑	☐
f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)	☑	☑	☐
g. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☑

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	2012 NEW Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7		○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☐	☐	☐
b. Laundries (larger than 100 sq. ft.)	☐	☐	☐
c. Repair, Maintenance, and Paint Shops	☐	☐	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☐	☐	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☐	☐	☐
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)	☐	☐	☐
g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)	☐	☐	☐
h. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, *Standard on Fire Protection for Laboratories Using Chemicals*. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	◉	○	○	.
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	**Interior Wall and Ceiling Finish** 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 *Indicate flame spread rating(s).* A	◉	○	○	
	2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 *Indicate flame spread rating(s).* _____	○	○	◉	
K332	**Interior Floor Finish** 2012 NEW (Indicate N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	○	○	◉	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	◉	○	○	
K343	**Fire Alarm – Notification** 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)	◉	○	○	
	2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	○	○	◉	
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	◉	○	○	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	◉	○	○	
K347	**Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	◉	○	○	
	2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	**Sprinkler System – Installation** 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	◉	○	○	
	2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10	○	○	◉	
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 9/10/19 b) Who provided system test. Brothers c) Water system supply source. City of Main *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	○	◉	○	Observations revealed multiple sprinkler heads throughout the facility were covered with dust and dirt.
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	**Corridors – Construction of Walls** 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. *If the walls have a fire resistance rating, give the rating* smoke resistant *if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.* 19.3.6.2, 19.3.6.2.7	◉	○	○	
	2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	**Corridor – Doors** 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	◉	○	○	
	2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	◉	○	○	
K371	**Subdivision of Building Spaces – Smoke Compartments** 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	◉	○	○	
	2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) *Describe any mechanical smoke control system in REMARKS.*	◉	○	○	
	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 *Describe any mechanical smoke control system in REMARKS.*	○	○	◉	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	◉	○	○	
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	○	○	◉	
K379	**Smoke Barrier Door Glazing** 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5	◉	○	○	
	2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	○	○	◉	
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485	◉	○	○	
	SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	**High-Rise Buildings** 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2	○	○	◉	
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2	○	○	◉	
	SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	◉	○	○	
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	◉	○	○	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	○	○	◉	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	○	○	◉	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. • Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)	○	○	◉	
K531	**Elevators** 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	○	○	◉	
K532	**Escalators, Dumbwaiters, and Moving Walks** 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2	○	○	◉	
	2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	◉	○	○	
	2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82	○	○	◉	
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	◉	○	○	
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	◉	○	○	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6	◉	○	○	
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	◉	○	○	
K771	**Engineer Smoke Control Systems** 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7	○	○	◉	
	2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	○	○	◉	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	◉	○	○	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	◉	○	○	
K902	**Gas and Vacuum Piped Systems – Other** List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)	◉	○	○	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	◉	○	○	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	◉	○	○	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	◉	○	○	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	◉	○	○	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	◉	○	○	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	○	○	◉	
K911	**Electrical Systems – Other** List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	◉	○	○	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	○	○	◉	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	◉	○	○	
K915	**Electrical Systems – Essential Electric System Categories** ○ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ◉ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ○ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	◉	○	○	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	◉	○	○	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	○	◉	○	Documentation review revealed there was no record of a generator inspection for the week of May 25th.

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	**Electrical Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)	◉	○	○	
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	◉	○	○	
K922	**Gas Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	◉	○	○	
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	○	○	◉	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	◉	○	○	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	◉	○	○	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	◉	○	○	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	○	○	◉	
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	○	○	◉	
K932	**Features of Fire Protection – Other** List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 15 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99)	○	○	◉	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

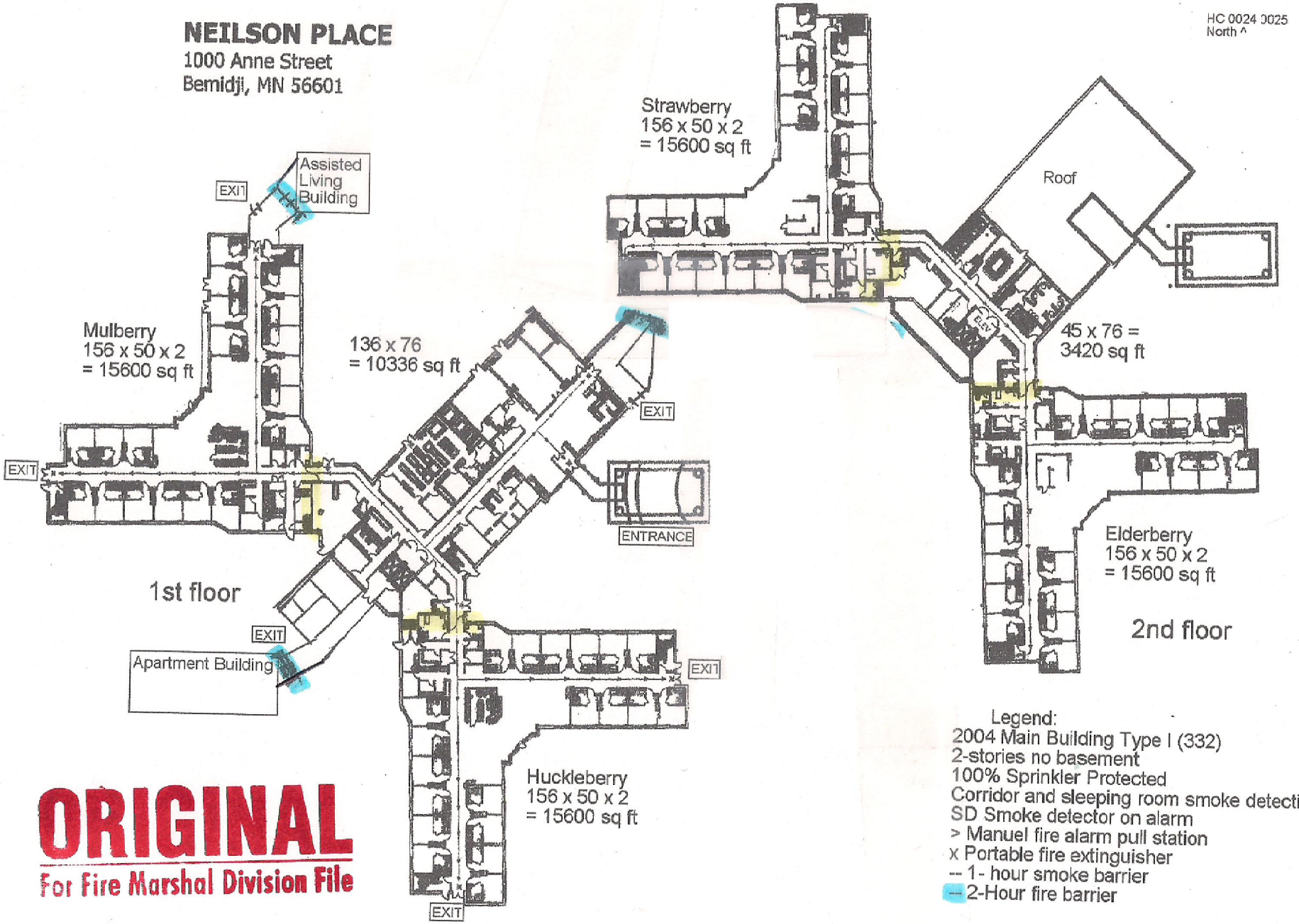
PROVISION NUMBER(S)	JUSTIFICATION
K400	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

NEILSON PLACE

1000 Anne Street
Bemidji, MN 56601

HC 0024 0025
North ^



Legend:
2004 Main Building Type I (332)
2-stories no basement
100% Sprinkler Protected
Corridor and sleeping room smoke detection
SD Smoke detector on alarm
> Manuel fire alarm pull station
x Portable fire extinguisher
-- 1- hour smoke barrier
— 2-Hour fire barrier

8-11

ORIGINAL
For Fire Marshal Division File

08/18/20 RWB

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5039030	Neilson PLace	08/18/20

Administrator: Adam Coe | Phone Number: 218-751-0220

Email address: adam.coe@sanfordhealth.org

State Fire Inspector: DSFM Robert Baumann, 612-430-1276, robert.baumann@state.mn.us

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

○ **At the time of this inspection, this facility was found to comply with the requirements of the 2012 Life Safety Code applicable to: ☐ SNF/NF ☐ Hospital ☐ ICFMR ☐ ASC Facilities participating in the Medicare/Medicaid programs.**

◉ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	◉ Draft Summary of Deficiency(ies) ○ Revisit ○ Clearance
K353 SS=F	Observations revealed multiple sprinkler heads throughout the facility were covered with dust and dirt.
K918 SS=F	Documentation review revealed there was no record of a generator inspection for the week of May 25th.